The Employment-Health Nexus:

Sufficiently Entrenched to Survive Healthcare-For-All

The coronavirus pandemic and ensuing unemployment crisis highlight a deep flaw in the United States' health insurance system. The employment-health nexus, or the connection between access to health insurance and employment status, means that as Americans lose their jobs in a pandemic-caused recession, they lose the very health insurance they needed for testing and treatment. The confluence of this pandemic and the 2020 presidential primaries' focus on healthcare foreshadows enormous changes to the health insurance system. This paper will show, however, that the connection between employment and health insurance is so deeply entrenched in American history and policy that it will inevitably survive even the most dramatic reforms.

While the next few years may bring about enormous changes to health insurance, employers will still play a large role in administering health insurance alongside or layered on top of a government-sponsored health insurance program. Given that this two-track insurance administration system is likely to endure, healthcare reformers and scholars should look to current regulatory frameworks to plan for regulatory and behavioral-economic issues that may arise. This paper examines several of the most popular healthcare reform plans and discusses how they might be implemented and regulated in a realistic manner. Ultimately, the best way to manage the gaps in coverage caused by the employment-health nexus will be for employers and the government to work together to provide comprehensive coverage for all Americans, no matter their employment status.

INTRODUCTION

The novel coronavirus pandemic and the ensuing unemployment crisis highlight the inadequacy of the United States healthcare system. Millions of Americans are un- or under-insured,[1] and early during the pandemic public health officials feared contagious COVID-19 victims were not being tested for lack of insurance.[2] Recent legislation ensuring coverage for testing of COVID-19 patients[3] underscores the inadequacy of our current health insurance system, and how lack of coverage may have contributed to the virus' spread. Thus far, legislation only mandates that costs of testing (not treatment)[4] will be covered by insurance plans. This limited legislation leaves uninsured Americans like Danni Askini, diagnosed and treated for COVID-19 in February and March of this year, on the hook for paying their coronavirus

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[1] Munira Z. Gunja & Sara R. Collins, *Who Are the Remaining Uninsured, and Why Do They Lack Coverage?*, THE COMMONWEALTH FUND (Aug. 28, 2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/who-are-remaining-uninsured-and-why-do-they-lack-coverage ("...in 2018, an estimated 30.4 million people were uninsured…"); *Underinsured Rate Rose From 2014-2018, With Greatest Growth Among People in Employer Health Plans*, THE COMMONWEALTH FUND (Feb. 7, 2019), https://www.commonwealthfund.org/press-release/2019/underinsured-rate-rose-2014-2018-greatest-growth-among-people-employer-health ("People who are "underinsured" have high health plan deductibles and out-of-pocket medical expenses relative to their income and are more likely to struggle paying medical bills or to skip care because of cost. Among adults who were insured all year, 29 percent were underinsured in 2018…")

[2] Reed Abelson & Sarah Kliff, *Waive Fees for Coronavirus Tests and Treatment, Health Experts Urge*, N.Y. TIMES (Mar. 3, 2020), https://www.nytimes.com/2020/03/03/health/coronavirus-tests-uninsured.html ("New York is among the first states in the country to waive some fees and expenses for people who undergo testing for the coronavirus, as public health officials are increasingly worried that medical bills will discourage the poor and uninsured from getting medical care.")

[3] Reed Abelson, *Now That Coronavirus Tests Are Free, Some Insurers Are Waiving Costs for Treatment*, N.Y. TIMES (Mar. 19, 2020), https://www.nytimes.com/2020/03/19/health/coronavirus-tests-bills.html ("Under the legislation just passed by Congress, testing for the coronavirus is free, as are the cost of a doctor's visit or trip to the emergency room to get the test. Worried that residents might hesitate because of the potential bills, many states, including California, New York and Washington, had already required the insurance companies they regulate to cover the cost of a test, according to a recent analysis from Georgetown University.")

[4] Anna Wilde Mathews, *What Will Coronavirus Testing and Treatment Cost Me?*, N.Y. TIMES (Mar. 22, 2020), https://www.wsj.com/articles/what-will-coronavirus-testing-and-treatment-cost-me-11584902030 ("For the uninsured, the new law doesn't include money to pay for Covid-19 treatment.") *But see* Kate Ashford, *What to Know About Coronavirus Testing and Treatment if You Have No Health Insurance*, HEALTH.COM (April 8, 2020), https://www.health.com/condition/infectious-diseases/coronavirus/coronavirus-testing-and-treatment-if-you-have-no-health-insurance (explaining that more funding may be on the way for COVID-19 treatment, writing "on April 3, the White House announced that it will be aiming $100 billion in emergency spending toward hospitals and health providers for treating uninsured coronavirus patients.")

treatment bills.[5] In Askini's case, those bills totaled over $34,000.[6] As the pandemic took hold and battered the United States economy, many newly unemployed people lost the insurance coverage they formally obtained through their employer.[7] As recently as May 2020, experts predicted that the approximately 31 million coronavirus layoffs would lead to an additional 6 million uninsured Americans.[8] The combination of a health and employment crisis implores critical study of the century-long link between health insurance and employment in America.

America's system of employer-sponsored health insurance is deeply entrenched. Watershed moments like the current pandemic, however, make it feel inevitable that change is in the air. For decades, reformers and scholars have argued about breaking the connection between

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[5] Abigail Abrams, *Total Cost of Her COVID-19 Treatment: $34,927.43*, TIME (Mar. 19, 2020), https://time.com/5806312/coronavirus-treatment-cost/.

[6] *Id.*

[7] Amy Goldstein, *First, the Coronavirus Pandemic Took Their Jobs. Then, it Wiped Out Their Health Insurance*, THE WASHINGTON POST (April 18, 2020), https://www.washingtonpost.com/health/first-the-coronavirus-pandemic-took-their-jobs-then-it-wiped-out-their-health-insurance/2020/04/18/1c2cb5bc-7d7c-11ea-8013-1b6da0e4a2b7_story.html ("Easley, out of a job and out of a health plan, and Health Right, swamped with new patients, represent[s] a ripple effect of the novel coronavirus sweeping the United States. In a nation where most health coverage is hinged to employment, the economy's vanishing jobs are wiping out insurance in the midst of a pandemic.")

[8] Sarah Hansard, *Premiums' Full Price May Leave 6 Million Without Health Coverage*, BLOOMBERG LAW (May 13, 2020), https://news.bloomberglaw.com/health-law-and-business/premiums-full-price-may-leave-6-million-without-health-coverage ("An estimated 26.8 million workers and dependents would become uninsured due to the loss of job-based coverage if they don't sign up for other coverage, the Kaiser [Family Foundation] said. Some 12.7 million are eligible for Medicaid and 8.4 million are eligible for ACA marketplace subsidies… But about 5.7 million people would be ineligible for ACA subsidies and would have to pay the full cost of coverage to avoid remaining uninsured. "Given their job losses, many won't be able to afford that," the foundation said.")

employment and health benefits.[9] Medicare for All and other recent reform proposals promise to break that link, but the conceptual promise of these proposals and the on-the-ground reality of their implementation are vastly different.

The recent 2019-2020 presidential primary campaign brought forth many detailed healthcare reform proposals, creating a repository of potential ways to retool the health insurance system. But each proposal ultimately struggled to uncouple health insurance from employment. All the proposals, including Sanders' Medicare for All, allow a private market to continue to exist for supplemental insurance, and it is likely employers will continue to play a significant role in the administration of that insurance. Many of the public option proposals allow for the employer-sponsored private market for insurance to continue alongside a more robust public government-sponsored option. While a consumer choice model allowing choice between an employer and a government plan is popular, it opens up many regulatory and behavioral-economic issues that will need careful navigation.

If the United States had the chance to do it all over, policymakers might not locate health insurance in the workplace. Now that we've come to rely on the system, it is complicated and imprudent to ditch it, at least fully. As this paper will show, the history of how Americans

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[9] Nicholas Drew, *Two Federally Subsidized Health Insurance Programs are One too Many: Reconsidering the Federal Income Tax Exclusion for Employer-sponsored Health Insurance in Light of the Patient Protection and Affordable Care Act*, 54 B.C. L. REV. 2047 (Nov. 2013) (arguing that employer based healthcare is undesirable because it produces both horizontal and vertical inequities and because it is a regressive benefit, rather than progressive); Uwe E. Reinhardt, *Employer-Based Health Insurance: A Balance Sheet*, 18 HEALTH AFF., Nov.-Dec. 1999, at 126, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.18.6.124 (arguing the employer-based health care system is flawed because of "unsurance", job lock, and inequity); Aaron E. Carroll, *The Real Reason the U.S. Has Employer-Sponsored Health Insurance*, N.Y. TIMES (Sept. 5, 2017), https://www.nytimes.com/2017/09/05/upshot/the-real-reason-the-us-has-employer-sponsored-health-insurance.html ("There are almost no economists I can think of who wouldn't favor decoupling insurance from employment.")

became reliant on employment for health insurance has led us into path dependence[10] on the employment-health nexus. Path-dependence theory suggests that history can lock people into certain habits and make systems resistant to change.[11] This theory as applied to reformers' attempts to unlock insurance access from employment status should inform realistic implementation of much-need reform.

Policymakers will need to grapple with the need for a private market to provide supplemental insurance. Additionally, as employer-sponsored coverage is so ingrained in American culture and most Americans are satisfied with their current coverage,[12] viable healthcare reform will likely allow for an element of consumer choice between employer- and government-sponsored plans. If a private market for insurance continues to exist alongside or layered atop of the government plan, budgetary pressures will encourage policymakers to shift as many costs to this private system. Decisions about who stays on an employer plan and who moves onto a government plan will raise complex, yet manageable, regulatory and behavioral hurdles. Policymakers should look to existing regulatory frameworks and rationales to plan how to address these issues. Ultimately, incremental reform is the wisest and most feasible option to improve and expand access to healthcare, both during this pandemic and beyond.

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[10] Oona A. Hathaway, *Path Dependence in the Law: The Course and Pattern of Legal Change in a Common Law System*, 86 IOWA L. REV 101, 104 ("... "path dependence" means that an outcome or decision is shaped in specific and systematic ways by the historical path leading to it. It entails, in other words, a causal relationship between stages in a temporal sequence, with each stage strongly influencing the direction of the following stage. At the most basic level, therefore, path dependence implies that "what happened at an earlier point in time will affect the possible outcomes of a sequence of events occurring at a later point in time.")

[11] *Id.* at 105 ("Applying path dependence theory to the law leads to both striking insights and troubling conclusions. It reveals, for example, that courts' early resolutions of legal issues can become locked-in and resistant to change.")

[12] Karen Pollitz et al, *What's The Role of Private Health Insurance Today and Under Medicare-for-all and Other Public Option Proposals?*, KAISER FAMILY FOUNDATION (July 30, 2019), https://www.kff.org/health-reform/issue-brief/whats-the-role-of-private-health-insurance-today-and-under-medicare-for-all-and-other-public-option-proposals/ ("...nearly seven in ten (68%) people with job-based coverage give their plan a grade of "A" or "B" and use words like "grateful" (72%) or "content" (69%) in describing how they feel about their insurance.")

This article will proceed in three parts. Part I will provide a historical overview of how the United States ended up with a health insurance system so dependent upon employers. Part I will also identify trends in the movement toward employer-sponsored healthcare to trace how those trends complicate the disruption of the employment-health nexus. Part II will explain how a two-track insurance system, administered by both the government and employers, will inevitably continue under any of the proposed healthcare reforms. This part will identify several complex issues arising out of this two-track system and look to existing regulatory and behavioral-economic guidelines to navigate these complexities. Part III will summarize the proposals of how to manage the challenges discussed in Part II, as well as question the proposition that the employment-health nexus should be broken in the first place.

I. PATH-DEPENDENCE ON EMPLOYERS FOR HEALTH INSURANCE: HOW WE GOT HERE

America's employment-health nexus stems from the historical context in which it developed. Early American interest groups' rejection of the European model of government-sponsored health insurance in the early 1900s led government-sponsored health insurance to take a back seat to other reforms and social welfare programs. The rise of anti-socialist and Red Scare sentiment, followed by WWII era wage controls and the rise of union collective bargaining allowed employers to swoop into a vacuum in the private insurance market and become the predominant issuer of health insurance. Finally, 1950s tax code revisions that bestowed

beneficial tax treatment on employee benefits cemented the employment-health nexus where the vast plurality of Americans receive their health care from work.[13]

While European governments like Germany, Austria, Norway, and Great Britain developed government-sponsored health care systems by the early 20th century (Germany was first in 1883, Austria in 1888, Norway in 1909, Britain in 1912), the United States was slow to contemplate adopting a government-based system.[14] American progressive reformers and some union leaders began to push for a government-based health insurance system in the years leading up to World War I, but without the support of strong political leaders (in Germany, healthcare reformers received support from Otto von Bismarck, and in Great Britain from David Lloyd George)[15] these American fringe reformers were unsuccessful in achieving their goals.[16]

Additionally, the United States' political climate at the time was very different than that of Germany under Bismarck or Great Britain under George. Both of those leaders saw health insurance and other government safety-net programs as defensive programs to stabilize political order by providing the working class with welfare benefits.[17] By extending valuable healthcare

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[13] *Health Insurance Coverage of the Total Population,* KAISER FAMILY FOUNDATION, https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (finding that 49% of Americans receive health insurance from work, with the next most common being Medicaid, 20%, and Medicare, 14%).

[14] PAUL STARR, SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 237 (Basic Books, Inc., 1982).

[15] *Id*. at 239.

[16] *Id*. at 257.

[17] *Id*. at 239.

benefits to their citizens, leaders like Bismarck and Lloyd George hoped to stave off a political revolution by influential socialists within their countries.[18]

While the United States certainly had its political problems during the late 19th and early 20th century, its political system was much more stable and entrenched in capitalistic democracy. At the height of the Socialist Party's power in the United States, the 1912 election, the party still only received 6% of the vote.[19] At the time, the American government was highly decentralized and engaged in little direct regulation of the economy or social welfare.

Even during the Progressive Era, when Teddy Roosevelt's Progressive Party platform included a line supporting social insurance, Roosevelt himself never actually addressed health insurance.[20] The understanding at the time was that those issues were the responsibility of the states, not the federal government, and any such legislation would have been overturned by the Supreme Court.[21] There simply was not the same political need nor political apparatus to design, implement, and administer a government-run national health insurance program.

Of course, the United States did eventually face the type of economic and political instability that led to the direct government regulation and social welfare practiced in Europe-namely, the Great Depression. By that time, however, a strong coalition of labor and doctors had

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[18] Karen S. Palmer, *A Brief History: Universal Health Care Efforts in the US*, PNHP, https://pnhp.org/a-brief-history-universal-health-care-efforts-in-the-us/ [https://perma.cc/EH54-LVE6] (last visited April 13, 2020) ("In a seeming paradox, the British and German systems were developed by the more conservative governments in power, specifically as a defense to counter expansion of the socialist and labor parties. They used insurance against the cost of sickness as a way of 'turning benevolence to power'.")

[19] *1912 Electoral Vote Tally, February 12, 1913*, THE CENTER FOR LEGISLATIVE ARCHIVES, https://www.archives.gov/legislative/features/1912-election [https://perma.cc/B5E9-5D6K] (last updated Aug. 15, 2016).

[20] PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 30 (Yale Univ. Press, 2011).

[21] *Id*.

coalesced to oppose a government-run health care system.[22] While many in those groups had been more open to government-sponsored health insurance in the early 1900s, by the 1930s these interest groups had seen the impacts of nationalized health care in Europe and felt the effects of other forms of government-funded insurance programs like workers compensation, and had, for the most part, turned against the idea of nationalized health care.[23]

Many labor leaders saw nationalized health insurance as a threat to labor's existence.[24] Rather than supporting government-sponsored health care as labor had in Europe, many labor leaders worked to quash it.[25] These labor leaders opposed a national healthcare system out of concern it would erode the incentive to join a union and "usurp their role in providing social benefits."[26] Doctors, organized into the American Medical Association ("AMA"), lobbied against government-sponsored insurance as an income-preservation technique.[27] They feared the government would follow the European trend away from the traditional fee-for-service model and to the capitation model (where doctors competed for contracts to care for groups on a per

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[22] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 249-251, 260-261 (Basic Books, Inc., 1982).

[23] *Id*. at 256.

[24] *Id*. at 249 ("He [Samuel Gompers] worried that a government insurance system would weaken unions by usurping their role in providing social benefits.")

[25] Karen S. Palmer, *A Brief History: Universal Health Care Efforts in the US*, PNHPhttps://pnhp.org/a-brief-history-universal-health-care-efforts-in-the-us/ [https://perma.cc/EH54-LVE6] (last visited April 13, 2020) ("They apparently worried that a government-based insurance system would weaken unions by usurping their role in providing social benefits. Their central concern was maintaining union strength…")

[26] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN Medicine 249 (Basic Books, Inc., 1982) ("He [Samuel Gompers] worried that a government insurance system would weaken unions by usurping their role in providing social benefits.")

[27] *Id*. at 260-261.

capita basis), which drove down physician income.[28] Additionally, doctors' experience with workers-compensation insurance had taught them that government-sponsored insurance would "like nothing better than to pay them as little as possible."[29]

Not only did significant portions of labor and doctors unite against government-sponsored health insurance, but the US government's propaganda bureau also turned a significant portion of the public against nationalized health insurance. For example, during WWI the United States propaganda bureau commissioned articles denouncing Germany's health care system, labeling it "a Prussian menace inconsistent with American values."[30] During the Red Scare following WWI that lasted through the 1920s, opponents of national healthcare tied the issue to Bolshevism and "buried it in an avalanche of anti-Communist rhetoric".[31]

With the knowledge that many Americans, especially those with powerful voices, had coalesced against the idea of nationalized health insurance, Franklin Roosevelt's New Deal programs in the 1930s side-stepped the issue. Abraham Epstein, one of FDR's Social Security advisors, advised him to "be politically realistic and … go slow on health insurance because of the opposition it would arouse."[32] With so many Americans out of work, other forms of

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[28] *Id*. at 248.

[29] *Id*. at 256.

[30] *Id*. at 253.

[31] Karen S. Palmer, *A Brief History: Universal Health Care Efforts in the US*, PNHP, https://pnhp.org/a-brief-history-universal-health-care-efforts-in-the-us/ [https://perma.cc/EH54-LVE6] (last visited April 13, 2020)

[32] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN Medicine 267 (Basic Books, Inc., 1982)

insurance took priority, such as unemployment insurance and old-age benefits.[33] When FDR set up his Committee on Economic Security to propose new forms of government insurance programs, the "prevailing sentiment" on the Committee was that "health insurance would have to wait", and "that medical society opposition precluded any action on health insurance."[34] FDR took this advice. When composing and passing the Social Security Act in 1935 he intentionally excluded the healthcare issue from the plan because it was politically unpopular.[35]

Although the government was unwilling or unable to provide health insurance, the need for some large scale health insurance program grew as the costs of medical care increased dramatically throughout the first half of the 20th century.[36] Strict licensing laws for doctors increased the educational requirements for medical education and ultimately restricted the number of physicians available to provide necessary medical care.[37] Physicians increased their fees and incomes, which then increased the medical profession's resistance to government regulation and/or involvement in the healthcare system through insurance.[38] Additionally, innovations in medical research led to an expansion and transformation of American hospitals,

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[33] Karen S. Palmer, *A Brief History: Universal Health Care Efforts in the US*, PNHP, https://pnhp.org/a-brief-history-universal-health-care-efforts-in-the-us/ [https://perma.cc/EH54-LVE6] (last visited April 13, 2020) ("We might have thought the Great Depression would create the perfect conditions for passing compulsory health insurance in the US, but with millions out of work, unemployment insurance took priority followed by old age benefits.")

[34] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 267 (Basic Books, Inc., 1982)

[35] Akilah Johnson, *Medicare-for-All Is Not Medicare, and Not Really for All. So What Does It Actually Mean?*, PROPUBLICA (Sept. 6, 2019), https://www.propublica.org/article/medicare-for-all-is-not-medicare-and-not-really-for-all-so-what-does-it-actually-mean

[36] PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 36 (Yale Univ. Press, 2011)

[37] *Id*.

[38] *Id*. at 36-37.

which led routine medical care to become less affordable even for middle-class families.[39] As fewer Americans could afford care, more hospitals started creating insurance plans.[40]

In the absence of government action in the face of rising health care costs, employers, some of whom had already been offering basic sickness and medical service plans,[41] seized the opportunity to provide an attractive benefit to workers. America's entrance into WWII led to a federally mandated wage freeze in an attempt to deal with war-time inflation.[42] Health benefits, however, were not classified as wages.[43] As such, while employers could not entice higher-quality workers by offering higher wages, they could offer more competitive benefit packages, including health insurance.[44] Additionally, by offering and enrolling all their employees in health insurance plans, employers were able to avoid some of the insurance problems faced by the private market, including adverse selection (everyone enrolled, regardless of health status), high administrative overhead (employers simply deducted premiums from paychecks, rather than incur high acquisition and collections costs),[45] and affordability of premiums (employers tended to have large risk pools, where healthy and young employees offset and cross subsidized the cost

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[39] *Id*. at 37.

[40] *Id*.

[41] EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK, at ch. 2 (Marilyn J. Field & Harold T. Shapiro eds., Nat'l Academies Press, 1993), available at https://www.ncbi.nlm.nih.gov/books/NBK235989/ ("Employment-related medical programs occasionally covered not only work-related injuries but also general medical care for workers, their families, and even the larger community ... In the early part of this century, company medical services could be one component of "welfare capitalism," a range of housing, education, social assistance, and other programs intended to socialize workers, bind them to their employer, and discourage unions.")

[42] David A. Hyman and Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 23, 25

[43] *Id*.

[44] *Id*.

[45] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 311 (Basic Books, Inc., 1982)

of insuring older and less healthy employees.[46]) Within one year of the War Labor Board's decision that fringe benefits, such as health care, were not considered inflationary wages subject to government price controls, total enrollment in private "group hospital plans" increased from 7 to 26 million, which represented one-fifth of the population at the time.[47]

As health insurance began to fall under the umbrella of fringe benefits offered by employers, unions began to negotiate for more comprehensive benefits packages. The Supreme Court's 1947 ruling in *Inland Steel* that benefit plans came within "conditions of employment" negotiable by unions led to further expansions of employer-sponsored health benefits.[48] By 1954, unions negotiated one-fourth of the health insurance purchased in the United States.[49]

One of the aspects that unions commonly bargained for was an employer contribution to help cover additional costs of insurance in addition to offering a package of insurance benefits.[50] As a result, employers became more invested in controlling the costs of healthcare, since they became committed to pay for a level of benefits, no matter the cost.[51] This interest would later become one of the most salient elements in the politics of American health care.

Finally, the 1954 amendments to the Internal Revenue Code served as the final boon for employer-sponsored insurance. These amendments confirmed that employers' contributions to

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[46] Uwe E. Reinhardt, *Employer-Based Health Insurance: A Balance Sheet*, 18 HEALTH AFF. 124, 125 (Nov.-Dec. 1999) https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.18.6.124

[47] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 311 (Basic Books, Inc., 1982)

[48] *Id*. at 313.

[49] *Id*.

[50] *Id*. at 314.

[51] *Id*. at 314-315.

health benefit plans were tax-exempt, further incentivizing workers to seek to obtain health benefits from their employers, as they could effectively purchase them with pre-tax dollars.[52][53]

As health insurance became more enticing to workers, more companies began to offer competitive health insurance benefits. By 1958, nearly two-thirds of the American population had some form of coverage for hospital costs, the most common form of health insurance at the time.[54] The employment-health nexus was complete -- a family's chance for having health insurance coverage was directly proportional to their employment status. A family with a fully-employed primary earner had a 78% chance of having insurance. If the primary earner was only temporarily employed, the chances dropped to 36%. If the primary earner was disabled, chances of insurance dropped to 29%.[55] American reliance on employment for health insurance began to lock-in. The employment-health nexus has resisted change ever since.

The cooperation of labor and employers in obtaining employer-sponsored health insurance satisfied many of the prior objections to government-sponsored health care. Labor showcased its usefulness for its members. Employers used health insurance benefits as a

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[52] David A. Hyman and Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 23, 25-26 ("In effect, this asymmetric tax treatment allows employers to purchase health insurance for their employees using employees' before-tax income, rather than forcing employees to purchase it themselves with after-tax income. The amount of the subsidy is a function of the marginal tax rate for any given taxpayer, but its size is larger for higher-income taxpayers because of the progressivity of federal taxation. In the aggregate, this subsidy is worth more than $100 billion in foregone tax revenue per year, and is the second largest tax expenditure, after home mortgage interest. The result is a substantial financial incentive for employees to obtain coverage through their employer if at all possible.")

[53] The alternative to receiving benefits from the employer would be to purchase health insurance privately out of an employee's own pocket, with his own post-tax dollars, rather than receive a slightly lower taxable salary from the employer and non-taxable in-kind benefits. In practice, this tax imbalance could be rectified by allowing for above-the-line deductions of health care costs when filing income taxes, but practical tax law suggestions are saved for Parts II and III of this article.

[54] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 334 (Basic Books, Inc., 1982)

[55] *Id*.

recruiting tool, competing on benefits during times they could not compete on wages.[56] The AMA, the largest and most influential professional association of American doctors, succeeded in limiting the government's regulation of and oversight of the profession and its rising costs (and their corresponding rising incomes.)[57] Employer-sponsored health insurance did not satisfy every American's need for health care coverage, however. The employment-health nexus left out some groups lacking political power:[58] the unemployed, retired, and disabled people. These groups were often worse off than before due to the inflationary effect that employer-sponsored insurance had on the overall costs of healthcare.[59] Their lack of political power prevented large-scale resistance to the status quo for many years.

II. CHALLENGES TO SEVERING THE EMPLOYMENT-HEALTH NEXUS

Health care reform has been at the heart of American presidential elections for decades, well before the coronavirus pandemic. It was only in the 2019-2020 presidential primary races, however, that the policy of Medicare for All has been featured front and center.[60] Medicare for All was the topic of the first question at the second Democratic debate in 2019 and the ensuing

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[56] *Id*. at 333.

[57] PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 32-33 (Yale Univ. Press, 2011)

[58] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 334 (Basic Books, Inc., 1982)

[59] *Id*. at 333.

[60] Adam Cancryn,The Army Built to Fight 'Medicare for All', POLITICO (Nov. 25, 2019), https://www.politico.com/news/agenda/2019/11/25/medicare-for-all-lobbying-072110 ("As recently as a year earlier, Medicare for All was little more than a progressive pipe dream, a policy proposal dismissed in most Democratic circles as pure fantasy. Yet suddenly it had leaped from the fringes into the center of the conversation, urged on by the party's progressive base and increasingly embraced by leading Democrats.")

discussion lasted more than 20 minutes.[61] Two of the initial front-runners for the Democratic nomination, Bernie Sanders and Elizabeth Warren, both proposed Medicare for All legislation promising to upend the employment-health nexus and shift health insurance from employer-sponsored to single-payer and entirely government-sponsored.[62] More centrist candidates, while shying away from endorsing a true Medicare for All that would curtail or shut down private insurance companies, proposed detailed public option plans purporting to reform America's relationship with health insurance.[63] While we do not know which, if any, of the plans will ultimately become law, they provide a starting point for policymakers to sift through and build off of as they rethink unlocking health insurance's dependence on employment.

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[61] Akilah Johnson, *Medicare-for-All Is Not Medicare, and Not Really for All. So What Does It Actually Mean?*, PROPUBLICA (Sept. 6, 2019), https://www.propublica.org/article/medicare-for-all-is-not-medicare-and-not-really-for-all-so-what-does-it-actually-mean

[62] Elizabeth Warren, *My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All*, ELIZABETHWARREN.COM, last accessed Mar. 5, 2020, https://elizabethwarren.com/plans/m4a-transition [https://perma.cc/L3LW-W4JJ] (detailing Elizabeth Warren's Medicare for All proposal); Medicare for All Act of 2019, S.1129, 116th Cong. (2019), available at https://www.congress.gov/bill/116th-congress/senate-bill/1129/text (reporting the text of Bernie Sanders 2019 Medicare for All bill)

[63] For a summary of Senator Joe Biden's plan, *see Health Care*, JOEBIDEN.COM, https://joebiden.com/healthcare/ [https://perma.cc/U7R8-K795] (last visited May 6, 2020). For a summary of Senator Kamala Harris' plan, *see* Kamala Harris, *My Plan for Medicare for All*, MEDIUM (July 29, 2019) (https://medium.com/@KamalaHarris/my-plan-for-medicare-for-all-7730370dd421 [https://perma.cc/82EX-Q84G]. For a summary of Mayor Pete Buttigieg's plan, *see* Dan Merica & Tami Luhby, *Buttigieg Outlines Middle-of-the-Road Approach to Health Care in New Plan*, CNN (Sept. 19, 2019), https://www.cnn.com/2019/09/19/politics/pete-buttigieg-health-care-plan/index.html. *See also* Clarrie Feinstein & Joseph Zeballos-Roig, *Bernie Sanders Just Cemented his Frontrunner Status with a Huge Victory in Nevada. Here's How his Medicare for All Plan would Remake the $3.6 Trillion US Healthcare Industry*, BUSINESS INSIDER (Feb. 23, 2020), https://www.businessinsider.com/how-medicare-for-all-would-affect-us-healthcare-system-2019-8 ("Moderate candidates like former Vice President Joe Biden and former South Bend Mayor Pete Buttigieg would preserve the current system. And they would create an optional government insurance plan — commonly known as the public option — and inject more federal subsidies into the state exchanges set up under the Affordable Care Act.")

Both Sanders'[64] and Warren's[65] campaigns released hundreds of pages detailing how Medicare for All would work. Sanders' plan was light on the exact funding details,[66] but Warren's campaign released extensive detail on how she would fund[67] Medicare for All. Warren's plan extensively details one path to transitioning the American health care system off of employer-sponsored coverage and onto government-sponsored coverage.

Warren's plan included a public option as part of the necessary transition from the current system, where a plurality of Americans receive health insurance from their employer, to a true Medicare for All, where all Americans would receive insurance from the government.[68] Sanders also hinted at a multi-year transition period with a public option, though he never spoke about it openly on the campaign trail.[69] Warren proposed an option that would last for approximately two

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[64] For the text of Sanders Medicare for all bill, *see* Medicare for All Act of 2019, S.1129, 116th Cong. (2019), available at https://www.congress.gov/bill/116th-congress/senate-bill/1129/text#toc-idF335B3FF5174480D932838EA6641DB1E . For the campaign website summarizing his Medicare for All plan, *see Bernie Sanders on Healthcare,* FEELTHEBERN.ORG, https://feelthebern.org/bernie-sanders-on-healthcare/ [https://perma.cc/TGZ9-QPBV] (last visited Mar. 5, 2020).

[65] Elizabeth Warren, *My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All*, ELIZABETHWARREN.COM, https://elizabethwarren.com/plans/m4a-transition [https://perma.cc/L3LW-W4JJ] (last visited Mar. 5, 2020).

[66] *Options to Finance Medicare for All*, SANDERS.SENATE.GOV, https://www.sanders.senate.gov/download/options-to-finance-medicare-for-all?inline=file [https://perma.cc/C33B-5YFX] (last visited Mar. 5, 2020) ("As the wealthiest country in the world, we have a variety of options available to support a Medicare for All single-payer health care system... This paper
explains just some of the policies that could provide revenue to finance Medicare for All.")

[67] Elizabeth Warren, *Ending the Stranglehold of Health Care Costs on American Families*, ELIZABETHWARREN.COM, https://elizabethwarren.com/plans/paying-for-m4a [https://perma.cc/L3LW-W4JJ] (last visited Mar.6, 2020).

[68] Elizabeth Warren, *My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All*, ELIZABETHWARREN.COM, https://elizabethwarren.com/plans/m4a-transition [https://perma.cc/L3LW-W4JJ] (last visited Mar. 5, 2020) ("There are many proposals that call themselves a Medicare for All "public option"...My approach is different.... I can also fund a true Medicare for All option.")

[69] *Options to Finance Medicare for All*, SANDERS.SENATE.GOV, https://www.sanders.senate.gov/download/options-to-finance-medicare-for-all?inline=file [https://perma.cc/C33B-5YFX] (last visited Mar. 5, 2020) ("During the four-year transition period to guarantee health care as a right, millions of workers will have the option to transfer from their employer-provided health care to the new Medicare for All system.")

years, with Medicare for All coexisting alongside private employer-sponsored insurance.[70] Note, however, that under Warren's plan, even once the transition to Medicare for All was complete, a small private market for insurance would still exist for workers who had negotiated for healthcare coverage under collective bargaining agreements.[71]

Other former presidential candidates, as well as leaders in the House of Representatives and Congress, proposed alternative "public option" plans. These plans would maintain the current system of employer-sponsored health care and allow for private insurance companies to co-exist alongside a more robust and affordable government-sponsored option for health insurance.[72] Many of these politicians have released extensive reports and bills outlining the

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[70] Clarrie Feinstein & Joseph Zeballos-Roig, *Bernie Sanders Just Cemented his Frontrunner Status with a Huge Victory in Nevada. Here's How his Medicare for All Plan would Remake the $3.6 Trillion US Healthcare Industry*, BUSINESS INSIDER (Feb. 23, 2020), https://www.businessinsider.com/how-medicare-for-all-would-affect-us-healthcare-system-2019-8 ("Warren unveiled her own plan last year that's projected to cost $20.5 trillion over ten years, and mirrors Sanders in many ways. But she has pledged to pursue a public option first and then pass Medicare for All through Congress in the third year of her presidency.")

[71] Elizabeth Warren, *My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All*, ELIZABETHWARREN.COM, https://elizabethwarren.com/plans/m4a-transition [https://perma.cc/L3LW-W4JJ] (last visited Mar. 5, 2020) ("[F]or unions that seek specialized wraparound coverage and individuals with specialized needs, a private market could still exist. In addition, we can allow private employer coverage that reflects the outcome of a collective bargaining agreement to be grandfathered into the new system…")

[72] Kamala Harris, *My Plan for Medicare for All*, MEDIUM (July 29, 2019) (https://medium.com/@KamalaHarris/my-plan-for-medicare-for-all-7730370dd421 [https://perma.cc/82EX-Q84G] (detailing Senator Kamala Harris, former candidate for the Democratic nomination, public option healthcare proposal); For a side-by-side comparison of the Medicare for All proposals with the public option proposals, *see Compare Medicare-for-all and Public Plan Proposals*, KAISER FAMILY FOUNDATION (May 15, 2019) https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/?gclid=Cj0KCQiAkePyBRCEARIsAMy5SctRXziPtrEzy89TePHx1tieQIq0wKN5nDmswvgyzksLlAgYTTkCvWkaAvMzEALw_wcB; for a chart comparing where various presidential candidates stand on Medicare for All, *see* Akilah Johnson, *Medicare-for-All Is Not Medicare, and Not Really for All. So What Does It Actually Mean?*, PROPUBLICA (Sept. 6, 2019), https://www.propublica.org/article/medicare-for-all-is-not-medicare-and-not-really-for-all-so-what-does-it-actually-mean

details of their plans, allowing for critical analysis of their plans' claims.[73] No matter the type of reform proposed, candidates universally derided the tight link between employment status and healthcare options.[74] The fact that access to healthcare so often rests on employment status feels all the more unsustainable in the face of the coronavirus and ensuing unemployment crisis.

Yet, severing the century-long tie between employment and healthcare in the United States is easier said than done. Specifically, this Part identifies multiple complexities that make it difficult and perhaps unnecessary to sever the employment-health nexus altogether.

A. Private Supplemental Insurance is Inevitable and Employers Will Play an Important Role in Providing It

First, even with a more robust Medicare for All style reform, supplemental insurance will likely continue and might be most easily administered at the employer level. The public option proposals allow for a private market to exist indefinitely alongside a government insurance program. Medicare for All, as proposed by Sanders and Warren, both plan to gradually eliminate

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[73] Elizabeth Warren, *My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All*, ELIZABETHWARREN.COM, https://elizabethwarren.com/plans/m4a-transition [https://perma.cc/L3LW-W4JJ] (last visited Mar. 5, 2020) (detailing Elizabeth Warren's Medicare for All proposal); Medicare for All Act of 2019, H.R.1384, 116th Cong. (2019) https://www.congress.gov/bill/116th-congress/house-bill/1384/text (detailing Congresswoman Jayapal's Medicare for All bill); *The Medicare for America Act of 2019*, DELAURO.HOUSE.GOV, https://delauro.house.gov/sites/delauro.house.gov/files/Medicare%20for%20America%20of%202019%20Summary.pdf (last visited May 6, 2020) (summarizing congresswoman DeLauro's public option plan);

[74] *Bernie Sanders on Healthcare,* FEELTHEBERN.ORG, https://feelthebern.org/bernie-sanders-on-healthcare/ [https://perma.cc/TGZ9-QPBV] (characterizing Sanders' plan as one that will "[e]mpower [p]eople" by "[s]eparat[ing] health coverage from employment" and stating "insurance would no longer be tied to employment, so if you lose your job, you don't have to worry about losing your healthcare. And if you hate your job and want to quit, you can do so without losing your healthcare coverage."); Senator Kamala Harris, *July 31 Democratic Presidential Debate*, https://www.nbcnews.com/politics/2020-election/democratic-debate-transcript-july-31-2019-n1038016 ("I have met so many Americans who stick to a job that they do not like, where they are not prospering simply because they need the healthcare that that employer provides. It's time that we separate employers from the kind of healthcare people get…"); Presidential candidate Andrew Yang, *July 31 Democratic Presidential Debate*, https://www.nbcnews.com/politics/2020-election/democratic-debate-transcript-july-31-2019-n1038016 ("As someone who's run a business, I can tell you flat out our current health care system makes it harder to hire, it makes it harder to treat people well and give them benefits and treat them as full-time employees, it makes it harder to switch jobs...look, we're going to get health care off the backs of businesses…")

the private market for health insurance.[75] As much as Sanders and Warren deride private insurance companies,[76] however, their plans allow private insurers to continue to exist, albeit in a much smaller role.[77] Additionally, no version of Medicare for All that could ever pass through Congress and the Congressional Budget Office will be as comprehensive as what they propose. There will be room, and a need, for supplemental insurance. Because of path-dependence on the employment-health nexus, Americans will look to their employers to be the sponsors of this supplemental insurance.

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[75] Elizabeth Warren, *My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All*, ELIZABETHWARREN.COM, https://elizabethwarren.com/plans/m4a-transition [https://perma.cc/L3LW-W4JJ] (last visited Mar. 5, 2020) (stating that Medicare for All will coexist alongside employer-sponsored insurance for approximately two years, before transitioning to a Medicare for All as the sole provider of coverage, but allowing a small private market to continue to provide health insurance for workers in unions who collectively bargained for their health benefits.)

[76] Jake Johnson, *Pramila Jayapal Frustrated by Democrats Using Medicare for All Label to Push Plans 'That Are Not Medicare for All',* COMMON DREAMS (July 31, 2019), https://www.commondreams.org/news/2019/07/31/pramila-jayapal-frustrated-democrats-using-medicare-all-label-push-plans-are-not ("'If you want stability in the healthcare system, if you want a system which gives you freedom of choice with regard to a doctor or a hospital, which is a system which will not bankrupt you," said Sanders, "the answer is to get rid of the profiteering of the drug companies and the insurance companies [and] move to Medicare for All.'"); *Senator Bernie Sanders Says He Is "Not Anti-China"*, YOUTUBE, May 28, 2019, at 1:34, https://www.youtube.com/watch?time_continue=96&v=sMUcjLKqh34&feature=emb_logo ("I think there is a profound disgust at a healthcare system which is by far the most expensive in the world… where we have 34 million people without any health insurance… where you have insurance companies and drug companies making billions and billions of dollars in profit, paying their CEO's outrageous compensation packages…"); *Sen. Elizabeth Warren pitches her Medicare-for-All plan*, YOUTUBE, Nov. 1, 2019, at 6:33 ("That's the role I think government ought to play. It shouldn't be on the side of giant insurance companies and protecting their profits… it ought to be on the side of the American people.")

[77] Jeff Spros, *No One Really Wants to Ban All Private Insurance. Not Even Bernie Sanders*, THE WEEK (July 3, 2019), https://theweek.com/articles/850638/no-really-wants-ban-all-private-insurance-not-even-bernie-sanders ("Sanders' Medicare-for-all bill doesn't ban private health insurance. What it does ban is any private health coverage that duplicates the coverage offered by the government.")

1. Room (and Need) for Supplemental Insurance

Both Sanders'[78] and Warren's[79] plans explicitly allow private insurance companies to offer supplemental insurance for individuals to layer on top of their government-sponsored insurance.[80] Sanders' bill even specifically mentions employers as possible providers of that insurance benefit.[81] While Sanders and Warren's Medicare for All plans promise extremely comprehensive coverage, the likelihood is that many Americans will continue to get supplemental insurance. Both out of force of habit, and because of the tax-beneficial treatment of employee benefits, Americans will likely turn to their employers for supplemental insurance, continuing the century-long employment-health connection.

If Sanders' or Warren's vision for Medicare for All could truly pass the bicameral legislature and become law, supplemental insurance might not be very useful. The blueprint for

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[78] Karen Pollitz & Tricia Neuman, *What's The Role of Private Health Insurance Today and Under Medicare-for-all and Other Public Option Proposals?*, KAISER FAMILY FOUNDATION (July 30, 2019) ("… under the Sanders bill, there could also be a continued role for private insurance to cover or defray the cost of care for people who can afford to privately contract for medical care.")

[79] Elizabeth Warren, *My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All*, ELIZABETHWARREN.COM, https://elizabethwarren.com/plans/m4a-transition [https://perma.cc/L3LW-W4JJ] (last visited Mar. 5, 2020) ("Per the terms of the Medicare for All Act, supplemental private insurance that doesn't duplicate the benefits of Medicare for All would still be available.")

[80] In the interest of brevity, this article will not be analyzing Congresswoman Jayapal's Medicare for All bill, which is very similar in substance to Sanders'. Her bill also allows for employers to provide supplemental insurance that is not duplicative to the insurance provided under Medicare for All. Katie Keith, *Unpacking The House Medicare-For-All Bill*, HEALTH AFFAIRS (March 3, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190302.150578/full/ ("Insurers and employers could still offer coverage of additional benefits that are not covered under M4A [Medicare for All]".)

[81] Medicare for All Act of 2019, S.1129, 116th Cong. §107(b) (2019) ("Nothing in this Act shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this Act, including additional benefits that an employer may provide to employees or their dependents, or to former employees or their dependents.")

Medicare for All proposed by Sanders and endorsed by Warren,[82] seems to provide all the coverage imaginable,[83] leaving not much in the way of medical services covered by non-duplicative supplemental insurance.[84] In an interview with CBS, Sanders suggested that one of the only uses for supplemental insurance would be for plastic surgery,[85] implying that the need and market for private insurers in the supplemental market would be minuscule. As this article discusses below, however, it is unlikely and probably politically impossible that an eventual Medicare for All plan would cover much more than what other countries' government plans cover, which are much more similar to what is currently covered under Medicare.

For comparison's sake, current Medicare beneficiaries certainly purchase a lot of supplemental health insurance. As of 2007, the average Medicare beneficiary covered 45% of his/her medical expenses out of pocket. Medigap, one of the most common forms of today's

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[82] Elizabeth Warren, *My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All*, ELIZABETHWARREN.COM, https://elizabethwarren.com/plans/m4a-transition [https://perma.cc/L3LW-W4JJ] (last visited Mar. 5, 2020) ("the benefits of the true Medicare for All option will match those in the Medicare for All Act. This includes truly comprehensive coverage for primary and preventive services, pediatric care, emergency services and transportation, vision, dental, audio, long-term care, mental health and substance use, and physical therapy.")

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

[84] Jeff Spros, *No One Really Wants to Ban All Private Insurance. Not Even Bernie Sanders*, THE WEEK (July 3, 2019), https://theweek.com/articles/850638/no-really-wants-ban-all-private-insurance-not-even-bernie-sanders ("Sanders' plan may allow private insurers to cover things the government doesn't, but under Sanders' plan, the government would also cover a ton. "It would cover hospital visits, primary care, medical devices, lab services, maternity care, and prescription drugs as well as vision and dental benefits," Sarah Kliff pointed out at Vox. "The plan is significantly more generous than the single-payer plans run by America's peer countries.")

[85] *Bernie Sanders on the Role of Insurance Companies Under "Medicare for All"*, YOUTUBE, April 10, 2019, https://www.youtube.com/watch?v=RdnLDR7fcIE (Interviewer: "So what happens to insurance companies under your plan?" Sanders: … "I suppose if you want to make yourself a bit more beautiful, work on that nose, your ears, they can do that." Interviewer: "So basically Blue Cross Blue Shield would be reduced to nose jobs?" Sanders: "Something like that.") *See also Bernie Sanders on Health Care*, FEELTHEBERN.ORG, https://feelthebern.org/bernie-sanders-on-healthcare/ [https://perma.cc/TGZ9-QPBV] (last visited Mar. 5, 2020) ("Private health insurers can offer coverage for services not covered by Medicare For All, such as elective cosmetic surgeries.")

Medicare supplemental insurance, covers some of the costs that Sanders' Medicare for All proposes to include[86] (though traditional Medicare does not), including copays, deductibles, and coinsurance.[87] Some Medigap policies cover medical care administered outside the U.S., a cost not discussed in any of the Medicare for All proposals.[88] Even Medigap does not cover certain services[89] that Medicare for All, as proposed by Sanders and Warren, would cover, including vision or dental care, hearing aids, and long term care (though what is included in long-term care under Medicare for All is ambiguous).[90] Additionally, Medigap doesn't cover certain services that Medicare for All is silent on, including eyeglasses and private-duty nursing.[91]

If Medicare for All would really cover the comprehensive scope of medical care that Sanders' proposes, there would be little need to purchase supplemental insurance. But it is unclear whether any politician could deliver a program as robust as Sanders'. It's also uncertain

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[86] *Bernie Sanders on Healthcare*, FEELTHEBERN.ORG, https://feelthebern.org/bernie-sanders-on-healthcare/ [https://perma.cc/TGZ9-QPBV] (last visited Mar. 5, 2020) ("Medicare For All is a universal healthcare system, where everyone is covered for all necessary health services, with no deductibles or copays.")

[87] *What's Medicare Supplement Insurance (Medigap)?,* MEDICARE.GOV, accessed March 4, 2020, https://www.medicare.gov/supplements-other-insurance/whats-medicare-supplement-insurance-medigap (last visited Mar. 4, 2020).

[88] *Id*.

[89] *Id*. ("Medigap policies generally don't cover long-term care, vision or dental care, hearing aids, eyeglasses, or private-duty nursing.")

[90] Medicare for All Act of 2019, S.1129, 116th Cong. §1013(c)(1) (2019), available at https://www.congress.gov/bill/116th-congress/senate-bill/1129/text#toc-idF335B3FF5174480D932838EA6641DB1E (amending what is covered currently under Social Security and Medicare to include hearing aids); *Bernie Sanders on Health Care*, FEELTHEBERN.ORG, https://feelthebern.org/bernie-sanders-on-healthcare/ [https://perma.cc/TGZ9-QPBV] (last visited Mar. 5, 2020) (stating Medicare for All would "[c]over[] 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.")

[91] *What's Medicare Supplement Insurance (Medigap)?,* MEDICARE.GOV, accessed March 4, 2020, https://www.medicare.gov/supplements-other-insurance/whats-medicare-supplement-insurance-medigap (last visited Mar. 4, 2020).

that such a comprehensive plan could succeed, given that no other country in the world has a government-sponsored health insurance program that is nearly as comprehensive.[92]

On many occasions, Sanders has compared his Medicare for All plan to the government-sponsored health insurance plan in Canada.[93] In Canada, however, the government-sponsored health insurance coverage is considerably narrower than what Sanders' proposed. Other countries with government-sponsored health insurance have coverage similar in scope to Canada's, leading to a robust market for private insurance in addition to or instead of the government-sponsored insurance program.[94] Canadian government-sponsored insurance does not cover vision or dental care, prescription drugs, rehabilitative services, or home health care.[95] Canadian coverage also

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[92] Sarah Kliff, *Private Health Insurance Exists in Europe and Canada. Here's How it Works*, VOX (Feb. 12, 2019) .https://www.vox.com/health-care/2019/2/12/18215430/single-payer-private-health-insurance-harris-sanders (explaining that it is unlikely a Sanders' style of comprehensive Medicare for All coverage could arise in the US, as no other countries have such comprehensive health insurance programs, and many ask "patients to kick in something for the parts the government can't afford.")

[93] *Bernie Sanders on the Role of Insurance Companies Under "Medicare for All"*, YOUTUBE, April 10, 2019, https://www.youtube.com/watch?v=RdnLDR7fcIE (Interviewer: "Is this proposal socialism?" Sanders: "No, actually no it is not. It is similar to what the Canadians have."); *Bernie Sanders on Health Care*, FEELTHEBERN.ORG, https://feelthebern.org/bernie-sanders-on-healthcare/ [https://perma.cc/TGZ9-QPBV] (last visited Mar. 5, 2020) ("Bernie is proposing a healthcare system like what is found in Canada.")

[94] For an overview of coverage in Australia, *see* Sarah Kliff, *What Australia Can Teach America About Health Care*, VOX (April 15, 2019), https://www.vox.com/policy-and-politics/2019/4/15/18311694/australia-health-care-system (detailing the dual role of Australia's government-sponsored basic health insurance and premium private supplemental insurance.) For an overview of coverage in Germany, *see* Erika Edwards & Lauren Dunn, *Is Germany's Health Care System a Model for the U.S.?*, NBC (June 24, 2019), https://www.nbcnews.com/health/health-news/germany-s-health-care-system-model-u-s-n1024491 (likening the difference between German government-sponsored and privately-purchased insurance to the difference between economy and business class on the same flight, with the same safety standards, but that private insurance allows access to higher-quality doctors and faster access to procedures such as knee surgery.) For an overview of coverage in Israel, *see* Ella Shienfeld, *What Americans Can Learn from Israel's Universal, Flexible, and Cost-Efficient Health Care System*, SCHOLARS.ORG (June 22, 2018), https://scholars.org/contribution/what-americans-can-learn-israels-universal-flexible-and-cost-efficient-health (detailing the role of private supplemental insurance.)

[95] Jeff Spros, *No One Really Wants to Ban All Private Insurance. Not Even Bernie Sanders*, THE WEEK (July 3, 2019), https://theweek.com/articles/850638/no-really-wants-ban-all-private-insurance-not-even-bernie-sanders

excludes podiatry and chiropractic treatment.[96] The Canadian system tracks more closely to what America's current Medicare program covers.[97]

Canadians, like American Medicare beneficiaries, spend money out-of-pocket on their health insurance, to the tune of about 1.3% of GDP.[98] Two-thirds of the population has private insurance to cover the services not covered by government-insurance, including vision, dental, and prescription drug benefits.[99] As a result, there is a large private market for supplemental insurance that individuals can procure to cover those out-of-pocket expenses.[100] Canadians often procure that supplemental insurance through work as an employee benefit.[101] Given that Sanders compares his Medicare for All plan to the Canadian system, and the lack of any other government-sponsored insurance system that offers benefits nearly as comprehensive as those in Sanders' current bill, it's likely that a version of Medicare for All that could pass the United

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[96] Clarrie Feinstein, *What I Learned as a Canadian Reporting on Healthcare in America — and What Americans Can Learn from Canada*, BUSINESS INSIDER, (Nov. 22, 2019) https://www.businessinsider.com/american-misconceptions-about-canadian-healthcare-2019-11

[97] Austin Frakt & Elsa Pearson, *A Question Rarely Asked: What Would Medicare for All Cover?*, N.Y. TIMES (July 29, 2019), https://www.nytimes.com/2019/07/29/upshot/medicare-for-all-coverage-question.html ("Traditional Medicare does not cover certain classes of care, including eyeglasses, hearing aids, dental or long-term care. When the classes of things it covers changes, or is under debate, there's a big, bruising fight with a lot of public comment. The most recent battle added prescription drug coverage through legislation that passed in 2003.")

[98] *Re: HR 1384 -- Medicare for All Act of 2019 Before the H. Rules Comm.* 4 (April 30, 2019) (testimony by Dr. Dean Baker, Senior Economic, Center for Economic and Policy Research), http://cepr.net/images/stories/testimonies/Testimony_Baker_M4A_2019-04-30.pdf

[99] Sarah Kliff, *Private Health Insurance Exists in Europe and Canada. Here's How it Works*, VOX (Feb. 12, 2019) .https://www.vox.com/health-care/2019/2/12/18215430/single-payer-private-health-insurance-harris-sanders ("In Canada, for example, two-thirds of the population takes out private plans to cover vision, dental, and prescription drug benefits — none of which are included in the public plan.")

[100] JOSEPH WHITE, COMPETING SOLUTIONS: AMERICAN HEALTH CARE PROPOSALS AND INTERNATIONAL EXPERIENCE 66 (Brookings Institution 1995)

[101] Clarrie Feinstein, *What I Learned as a Canadian Reporting on Healthcare in America — and What Americans Can Learn from Canada*, BUSINESS INSIDER, (Nov. 22, 2019) https://www.businessinsider.com/american-misconceptions-about-canadian-healthcare-2019-11 ("Often, employers offer supplemental private health insurance to their employees to cover some of the expenses that are not covered under the public healthcare plan."); ("many [Canadians] have health insurance through employers…")

States House and Senate would track the Canadian system much more closely than Sanders admits. As such, it is likely that American Medicare for All beneficiaries would turn to privately-sponsored supplemental insurance, which would be legal under Medicare for All.

As in Canada, many American employees would likely look to their employers as issuers of supplemental insurance, given the long history and path-dependence on the employment-health nexus. Americans look to employers as low-cost issuers of insurance due to the broad risk pool[102] little administrative overhead,[103], and tax benefit.[104] Employers often rely on generous employee benefits packages as a recruitment tool to secure the best talent.[105] Employers sponsoring and administering supplemental health insurance plans would be the path of least resistance and the one most likely for Americans to adopt.

2. Favorable Tax Treatment for Employer-Sponsored Supplemental Health Insurance Should Continue

As discussed in Part I, one reason Americans are keen on getting health insurance from their employer is because of the tax beneficial nature of health insurance when sponsored as a

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[102] Uwe E. Reinhardt, *Employer-Based Health Insurance: A Balance Sheet*, 18 HEALTH AFF. 124, 125 (Nov.-Dec. 1999) https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.18.6.124 ("credit[ing] employer coverage for risk pooling that typically is much broader than that in the market for individually purchased health insurance.")

[103] Paul Starr, the Transformation of American Medicine, 311 (explaining how employers can incur relatively low administrative costs in administering health insurance, since they simply deduct subsidized premiums from employee's paychecks, rather than incurring high acquisition and collections costs).

[104] *How Does the Tax Exclusion for Employer-Sponsored Health Insurance Work?*, TAX POLICY CENTER, https://www.taxpolicycenter.org/briefing-book/how-does-tax-exclusion-employer-sponsored-health-insurance-work (last visited Mar. 4, 2020) ("Employer-paid premiums for health insurance are exempt from federal income and payroll taxes. Additionally, the portion of premiums employees pay is typically excluded from taxable income. The exclusion of premiums lowers most workers' tax bills and thus reduces their after-tax cost of coverage. This tax subsidy partly explains why most American families have health insurance coverage through employers.")

[105] Mark Carroll, *How Small Businesses Can Leverage Benefits as a Recruiting Tool*, EMPLOYEE BENEFITS NEWS (Feb. 27, 2020), https://www.benefitnews.com/opinion/how-small-businesses-can-leverage-benefits-as-a-recruiting-tool (explaining how small businesses can use generous employee benefit packages to differentiate themselves and recruit top talent).

fringe benefit. To recap, when American employees receive health benefits from work, the cash value of those benefits are excluded from their gross income and are not subject to income and payroll taxes.[106] If Americans instead purchased private insurance coverage themselves, they would pay for it in after-tax dollars. This is because, except for the 10% of Americans who are self-employed,[107] cash paid for individually purchased health insurance premiums is not a deductible expense unless your healthcare expenses exceed 10% of your adjusted gross income ("AGI") and you itemize your deductions, rather than taking the standard deduction.[108] Healthcare costs exceeding 10% of AGI are uncommon,[109] but even Americans who incurred those large expenses are not usually able to deduct them. Approximately 90% of Americans took

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[106] *How Does the Tax Exclusion for Employer-Sponsored Health Insurance Work?*, TAX POLICY CENTER, https://www.taxpolicycenter.org/briefing-book/how-does-tax-exclusion-employer-sponsored-health-insurance-work (last visited Mar. 4, 2020) ("Employer-paid premiums for health insurance are exempt from federal income and payroll taxes. Additionally, the portion of premiums employees pay is typically excluded from taxable income. The exclusion of premiums lowers most workers' tax bills and thus reduces their after-tax cost of coverage. This tax subsidy partly explains why most American families have health insurance coverage through employers.")

[107] Some qualified self-employed taxpayers can deduct 100% of their healthcare expenses in Section 1 of the tax form. *See Publication 525 (2019), Business Expenses,* INTERNAL REVENUE SERVICE, https://www.irs.gov/publications/p535#en_US_2019_publink1000208843 (last visited May 8, 2020). Section 1 deductions are "above-the-line" deductions that are more favorable to the taxpayer, as they reduce the taxpayer's overall taxable income. Derek Silva, *Above-the-Line vs. Below-the-Line Deductions*, POLICYGENIUS (Jan. 31, 2020), https://www.policygenius.com/taxes/above-the-line-vs-below-the-line-deductions/. As of 2016, approximately 10% of the American workforce was self-employed, and therefore eligible for this tax-favorable treatment of health expenses. STEVEN F. HIPPLE AND LAUREL A. HAMMOND, SELF-EMPLOYMENT IN THE UNITED STATES 2 (U.S. Bureau of Labor Statistics Mar. 2016), https://www.bls.gov/spotlight/2016/self-employment-in-the-united-states/pdf/self-employment-in-the-united-states.pdf.

[108] Daniel Kurt, *Are Health Insurance Premiums Tax-Deductible?*, INVESTOPEDIA (Oct. 16, 2019), https://www.investopedia.com/are-health-insurance-premiums-tax-deductible-4773286 ("For the 2019 tax year, you're allowed to deduct any qualified unreimbursed healthcare expenses...but only if they exceed 10% of your adjusted gross income (AGI)... Qualified expenses include premiums paid for a health insurance policy, as well as out-of-pocket outlays for things like doctor visits, surgeries, dental and vision care, and mental health.")

[109] *Deducting Medical Expenses for a Major Illness or Injury*, TURBOTAX (updated for Tax Year 2019), https://turbotax.intuit.com/tax-tips/health-care/deducting-medical-expenses-for-a-major-illness-or-injury/L5fSkrd6C ("Although it seems difficult to claim these deductions, there are situations when it actually works out. Mostly when: Your medical expenses are high, perhaps due to a serious illness or injury, or just needing braces for a couple of teenagers; Your AGI is low, maybe due to low taxable retirement income or being out of work for part of the year.")

the standard deduction in 2018,[110] and therefore were unable to itemize their deductions and deduct any other expenses,[111] including healthcare expenses. As such, healthcare when received as an employee benefit is worth much more to the average American taxpayer than similarly-priced healthcare purchased on one's own. Therefore, if U.S. tax law continued to allow employer-sponsored supplemental health insurance to be excluded from an employee's gross income, employees would be incentivized to procure that benefit through work, rather than to purchase it on their own. If supplemental health insurance were seen by employees as a valuable employee benefit, employers would presumably offer it as a way to incentivize workers to join and stay at their company, much like what happened in the 1940s and 1950s with employer-sponsored health insurance.[112]

As the long history of the employment-health nexus has made Americans dependent on the workplace for insurance benefits, many employees and employers will resist a change in the tax code taking away the beneficial tax treatment of health insurance benefits. Healthcare reform should allow this beneficial tax treatment to continue. Beneficial tax treatment of employer-sponsored supplemental health insurance will incentivize offering supplemental insurance, keep down the costs of a government health insurance program, and remove barriers to corporate support of the reform effort. Additionally, American tax law already extends beneficial tax

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[110] *What is the Standard Deduction*, TAX POLICY CENTER, https://www.taxpolicycenter.org/briefing-book/what-standard-deduction (last visited Mar. 4, 2020) ("The Urban-Brookings Tax Policy Center estimates that about 90 percent of households will take the standard deduction rather than itemizing their deductions in 2018.")

[111] Beverly Bird, *How to Use the Standard Tax Deduction*, THE BALANCE (Feb. 21, 2020) https://www.thebalance.com/standard-deduction-3193021, ("Taxpayers can deduct the amount of the tax year's standard deduction on their tax returns, or they can add up everything they spent on tax-deductible expenses over the course of the year, such as medical expenses and charitable giving, then subtract that total from their incomes instead. "Instead" is the pivotal word here. It's an either/or decision...")

[112] *See* discussion in Part I, *supra*

treatment to certain types of supplemental insurance for retirees,[113] providing a model for how supplemental insurance should be treated in a Medicare for All style health insurance regime.

One popular argument against incentivizing employer-sponsored insurance is economic: incentivizing employers to provide premium supplemental insurance leads to "overinsurance", and therefore inflates health care prices. The American healthcare system did in fact see inflation of health care costs once employers got into the business of providing insurance, as detailed in Part I. But this argument, termed "moral hazard" by economists and insurance experts, does not always apply in the healthcare market.[114] Increased insurance coverage does not necessarily lead to over-usage of healthcare services.[115] Health care is not the same type of commodity as other goods in our economy- just because someone's plan might cover certain types of knee surgeries, does not mean that person would elect for an unneeded knee surgery. Or, just because a supplemental insurance plan may allow faster access to a cardiologist, does not mean a plan member with no heart issues would go and see a cardiologist.

Even if increased insurance coverage leads Americans to use healthcare more often, thereby driving up the price, that usage and inflation does not necessarily cause more bad than

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[113] Rocco Beatrice, *401(h) Plans: The Qualified Plan Tax-Free Triple Play*, THE WHITE COAT INVESTOR (May 10, 2017), https://www.whitecoatinvestor.com/401h-plans-the-qualified-plan-tax-free-triple-play/ [("AARP estimates that those in their 50's today can expect medical-related costs to be around $500,000 after they retire; not including the costs of long term care. With escalating costs in healthcare, wouldn't it be nice to set aside a tax-deductible and tax-free account to help pay these future costs? They do. It's called a 401(h).")

[114] Malcolm Gladwell, *The Moral Hazard Myth*, THE NEW YORKER (August 22, 2005), https://www.newyorker.com/magazine/2005/08/29/the-moral-hazard-myth ("The moral-hazard argument makes sense, however, only if we consume health care in the same way that we consume other consumer goods, and to economists like Nyman this assumption is plainly absurd. We go to the doctor grudgingly, only because we're sick. "Moral hazard is overblown," the Princeton economist Uwe Reinhardt says. "You always hear that the demand for health care is unlimited. This is just not true. People who are very well insured, who are very rich, do you see them check into the hospital because it's free? Do people really like to go to the doctor? Do they check into the hospital instead of playing golf?"")

[115] *Id*.

good. This is especially true if the inflation is only happening in a supplemental market. Should we deny people the ability to insure premium or experimental treatments because we are afraid of inflating their cost? Without insurance coverage, most Americans wouldn't be able to access premium or experimental care. With premium or experimental care insurable under supplemental insurance programs, more Americans would be able to access that care if they needed it- and those who neither need nor want it would not pay for it in a basic insurance premium.

A second argument against incentivizing employers to issue healthcare benefits is moral. Some scholars attack employer-sponsored benefits as inequitable and regressive, since the beneficial tax treatment effectively means that higher-paid employees get more when they receive their benefits tax-free (tax-free benefits are worth more if you are in a higher tax bracket).[116] Additionally, many reformers classify healthcare as a human right, and allowing certain employees to get better healthcare because they are employed may continue the perception that health insurance is an earned benefit, rather than a fundamental right.[117]

If Medicare for All or a public option plan succeeds in creating a robust government-sponsored insurance option, however, these moral arguments seem less weighty. Employers already offer certain benefits, like higher salaries or cushy retirement packages, to workers as a way to encourage better employees to work for them and as a form of compensation for a job well done. If there is a strong floor of a government-sponsored insurance that everyone has

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[116] Gabriel Zucman (@gabril_zucman), TWITTER (Nov. 3, 2019, 12:28 PM), https://twitter.com/gabriel_zucman/status/1191044434999119872/photo/1 (arguing that health insurance premiums are "the most unfair type of tax- the secretary pays the same as the executive."); Emmanuel Saez & Gabriel Zucman, *Make No Mistake: Medicare for All Would Cut Taxes for Most Americans*, THE GUARDIAN (Oct. 25, 2019), https://www.theguardian.com/commentisfree/2019/oct/25/medicare-for-all-taxes-saez-zucman

[117] Allison K. Hoffman, *Health Care's Market Bureaucracy*, 66 UCLA L. REV. (Forthcoming), at 51, available at https://scholarship.law.upenn.edu/faculty_scholarship/2085/

access to simply as a virtue of living in this country, a premium supplemental plan sponsored by employers probably wouldn't erode the conception of basic healthcare as a fundamental right (and if it did, that would be a strong argument to abolish private markets for any government-sponsored benefit, like private schools or even private transportation).

The moral hazard and inequitable arguments against tax-beneficial treatment of insurance weaken significantly when the type of insurance discussed is only supplemental insurance. From a supplemental coverage perspective, there are more convincing arguments in favor of continuing the beneficial tax treatment.

An economic argument in support of tax-beneficial treatment for supplemental insurance is that siphoning off high-cost and under-utilized healthcare from the general government plan and into supplemental plans helps to keep the costs of the government plan down. In Australia, for example, specialty dental care is not covered under the general government insurance, but is covered by certain private supplemental plans.[118] From an economic standpoint, it makes sense to take that specialty and high-cost care out of the general pool, as it is not the kind of basic healthcare cost that most Australians should expect to incur regularly. Instead, Australians can choose to procure additional insurance, which costs more and is often sponsored by employers, to cover the cost of that specialty care.[119]

In addition to the economic argument that supplemental insurance keeps down the costs of government insurance, there is a practical argument for continuing the tax benefit. Healthcare

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[118] *Getting Health Insurance in Australia: A Complete Guide*, TRANSFERWISE (Dec 5, 2017), https://transferwise.com/us/blog/health-insurance-australia

[119] Additionally, Australia offers aggressive tax benefits to individuals who purchase private coverage, by offering tax rebates and a lower lifetime premium for those who enroll before they turn 30. *See* Sarah Kliff, *Private Health Insurance Exists in Europe and Canada. Here's How it Works*, VOX (Feb. 12, 2019), https://www.vox.com/health-care/2019/2/12/18215430/single-payer-private-health-insurance-harris-sanders.

reform should allow employers to provide these benefits tax-free as a way to keep employers happy and discourage them from lobbying against healthcare reform. Allowing employers to keep the tax benefit for providing supplemental insurance puts money into employers pockets, by allowing them to deduct the cost of the healthcare premiums and therefore pay employees a little less than they would otherwise.[120] For better or worse, history has shown the immense power that the corporate lobby has over the success of major legislation (see Part I above and §II.B.2 below) and it may benefit the healthcare reform effort to throw employers a tax benefit bone to encourage support of healthcare reform.

In addition to the economic and practical arguments for beneficial tax treatment, there is also the simple fact that the United States *already* offers this tax treatment to these types of benefits. Under current Medicare regulations, certain employer-sponsored supplemental health insurance benefits already are tax-advantaged. Employers can set up 401(h) plans for their retired employees to fund their retiree health benefits,[121] and these plans operate as supplemental insurance plans that can layer on top of Medicare plans.[122] Similar to employer contributions to their employees' health insurance, employer contributions to a retiree's 401(h) plan are tax-deductible to the employer and excluded from income for the retiree.[123] A 401(h) plan can

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[120] *Tax Implications*, HEALTHCOVERAGEGUIDE.ORG, https://healthcoverageguide.org/reference-guide/laws-and-rights/tax-implications/ (last visited May 7, 2020)

[121] Daniel Jock, *Retiree Health Accounts Under Section 401(h)*, AMERICAN SOCIETY OF PENSION PROFESSIONALS AND ACTUARIES (April 2, 2019), https://www.asppa.org/news/browse-topics/retiree-health-accounts-under-section-401h

[122] *401(h) Retiree health Account*, ICMA-RC, https://www.icmarc.org/x3333.html?RFID=C2870 (last visited May 6, 2020) ("Your 401(h) Retiree Health account gives you a head start on covering future health-care costs, including gaps that Medicare doesn't cover.")

[123] Daniel Jock, *Retiree Health Accounts Under Section 401(h),* AMERICAN SOCIETY OF PENSION PROFESSIONALS AND ACTUARIES (April 2, 2019), https://www.asppa.org/news/browse-topics/retiree-health-accounts-under-section-401h

effectively work as a supplemental insurance plan for Medicare and cover the costs of healthcare that Medicare does not cover.[124] Retirees can use the money from their 401(h) plans to purchase a Medicare supplemental insurance plan.[125] Since United States tax law already affords beneficial tax treatment to employer-sponsored supplemental insurance that layers on top of a government-sponsored Medicare, it would be a natural extension to afford the same treatment to supplemental insurance on top of a Medicare for All.

Although this paper argues for continuing the tax-beneficial treatment of supplemental insurance provided through employers, one could also make an argument for extending that tax-beneficial treatment for individuals who buy supplemental insurance on their own. The economic reason to continue the tax-beneficial treatment (and therefore incentivize more people to purchase it and keep costs of a government program down) applies even when it is not the employer offering the plan, but simply a private insurance company selling direct-to-consumer.

There are, however, a few unique benefits to employers offering coverage to all of their employees, rather than an individual procuring insurance. First of all, if the employer provides supplemental insurance as an employee benefit to all employees, the overall risk pool of the insurance plan will be lower than if only individuals who predicted they'd need more care purchased more coverage. Since employers tend to have a mix of healthy and young employees, along with older or more sick employees, the risk pool, and therefore the cost of coverage, is

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[124] *401(h) Retiree health Account,* ICMA-RC, https://www.icmarc.org/x3333.html?RFID=C2870 (last visited May 6, 2020) ("Your 401(h) Retiree Health account gives you a head start on covering future health-care costs, including gaps that Medicare doesn't cover.")

[125] *401(h) Supplemental Insurance Subsidy*, SHEET METAL WORKERS NATIONAL PENSION FUND, https://www.smwnpf.org/summary_plan/401h-supplemental-insurance-subsidy/ [https://perma.cc/93JZ-H4EZ] (last visited May 6, 2020)

lower when a large employer enrolls all its employees in the plan.[126] Additionally, since employers are more often in the business of administering health care plans to large groups of employees, rather than individuals purchasing health insurance privately,[127] it may be more efficient to continue using the employer as the administrator of the plan.

No matter if policymakers decide to extend deductibility of supplemental health insurance premiums to individuals who purchase insurance, or keep it only for employers who offer these plans as an employee benefit, it is likely that a private market for supplemental insurance will exist. The most likely administrator of those private plans will continue to be employers, maintaining the employment-health nexus even in the face of drastic reform.

B. Managing the Complexities of Employer-Sponsored Insurance Within Existing Frameworks

Most proposals for healthcare reform allow some form of choice between employer- and government-sponsored insurance. Americans place a high premium on the availability of choice when determining which version of healthcare reform they prefer[128] and current Medicare regulations allow eligible Americans the choice between an employer-sponsored plan and a

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[126] Uwe E. Reinhardt, *Employer-Based Health Insurance: A Balance Sheet*, 18 HEALTH AFF. 124, 125 (Nov.-Dec. 1999) https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.18.6.124.

[127] *How Many Americans Buy Their Own Health Insurance?*, EHEALTHINSURANCE (Dec. 18, 2019), https://www.ehealthinsurance.com/?menuFirst=ifp&allid=seo11276000&adobe_mc_ref=https%3A%2F%2Fwww.ehealthinsurance.com%2Fresources%2Findividual-and-family%2Fhow-many-americans-buy-their-own-health-insurance&adobe_mc_sdid=SDID%3D7C61D56B86A6249F-1EC6C0211616084C%7CMCORGID%3DA821776A5245B31A0A490D44%2540AdobeOrg%7CTS%3D1587752811 ("According to a 2017 Kaiser Family Foundation (KFF) survey, almost half (49%) of people have employer-sponsored insurance. So, how many people buy their insurance on their own? According to the same 2017 KFF survey only around 7% of people buy individual health insurance.")

[128] *See* Allison Hoffman, *Health Care's Market Bureaucracy*, 66 UCLA L. REV. __ (Forthcoming), at 5 (https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=3087&context=faculty_scholarship) ("Although historically not the case, individual choice has emerged as a sacred value in health care decisionmaking.... Market choice is sold as equivalent to freedom or autonomy.")

government-sponsored plan.[129] Creating a choice for consumers between various plans will raise regulatory and behavioral-economic issues. Current regulations, however, provide guidance as to how these issues could be navigated and resolved under a variety of healthcare reform proposals.

Warren's Medicare for All transition plan is an example of a plan temporarily allowing for employee choice between government-sponsored and employer-sponsored options.[130] This choice would last only until the transition to Medicare for All is complete, whereupon Americans would be enrolled in government-sponsored plans.[131] Note, as mentioned above,[132] Warren's plan would still allow a small market for private insurance for employees under collective bargaining agreements who had bargained for health insurance.[133]

Other public option proposals allow Americans the permanent choice between remaining with their employer-sponsored health insurance or joining a government-sponsored health

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[129] *Do I have to enroll in Medicare if I continue to have health coverage after age 65 from my own or my spouse's employer*?, AARP: MEDICARE QUESTION AND ANSWER TOOL, https://www.aarp.org/health/medicare-qa-tool/do-i-enroll-in-medicare-age-65-even-if-still-working/ (last visited May 7, 2020) ("It is entirely your choice (not the employer's) whether to: accept the employer health plan and delay Medicare enrollment [or] decline the employer coverage and rely wholly on Medicare…")

[130] Elizabeth Warren, *My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All,* ELIZABETHWARREN.COM, https://elizabethwarren.com/plans/m4a-transition [https://perma.cc/L3LW-W4JJ] (last visited Mar. 5, 2020) (""[w]orkers with employer coverage can opt into the Medicare for All option, at which point their employer will pay an appropriate fee to the government to maintain their responsibility for providing employee coverage….millions more Americans will have the choice to ditch their private insurance and enter a high-quality public plan.")

[131] *Id.*

[132] *Supra* p. 15

[133] Elizabeth Warren, *My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All,* ELIZABETHWARREN.COM, https://elizabethwarren.com/plans/m4a-transition [https://perma.cc/L3LW-W4JJ] (last visited Mar. 5, 2020) ("for unions that seek specialized wraparound coverage and individuals with specialized needs, a private market could still exist. In addition, we can allow private employer coverage that reflects the outcome of a collective bargaining agreement to be grandfathered into the new system…")

insurance plan. One example of such a plan is Congresswoman Rosa DeLauro's May 2019 bill entitled "Medicare for America".[134] The plan would allow large employers to

> continue to provide insurance, if it is gold-level coverage with benefits comparable to Medicare for America. Or, they can enroll their employees in Medicare for America and contribute 8% of annual payroll to the Medicare Trust Fund. Employees can choose to enroll in Medicare for America… if an employer contributes to Medicare for America in lieu of ESI or an employee chooses it over ESI, the employee's premiums will be based on income.[135]

It is not surprising that so many of the healthcare reform proposals promote individual choice, even as contemporary healthcare scholars say choice may be overemphasized,[136] confusing,[137] and inefficient.[138] The importance of choice is another example of the path-dependence determined by America's history of healthcare regulation. Americans have long valued choice and free will and politicians draw upon those values when discussing healthcare

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[134] *The Medicare for America Act of 2019*, DELAURO.HOUSE.GOV, https://delauro.house.gov/sites/delauro.house.gov/files/Medicare%20for%20America%20of%202019%20Summary.pdf (last visited May 6, 2020)

[135] *Id*.

[136] Allison K. Hoffman, *Health Care's Market Bureaucracy*, 66 UCLA L. REV. (Forthcoming), at 75, available at https://scholarship.law.upenn.edu/faculty_scholarship/2085/
("If health policy and law is to progress, it is imperative to examine the overemphasis on individual choice. In many cases, individual choice is altogether the wrong organizing principle to animate health regulation.")

[137] Richard G. Frank, *Making Choice and Competition Work in Individual Insurance in Health Reform Proposals*, THE COMMONWEALTH FUND (Jan. 30, 2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/jan/choice-competition-individual-insurance-health-reform ("[C]hoice among plans may fail consumers if they select plans that do not fit their needs because they do not understand their choices.")

[138] Allison K. Hoffman, *Health Care's Market Bureaucracy*, 66 UCLA L. REV. (Forthcoming), at 75, available at https://scholarship.law.upenn.edu/faculty_scholarship/2085/ ("In many cases, better regulatory responses, including to inefficiencies in the system, reveal themselves only through push back on the modern sanctification of choice.379 When choice is illusory or unnavigable or makes people miserable, it is not worth privileging. Sometimes there is only one best option. When one treatment option is far superior to another, enabling choice between the two is illogical, and arguably cruel. If a particular treatment does not work, or when it is very expensive and does little good, having it as an option is a rouse.")

reform.[139] Even dating as far back as the 1930s, Americans have resisted the idea of government-sponsored health benefits. As discussed above in Part I, industry groups opposed to mandatory government-sponsored health insurance derided it as a "Prussian menace inconsistent with American values."[140] American leaders today continue to tout individual choice as a feature of their healthcare reform proposals. Barack Obama famously promised to the American Medical Association that under the Affordable Care Act ("ACA"), Americans would maintain choice, stating, "no matter how we reform health care, we will keep this promise to the American people: If you like your doctor, you will be able to keep your doctor, period. If you like your health-care plan, you'll be able to keep your health-care plan, period. "[141] Former Vice President Joe Biden promised that under his public option plan, ""If you like your health care plan, your employer-based plan, you can keep it. If in fact you have private insurance, you can keep it..."[142] Even Warren touted her transition to Medicare for All as allowing room for individual choice.[143]

It is not just consumers who value choice. Choice between employer-sponsored and government-sponsored plans can dramatically reduce the cost of administering a government-

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[139] For a discussion about whether Americans actually want choices in healthcare plans, *see* Sarah Jones, *Do Americans Want Choice, or Do They Just Want Health Care?*, THE INTELLIGENCER (Dec. 7, 2019), https://nymag.com/intelligencer/2019/12/do-americans-want-choice-or-do-they-just-want-health-care.html. For a discussion on whether Americans are equipped with the know-how to evaluate and choose between different health insurance options, *see* Allison Hoffman, *Health Care's Market Bureaucracy,* 66 UCLA L. REV. __ §III.B. (forthcoming 2019), https://ssrn.com/abstract=3394970

[140] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 253 (Basic Books, Inc., 1982)

[141] President Obama, Remarks by the President to the Annual Conference of the American Medical Association, June 15, 2009, https://obamawhitehouse.archives.gov/the-press-office/remarks-president-annual-conference-american-medical-association

[142] Nathaniel Wiexel, *Biden: If You Like Your Private Health Insurance, 'You Can Keep It*', THE HILL (July 15, 2019), https://thehill.com/policy/healthcare/453173-biden-if-you-like-your-private-health-insurance-you-can-keep-it

[143] Daniella Diaz and Maeve Reston, *In a Rhetorical Shift, Elizabeth Warren Emphasizes 'Choice' on Health Care*, CNN (Dec. 16, 2019) ("Warren has described the transition into her Medicare For All plan as a "choice" for Americans to try it".)

sponsored health insurance plan. Current Medicare regulations mandate that employer coverage must operate as primary to Medicare so that the government can shift costs and reduce the amount of healthcare expenses Medicare pays for.[144] Realistically, it is likely that any healthcare reform plan would likely continue this cost-shifting. Policymakers should look to existing frameworks for how to allow an employer option and a government option to coexist without running afoul of current regulations or causing detrimental adverse selection.

1. Regulatory Hurdles

A choice-based healthcare policy raises complex regulatory issues for policymakers. Current regulations provide a framework for how policymakers should think about thorny issues like coordination of benefits and nondiscrimination requirements in a choice-based regime. Current coordination of benefits plan regulations control how employers can and cannot influence Medicare-eligible employees' insurance choices[145] and mandate the employer plan must pay first if an employee is also covered by Medicare.[146] Allowing consumers a choice between Medicare for All, for which everyone would theoretically be eligible, and their employer-sponsored coverage, as in Warren's and DeLauro's plans above, expands the

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[144] *Medicare Secondary Payer*, CENTERS FOR MEDICARE AND MEDICAID SERVICES (Feb. 11, 2020), https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer ("In 1980, Congress passed legislation that made Medicare the secondary payer to certain primary plans in an effort to shift costs from Medicare to the appropriate private sources of payment.")

[145] Phillip Moelher, *Can Employers Make You Rely on Medicare and Drop Their Insurance?*, PBS: NEWS HOUR (May 4, 2017), https://www.pbs.org/newshour/economy/can-employers-make-rely-medicare-drop-insurance

[146] *Medicare Secondary Payer*, CENTERS FOR MEDICARE AND MEDICAID SERVICES (Feb. 11, 2020), https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer ("In 1980, Congress passed legislation that made Medicare the secondary payer to certain primary plans in an effort to shift costs from Medicare to the appropriate private sources of payment.")

preexisting complexities of figuring out the coordination of benefits rules between a robust public option and employer-sponsored plans.

Additional regulatory complexities arise around ACA nondiscrimination requirements for employer-sponsored insurance plans.[147] [148] Allowing employees to choose between a public option and employer insurance without proper guidance may end up with the unintended result of the employer plan being deemed discriminatory, leading to penalty excise taxes for employers.[149]

While the majority of Americans prefer a healthcare plan that allows for choice, policymakers and advisors should look to how the current regulatory framework limits and frames choice as to manage this choice.

a. Coordination of Government and Employer Benefits

One regulatory issue that will arise in a choice-based healthcare reform is the coordination of benefits between government- and employer-sponsored health insurance. The current Medicare regulations offer guidance of how policymakers could proceed. Under current Medicare rules, employers are banned from incentivizing their employees to turn down employer-sponsored coverage and choose Medicare coverage instead. Additionally, current

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[147] *Summary: Final Rule Implementing Section 1557 of the Affordable Care Act,* HHS.GOV, https://www.hhs.gov/sites/default/files/2016-06-07-section-1557-final-rule-summary-508.pdf

[148] Note that the nondiscrimination rules do not apply to every employer-sponsored health insurance plan. The nondiscrimination rules apply to self-insured plans and new insured plans, but insured plans that are grandfathered into the Affordable Care Act do NOT have to comply with nondiscrimination requirements. NONDISCRIMINATION REQUIREMENTS FOR INSURED GROUP HEALTH PLANS UNDER THE ACA, PRACTICAL LAW EMPLOYEE BENEFITS & EXECUTIVE COMPENSATION SECTION 2 (Westlaw Jan. 4, 2016), https://www.westlaw.com/4-516-9478?transitionType=Default&contextData=(sc.Default)&VR=3.0&RS=cblt1.0

[149] *Id*. at § 5.

Medicare (and Medicaid) regulations allow Medicare (and Medicaid[150]) to operate as a secondary insurance if a Medicare-beneficiary is also covered under an employer plan. [151] Policymakers should look to the rationale behind these current Medicare regulations when deciding whether or not they should apply to a Medicare for All or healthcare reform that drastically expands eligibility for the government-sponsored insurance plan.

i. Regulating Employer Incentives

The first coordination of benefits problems that a choice-based insurance regime would need to grapple with is whether and how to regulate employer incentives. Currently, employers are not allowed to incentivize their employees who may otherwise be eligible for Medicare because they are 65+ or disabled, to turn down employer-sponsored insurance and take Medicare instead,[152] (provided the company employs at least 20 employees or at least one employer is a multi-employer group that employs 20 or more individuals.[153]) Employees are free to choose

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[150] *How Medicaid Works with other Health Coverage*, FIERCE HEALTHCARE (Aug. 26, 2019), https://www.fiercehealthcare.com/sponsored/how-medicaid-works-other-health-coverage

[151] Kylie McKee, *How to Deal with Medicare as a Secondary Insurance*, WEBPT (Oct. 31, 2019), https://www.webpt.com/blog/post/how-to-deal-with-medicare-as-a-secondary-insurance/ ("Here are some common scenarios and plan types where Medicare functions as secondary to another payer (as adapted from this resource): The beneficiary receives benefits through an employer with 20 or more employees. The beneficiary is on his or her spouse's insurance as part of the spouse's employment benefits, and the employer has 20 or more employees. The beneficiary is retired and is on his or her spouse's insurance as part of the spouse's employer's plan, and the employer has 20 or more employees. The beneficiary is under 65 years of age, disabled, and receives coverage through a family member's employment benefits, and the employer has 100 or more employees. The beneficiary is receiving workers' compensation. The beneficiary's coverage is under no-fault or liability insurance.")

[152] Phillip Moelher, *Can Employers Make You Rely on Medicare and Drop Their Insurance?*, PBS: NEWS HOUR (May 4, 2017), https://www.pbs.org/newshour/economy/can-employers-make-rely-medicare-drop-insurance

[153] *Medicare Secondary Payer*, CENTERS FOR MEDICARE AND MEDICAID SERVICES (Feb. 11, 2020), https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer

Medicare coverage in lieu of employer coverage if they so wish,[154] but employers are prohibited from actively encouraging that choice through incentive payments, offers to cover the cost of Medicare premiums, etc.[155] The rationale behind this prohibition is that the government does not want to have to foot the bill for paying insurance for someone who could receive it elsewhere.[156] (Medicare already consumes 15% of the federal budget.[157])

Although Medicare is often described as a safety net insurance program for all who qualify,[158] Medicare regulations attempt to narrow coverage by encouraging employed Medicare-eligible Americans to choose employment-sponsored insurance over Medicare. If of Medicare for All or a robust public option was adopted, current Medicare regulations suggest employees would still be encouraged to choose employer-based health insurance. Medicare is expensive,[159]

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[154] *Medicare and Employer Coverage*, BOOMERBENEFITS, https://boomerbenefits.com/new-to-medicare/medicare-and-employer-coverage/ (last visited April 24, 2020) ("People with large group employer insurance also have another option. You can leave your group health plan and choose Medicare as your primary insurance…")

[155] Phillip Moelher, *Can Employers Make you Rely on Medicare and Drop Their Insurance?*, PBS: NEWS HOUR (May 4, 2017), https://www.pbs.org/newshour/economy/can-employers-make-rely-medicare-drop-insurance ("it is illegal for employers to subsidize Medicare premiums. Doing so is viewed by Medicare as potentially being a "bribe" to convince the employee to drop employer insurance in favor of Medicare, thus saving the employer money and shifting costs to Medicare and, by extension, taxpayers.")

[156] *Medicare Secondary Payer*, CENTERS FOR MEDICARE AND MEDICAID SERVICES (Feb. 11, 2020), https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer ("In 1980, Congress passed legislation that made Medicare the secondary payer to certain primary plans in an effort to shift costs from Medicare to the appropriate private sources of payment.")

[157] Juliette Cubanski, et. al, *The Facts on Medicare Spending and Financing*, THE KAISER FAMILY FOUNDATION, at Fig. 1 (Aug. 20, 2019), https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/ (showing that, in 2018, net federal outlays for Medicare total $4.1 trillion, or 15% of the federal budget.)

[158] *What Are the Major Federal Safety Net Programs in the U.S.*?, UNIVERSITY OF CALIFORNIA DAVIS: CENTER FOR POVERTY RESEARCH (March 18, 2018), https://poverty.ucdavis.edu/article/war-poverty-and-todays-safety-net-0 (including Medicare in a list of federal safety net programs.)

[159] Juliette Cubanski, et. al, *The Facts on Medicare Spending and Financing*, THE KAISER FAMILY FOUNDATION, at Fig. 1 (Aug. 20, 2019), https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/ (showing that, in 2018, net federal outlays for Medicare total $4.1 trillion, or 15% of the federal budget.)

so the regulations encourage the private sector to provide insurance when possible.[160] Medicare for All, rather than just for those currently eligible, would be exponentially more expensive, so one can imagine the private sector would be encouraged, through continued coordination of benefits regulation, to keep costs of a government program down.

This coordination of benefits problem is a more serious regulatory thorn when considering public options proposals than when considering comprehensive Medicare for All proposals. Under Sanders' Medicare for All proposal, after a short transition period everyone would be enrolled on a single, universal health insurance plan provided by the government. Except for the time period of the transition period, there would not be multiple sources of insurance to coordinate between or to regulate choice between the programs.

Regulating employer incentives for insurance choice becomes slightly thornier under Warren's proposal. While she also has a short transition period, followed by near-universal coverage under a government-sponsored Medicare for All, she does carve out an exception for employees who receive employer-sponsored insurance as part of a collective bargaining agreement. Presumably, this concession to unions and their bargained-for benefits harkens back to the power of labor in supporting or protesting universal health coverage as discussed in Part I. Warren may have thought it prudent to allow union-bargained benefit plans to continue, so that unions could continue incentivizing employees to join because of the benefits they can negotiate.

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[160] *Medicare Secondary Payer*, CENTERS FOR MEDICARE AND MEDICAID SERVICES (Feb. 11, 2020), https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer ("In 1980, Congress passed legislation that made Medicare the secondary payer to certain primary plans in an effort to shift costs from Medicare to the appropriate private sources of payment.")

Regulating employers' role becomes trickiest in a public option plan that allows for employee choice between a government plan and an employer plan. Many current healthcare reform proposals allow room for this employee choice.[161] For example, DeLauro's plan discussed above would allow employees to choose to enroll in a government plan and turn down employer-sponsored coverage.[162] In a choice-based plan such as this, employers might be incentivized to encourage some employees to choose the government plan (especially if the employees are high-risk/ high-cost, as discussed in Part II.B.1.a.) Employers might incentivize their employees through direct incentives, currently banned under Medicare regulation, such as paying the Medicare premiums on behalf of their employees. Or, they might indirectly incentivize that choice, by offering low-quality coverage for certain high-cost health services.

The rationale behind current coordination of benefits regulation seems to apply in public option proposals that allow for employee choice between a government-sponsored plan and an employer-sponsored plan. Employers should not be allowed to actively incentivize certain workers to opt for Medicare for All, as they may end targeting the higher-risk and higher-cost individuals to leave their plan. This strategic coverage-shifting saves their own costs while

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[161] Tricia Neuman, et. al, *10 Key Questions on Public Option Proposals*, KAISER FAMILY FOUNDATION (Dec. 18, 2019), https://www.kff.org/health-reform/issue-brief/10-key-questions-on-public-option-proposals/ ("Presidential candidates Biden, Buttigieg, Steyer, and Warren as well as a congressional proposal, known as Medicare for America, would adopt a more expansive approach that allows workers (and their dependents) who are offered job-based coverage to instead enroll in the public option and receive subsidies for their coverage. This approach differs from current law in that those with an offer of job-based coverage are generally ineligible for marketplace subsidies.1 Allowing people to get coverage through a subsidized public option, instead of their employer, could make the public option a particularly attractive alternative for low-wage workers and their families.")

[162] *The Medicare for America Act of 2019*, DELAURO.HOUSE.GOV, https://delauro.house.gov/sites/delauro.house.gov/files/Medicare%20for%20America%20of%202019%20Summary.pdf (last visited May 6, 2020)

shifting those costs to the government program. This cost-shifting could have grave consequences for the viability of a government-program.[163]

On the other hand, if the government program does not end up with unsustainable costs because of cost-cutting or risk reduction methods, it may actually make sense to allow, or even incentivize, employers to selectively offload employees. Such selective offloading to the government program would keep the costs of insurance down for those employees who did stay on the employer-plan, and the government-plan would be a well-funded and well-run safety net program for the unemployed or high-risk/ high-cost employees. In that case, selective offloading and strategic behavior would be a feature, not a bug, of a choice-based regime. Such a solution would benefit companies (by keeping down benefits costs), employees (giving them the option between affordable employer coverage or affordable government-coverage), and the government (affording them political capital from offering a well-run government safety net program.)

ii. Medicare as Secondary to Employer-Sponsored Insurance

A second regulatory complexity in the coordination of benefits sphere is how a public option should operate, if at all, for employees who choose employer-sponsored coverage in lieu of the public option. Currently, an employee who is eligible for Medicare, but opts for employer-

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[163] Amy Monahan and Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees*, 97 VA. L. REV. 125, 131-132 (2011), http://virginialawreview.org/sites/virginialawreview.org/files/125.pdf ("employer dumping of high-risk employees could undermine the exchanges on which individual markets are expected to operate
by rendering the pool of policyholders seeking coverage in exchanges disproportionately risky relative to the general population. Such adverse selection, in turn, would simultaneously increase premiums, lower coverage rates, and increase the cost to the federal government of subsidizing coverage for low- and moderate income individuals. Ultimately, these forces could render insurance exchanges unsustainable and thereby jeopardize health insurance reform writ large.")

sponsored coverage instead, can still be covered by Medicare, but only as secondary coverage.[164] This means if an employee incurs medical costs not covered by their employer plan, but covered by Medicare, Medicare will cover those costs rather than the individual paying out-of-pocket.[165]

There are many reasons why Medicare provides secondary coverage for someone who is otherwise insured. First, and most practically, it ensures that more doctors and other medical service providers are paid for their services.[166] Even if the employee incurred a cost not covered by his or her employer-sponsored plan, the health care provider isn't worried that the individual won't be able to pay. Instead, the health care provider can simply bill Medicare for payment (provided it is within the scope of Medicare coverage.)

A second rationale gets more at the heart of Medicare's *raison d'être*. Medicare exists as a safety net program for elderly and disabled Americans.[167] It would seem unfair to withhold coverage of a safety net program from people lucky enough to still have coverage through their

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[164] *Medicare Secondary Payer*, CENTER FOR MEDICARE AND MEDICAID SERVICES (Feb. 11, 2020), https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer ("individual is age 65 or older, is covered by a GHP through current employment or spouse's current employment AND the employer has 20 or more employees (or at least one employer is a multi-employer group that employs 20 or more individuals): GHP [group health plan] pays Primary, Medicare pays secondary.")

[165] *How Medicare Works with Other Insurance*, MEDICARE.GOV, https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance (last visited April 24, 2020); *What It Means When Medicare Is A Secondary Payer*, AGINGINPLACE (April 2020), https://www.aginginplace.org/what-it-means-when-medicare-is-a-secondary-payer/ ("The primary payer may not cover some things that Medicare does, and vice versa, so it's especially nice to have both sources to cover healthcare costs.")

[166] *How Medicaid Works with other Health Coverage*, FIERCE HEALTHCARE (Aug. 26, 2019), https://www.fiercehealthcare.com/sponsored/how-medicaid-works-other-health-coverage ("Because commercial payers almost always yield a higher payment rate than Medicaid, neglecting to identify third-party coverage prior to billing is more than an administrative headache — it's a lost revenue opportunity.")

[167] *What It Means When Medicare Is A Secondary Payer*, AGINGINPLACE (April 2020), https://www.aginginplace.org/what-it-means-when-medicare-is-a-secondary-payer/ ("The goal of Medicare is to help the elderly, and those living under very specific conditions, pay for a majority of their medical bills. Sometimes, though, seniors are fortunate enough to have acquired benefits in their elderly age through companies they've worked for or continue to work for as they near retirement. In these cases, elderly people can have two sources of insurance: benefits through a private insurer, a spouse's insurance, or other federal agency like the Department of Veterans Affairs (VA), and then Medicare as a secondary payer, so long as you qualify.")

employer (or, from people who, because of financial circumstances, need to still be working after the typical retirement age and therefore are eligible for an employer-sponsored plan.)

In a similar vein, it would also seem unfair to deny Medicare coverage to employed, but otherwise eligible, Americans, since all Americans have "paid for" their Medicare coverage through the Medicare payroll tax, which is 1.45% of every American's paycheck up to $137,700[168] (and an additional 0.9% payroll tax[169] and 3.8% net investment income tax[170] for higher-income American taxpayers). Denying certain Americans access to Medicare services, which they effectively pre-paid for through taxes, seems unreasonable.

Similar rationale seems to apply to many, but not all, of the public option plans that allow for employee choice. The access to payment argument still holds some weight. Healthcare providers should be compensated for their services, even if the individual's employment-sponsored insurance does not cover the service. Some of the healthcare reform proposals plan to beef up the quality and scope of employer-sponsored coverage, however, so healthcare services going unpaid for by employer plans might be less of a problem. For example, DeLauro's Medicare for America plan only allows large employers to offer health insurance plans if they " it is gold-level coverage with benefits comparable to Medicare for America."[171] This requirement would probably mean there would be fewer instances where an employer plan would not cover a

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[168] *Topic No. 751 Social Security and Medicare Withholding Rates*, INTERNAL REVENUE SERVICE (Feb. 14, 2020), https://www.irs.gov/taxtopics/tc751.

[169] *Questions and Answers for the Additional Medicare Tax*, INTERNAL REVENUE SERVICE (Feb. 11, 2020), https://www.irs.gov/businesses/small-businesses-self-employed/questions-and-answers-for-the-additional-medicare-tax.

[170] *The Medicare Surtax on Investment Income*, VANGUARD, https://investor.vanguard.com/investing/taxes/medicare-surtax, last visited May 11, 2020.

[171] *The Medicare for America Act of 2019*, DELAURO.HOUSE.GOV, https://delauro.house.gov/sites/delauro.house.gov/files/Medicare%20for%20America%20of%202019%20Summary.pdf (last visited May 6, 2020).

the service but Medicare for America would. However, since her plan mandates comparable, not identical, coverage there may still be some gaps that could be filled by Medicare for America.

The social safety net and fairness arguments apply as well to a robust public option that allows for employee choice. If reformers want to increase healthcare access because healthcare is a basic human right, it seems unfair to deny some American coverage for healthcare services, just because their employer doesn't cover those services, while other unemployed Americans, or Americans who opted into the public option, do get coverage for those services.

Whether the payroll tax argument applies to proposed reforms depends on how they will be funded. Different healthcare reforms have different funding proposals, but Warren promised she would not increase taxes on the middle class in order to pay for Medicare for All.[172] In some sense, that is great, because who wants to pay higher taxes? But when determining whether Americans who opted for employer coverage *deserve* the government option as secondary coverage, this lack of direct payroll taxes seems to suggest they don't.

One other argument for refusing to allow a robust public option to operate as secondary coverage to an employer-sponsored plan is simply the cost. Currently, the majority of Americans under 65 receive their health insurance through their employer.[173] And the majority of Americans

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[172] Elizabeth Warren, *Ending the Stranglehold of Health Care Costs on American Families*, ELIZABETHWARREN.COM, https://elizabethwarren.com/plans/paying-for-m4a [https://perma.cc/SY74-TA2C] (last visited Mar. 6, 2020) ("My Medicare for All plan gives everyone good insurance and cuts their health care costs to nearly zero - without increasing middle-class taxes one penny.")

[173] *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029*, CONGRESSIONAL BUDGET OFFICE (May 2, 2019), https://www.cbo.gov/publication/55085("between 240 million and 242 million such people are projected to have health insurance, mostly from employment-based plans.")

are happy with the quality of the insurance they currently receive.[174] To allow a government-sponsored option to step in to cover costs not covered by that employer-plan would massively increase the claims that the government plan would be responsible for.

b. Affordable Care Act Nondiscrimination Requirements

Another regulatory complexity arises concerning uncertain nondiscrimination requirements under the ACA. Currently, the ACA attempts to prohibit employer health plans from discriminating against certain employees based on race, color, national origin, sex, age, or disability.[175] Uncertainty about the scope of the nondiscrimination regulations[176] and how they relate to abortion and transgender services opens up opportunities for employers to design low-cost plans that may inadvertently cause ACA regulatory issues in the future. If employers and/or employees were given the choice to decide between employer- or government-sponsored

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[174] Justin McCarthy, *Most Americans Still Rate Their Healthcare Quite Positively*, GALLUP (Dec. 7, 2018), https://news.gallup.com/poll/245195/americans-rate-healthcare-quite-positively.aspx ("...solid majorities of Americans rate the coverage (69%) and quality (80%) of the healthcare they personally receive as "excellent" or "good.""); Karen Pollitz, et. al, *What's The Role of Private Health Insurance Today and Under Medicare-for-all and Other Public Option Proposals*?, THE KAISER FAMILY FOUNDATION (July 30, 2019), https://www.kff.org/health-reform/issue-brief/whats-the-role-of-private-health-insurance-today-and-under-medicare-for-all-and-other-public-option-proposals/ ("...nearly seven in ten (68%) people with job-based coverage give their plan a grade of "A" or "B" and use words like "grateful" (72%) or "content" (69%) in describing how they feel about their insurance.")

[175] Elizabeth Guo, Douglas B. Jacobs, & Aaron S. Kesselheim, *Eliminating Coverage Discrimination Through the Essential Health Benefit's Anti-Discrimination Provisions*, 107(2) AM. J. PUBLIC HEALTH, 253, 253-254 (Feb. 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5227931/ ("Section 1557 prohibits discrimination based on race, color, national origin, sex, age, or disability. The Office for Civil Rights (OCR) applies section 1557 to all plans issued by insurers that receive financial assistance from the US Department of Health and Human Services (HHS). If OCR suspects that a health plan is discriminatory, OCR can conduct a review or investigation to determine whether an issuer used a neutral rule to adopt the suspect feature or whether the design was pretext for discrimination.")

[176] MaryBeth Musumeci, et. al, *HHS's Proposed Changes to Non-Discrimination Regulations Under ACA Section 1557*, THE KAISER FAMILY FOUNDATION (July 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/
("On June 14, 2019, the Department of Health and Human Services (HHS) proposed what it describes as "substantial revisions" to its regulations implementing Section 1557 of the Affordable Care Act. … The proposal cannot change Section 1557's protections in the law enacted by Congress but would significantly narrow the scope of the existing HHS implementing regulations")

coverage, employers may end up designing plans nudging certain individuals into the government plan, and putting the company at risk of violating ACA nondiscrimination rules.

If employees are given the choice between their employer-sponsored plan and a robust government-sponsored plan, employers might decide to pare down the benefits offered in their plan with the knowledge that their employees could just choose the government plan instead.[177] Dialing back the benefits offered by the employer-plan would make financial sense for employers in two ways. First, it would decrease the cost of purchasing insurance, as the insurance would cover fewer services, and/or cheaper services. Second, it would encourage those who are more likely to use more health care services, and/or those who are more likely to incur higher cost services, to opt-out of the employer risk pool and join the government risk pool instead, improving the risk pool and lowering costs for employers. However, companies engaging in this type of strategic plan design are playing with fire, as they risk running afoul of uncertain and in-flux nondiscrimination regulations in the ACA.

The most powerful nondiscrimination provision of the ACA is Section 1557, which "prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs and activities."[178] Section 1557 does not apply to all employer-sponsored healthcare plans, but does apply to many, such as fully-insured group health plans whose

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[177] Professors Amy Monhan and Dan Schwartz discussed the possibility of what they dubbed "strategic dumping" in a 2011 article about the Affordable Care Act. *See Will Employers Undermine Health Care Reform by Dumping Sick Employees*, 97 VA. L. REV. 125, 128 (2011), http://virginialawreview.org/sites/virginialawreview.org/files/125.pdf. ("that there is a substantial prospect that ACA will lead some, and perhaps many, employers to implement a targeted dumping strategy designed to induce low-risk employees to retain ESI but incentivize high-risk employees to voluntarily opt out of ESI and instead purchase insurance through the exchanges that ACA establishes to organize individual insurance markets. Although ACA and other federal laws prohibit employers from excluding high-risk employees from ESI, these laws do little to prevent employers from designing their plans and benefits to incentivize high-risk employees to voluntarily seek coverage elsewhere.")

[178] *Summary: Final Rule Implementing Section 1557 of the Affordable Care Act*, HHS.GOV, https://www.hhs.gov/sites/default/files/2016-06-07-section-1557-final-rule-summary-508.pdf (last visited May 8, 2020).

underlying carrier receives funding from HHS, and self-insured employer-sponsored plans[179] if either the employer or the plan receives funding from HHS.[180] The scope of what Section 1557 prohibits is currently uncertain, and this uncertainty may end up with employers designing plans based on uncertain regulations that are later deemed to be statutorily discriminatory.

One area of Section 1557 that is currently in-flux is the scope of its prohibition of discriminatory coverage on the basis of sex. Section 1557 prohibits plans from discriminating by limiting accessibility to health services typically or exclusively available to one gender.[181] However, a 2016 court order enjoined the government from enforcing Section 1557 as it relates to termination of pregnancy and gender transition services, and proposed changes to the regulations in 2019 removed these services from Section 1557 protection. [182] Under the revised rule, group health plans would no longer be required to cover these services.

The uncertainty of the scope of Section 1557 means that employers can currently choose to exclude certain services from their plans without running afoul of Section 1557 nondiscrimination rules. Some of these services, such as medication and surgery for transition services, are expensive, and cost-conscious employers may be happy to exclude those services

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[179] Employer plans are self-insured where the employer retains the risk of loss associated with claims under the health plan. *See, e.g.*, Thompson v. Talquin Bldg. Prods. Co., 928 F.2d 649, 653 (4th Cir. 1991).

[180] Laura Miller Andrew, et. al, *HHS Proposes to Revise ACA Section 1557 Rule: Impacts Transgender Benefits and Group Health Plan Notices*, SGRLAW.COM: CLIENT ALERT (May 28, 2019), https://www.sgrlaw.com/client-alerts/hhs-proposes-to-revise-aca-section-1557-rule-impacts-transgender-benefits-and-group-health-plan-notices/

[181] SECTION 1557 OF THE AFFORDABLE CARE ACT NONDISCRIMINATION REQUIREMENTS 2 (Cigna June 2017), https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/informed-on-reform-nondiscrimination-fact-sheet.pdf?WT.z_nav=health-care-reform%2Fsection-1557-nondiscrimination-requirements%3BBody%3BRead%20the%20Nondiscrimination%20Fact%20Sheet [https://perma.cc/R9K5-SLRE]

[182] Laura Miller Andrew, et. al, *HHS Proposes to Revise ACA Section 1557 Rule: Impacts Transgender Benefits and Group Health Plan Notices*, SGRLAW.COM: CLIENT ALERT (May 28, 2019), https://www.sgrlaw.com/client-alerts/hhs-proposes-to-revise-aca-section-1557-rule-impacts-transgender-benefits-and-group-health-plan-notices/

using the logic discussed above. As such, there is room for companies to strategically design their plans to not cover certain types of benefits that may be included a in a government plan. While it is uncertain what exact services would be covered in a Medicare for All/ robust public option plan, Sanders' campaign confirmed that his Medicare for All plan would cover abortion services.[183] Sanders' plan would also provide coverage for transition services[184] (which are already covered under Medicaid).[185] This imbalanced coverage could lead employees likely to utilize abortion or transition services more likely to choose the government plan, shifting costs to the government pool as well as raising discrimination issues (even if current regulations claim this is not statutorily discriminatory.)

DeLauoro's Medicare for America proposal shows one potential solution to avoid discriminatory shedding of certain employees onto a government plan. While her plan is light on the details of how exactly she would test for and regulate this type of strategic design, her plan does mandate that employers may only "continue to provide insurance, if it is gold-level coverage with benefits comparable to Medicare for America."[186] Any healthcare reform that allows for the continued existence of comprehensive employer-sponsored health insurance

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[183] Jessica Washington, *Bernie Sanders Said Medicare for All Would Protect Abortion. Here's Why*, MOTHER JONES (June 28, 2019), https://www.motherjones.com/politics/2019/06/bernie-sanders-said-medicare-for-all-would-protect-abortion-heres-why/ ("Sanders' Medicare for All bill promises free "comprehensive reproductive, maternity, and newborn care." Although the bill does not explicitly state this, Sanders' team confirmed that this provision would cover abortions.")

[184] Jamie Ganrder & Maddy Grace Webbon, *Why Bernie Sanders Is the Strongest Candidate for Transgender People*, JACOBINMAG (Jan. 31, 2020), https://www.jacobinmag.com/2020/01/bernie-sanders-medicare-for-all-transgender-rights-health-care ("Bernie's bill explicitly includes transition-related procedures, along with HIV prevention, birth control, and abortion…")

[185] Elana Redfield, *Medicaid Programs Will Now Cover Transgender Healthcare Following SRLP's Twelve-Year Campaign*, SYLVIA RIVERA LAW PROJECT (Dec. 17, 2014), https://srlp.org/medicaid-programs-will-now-cover-transgender-healthcare-following-srlps-twelve-year-campaign/

[186] *The Medicare for America Act of 2019*, DELAURO.HOUSE.GOV, https://delauro.house.gov/sites/delauro.house.gov/files/Medicare%20for%20America%20of%202019%20Summary.pdf (last visited May 6, 2020).

should regulate the types of and extent of benefits covered by the insurance, to prevent employers from strategically designing plans excluding certain individuals and types of care from coverage.

This thought experiment about how employers may strategically play with uncertain nondiscrimination regulations in a choice-based health insurance regime is only one hypothetical of how choice can introduce regulatory complexity. Even if strategically designing plans to exclude certain services, and therefore certain individuals, from employer coverage does not end up running afoul of the ACA's nondiscrimination provisions, companies still shouldn't do it (and regulation should prohibit it.) Strategic exclusion can significantly impair healthcare reform by overwhelming the government-sponsored option and inflating costs.[187] It also feels adverse to the point of the nondiscrimination provision in the first place, which was to prohibit any form of discrimination based on sex.[188]

This paper does not purport to offer the solution to complex coordination of benefits and nondiscrimination problems that may arise in a new healthcare regime. It serves to identify and discuss some of the complexities that will arise under a choice-based health insurance regime.

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[187] Amy Monahan and Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees*, 97 VA. L. REV. 125, 131-132 (2011), http://virginialawreview.org/sites/virginialawreview.org/files/125.pdf ("employer dumping of high-risk employees could undermine the exchanges on which individual markets are expected to operate
by rendering the pool of policyholders seeking coverage in exchanges disproportionately risky relative to the general population. Such adverse selection, in turn, would simultaneously increase premiums, lower coverage rates, and increase the cost to the federal government of subsidizing coverage for low- and moderate income individuals. Ultimately, these forces could render insurance exchanges unsustainable and thereby jeopardize health insurance reform writ large.")

[188] Elizabeth Guo, Douglas B. Jacobs, & Aaron S. Kesselheim, *Eliminating Coverage Discrimination Through the Essential Health Benefit's Anti-Discrimination Provisions*, 107(2) AM. J. PUBLIC HEALTH, 253, 253-254 (Feb. 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5227931/ ("Section 1557 prohibits discrimination based on race, color, national origin, sex, age, or disability. The Office for Civil Rights (OCR) applies section 1557 to all plans issued by insurers that receive financial assistance from the US Department of Health and Human Services (HHS). If OCR suspects that a health plan is discriminatory, OCR can conduct a review or investigation to determine whether an issuer used a neutral rule to adopt the suspect feature or whether the design was pretext for discrimination.")

Choice is powerful for Americans and is a value locked into our culture. Choice may cause a sea of regulatory weeds, but well-advised policymakers will be able to navigate it using existing regulatory guidelines.

2. Adverse Selection and Complicated Pricing of Risk Pools

The choice afforded to employers under a Warren-style Medicare for All or DeLauro-style public option does not only raise potential regulatory compliance issues for employers who may attempt to strategically exclude certain employees from coverage or encourage some to opt-into Medicare. Allowing for choice, although it is popular, also raises adverse selection issues. Adverse selection, if not adequately anticipated and regulated, may doom a government-sponsored health insurance pool to failure. Policymakers and advisors can look to other reform attempts at managing adverse selection to inform if and how they should avoid adverse selection.

Even in the absence of strategically designed employer plans intended to exclude high-risk employees as discussed above,[189] many high-risk or low-income employees may independently choose a government-sponsored plan rather than an employer-sponsored plan. Under DeLauro's healthcare plan, the premiums for government-sponsored insurance will be based on income and subsidies will be available for individuals under certain income thresholds. During the two-year transition to Medicare for All period proposed by Warren, Medicare for All would be free for families at or below 200% of the federal poverty level, and for Americans above that income level, premiums would be capped at 5% of their income.[190] DeLauro's and

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[189] *See supra* II.B.1.b.

[190] Dylan Scott, *Elizabeth Warren's New Medicare-for-All Plan Starts Out With a Public Option*, VOX (Nov. 15, 2019), https://www.vox.com/policy-and-politics/2019/11/15/20966674/elizabeth-warren-medicare-for-all-plan-public-option

Warren's subsidized, free, or capped premiums may make it more economical for certain individuals to choose to enroll in a government insurance plan and forgo employer coverage, especially if the employer offers a health insurance opt-out arrangement,[191] offering employees cash in exchange for denying the employer-sponsored insurance[192] (see Part II.B.1.a.i for an argument about why this type of employer incentive should be banned). Given the connection between income level, health outcomes, and health risk in the United States,[193] lower-income individuals would be more likely to choose the government insurance, thereby increasing the level of risk in the government pool and decreasing the risk in the employer pool.

Even in the absence of an opt-out arrangement making it more economical for low-income employees to forego employer insurance and choose subsidized government insurance, there is potential for adverse selection. Certain higher-income workers, who don't qualify for

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[191] *What is a Health Insurance Opt-Out?*, SHRM, https://www.shrm.org/resourcesandtools/tools-and-samples/hr-qa/pages/insuranceoptout.aspx

[192] Note there may be tax code compliance issues with employers allowing employees to opt out in order to purchase insurance on the individual market. In the 2018 proposed regulations, the IRS ruled that any non eligible opt outs would could as employee contributions towards an employer's affordability tests (if an employer fails the affordability test, the ACA mandates they must pay a large penalty fee). In order for an opt out to be an eligible opt out (and therefore not count towards the dreaded affordability test), the employee must prove they have adequate coverage elsewhere (such as under a spouse's plan). Importantly, purchasing individual insurance from the ACA healthcare exchanges is not considered adequate insurance for purposes of determining eligibility. However, the regulations also stated that Medicare Part A, most of Medicaid, and CHIP would be considered adequate insurance, so it is unclear whether a government-sponsored Medicare for All/ Medicare for Americans type program, as proposed by Warren or DeLauro, would be considered adequate in determining whether or not an employee would have the option of an opt out payment. *See* Lisa Klinger, *Opt-Out Arrangements: 2018 and Beyond,* LEAVITT GROUP (Oct. 3, 2018), https://news.leavitt.com/employee-benefits-compliance/opt-out-arrangements-2018-and-beyond/. Elizabeth Warren's transition plan seems to suggest that there would be no ACA penalty if employees opted out of employer-coverage in favor of the exchanges. *See* 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) ("We will allow any person or family to receive ACA tax credits and opt into ACA coverage, regardless of whether they have an offer of employer coverage. If an individual currently enrolled in qualifying employer coverage moves into an ACA plan, their employer will pay an appropriate fee to the government to maintain their responsibility for providing employee coverage.")

[193] Peter J. Cunningham, *Why Even Healthy Low-Income People Have Greater Health Risks Than Higher-Income People*, THE POINT (Sept. 27, 2018) ("The health of people with low incomes often suffers because they can't afford adequate housing, food, or child care. Such living conditions, and the stress they cause, can lead to higher rates of tobacco and alcohol use and increase the risk of health problems developing or worsening over time.")

subsidies, but are high-risk, would likely still self-select a government-sponsored plan. Higher-income workers would not qualify for subsidies that decrease the cost of a government option under either a DeLauro style plan or a Warren style plan.[194] But these high-risk workers might choose government coverage even if it were more expensive for them than their employer plan if the government option provides more robust coverage. Warren's Medicare for All plan would have comprehensive coverage that includes many benefits employers often do not, including eye and dental care.[195] If employees could get better coverage under Medicare for All, even if they do not qualify for subsidies, presumably many of the high-risk employees who need those services will opt to leave their employer plan for the government plan. Once again, higher-risk employees are more likely to leave the employer pool and enter the government pool.

DeLauro's plan provides a potential solution for this employee-generated adverse selection by requiring that employer-sponsored insurance must match the benefits provided by

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[194] Warren's transition plan caps premiums at 5% of income for anyone who makes more than 200% of the poverty line. *See* Dylan Scott, *Elizabeth Warren's New Medicare-for-All Plan Starts Out With a Public Option*, VOX (Nov. 15, 2019), https://www.vox.com/policy-and-politics/2019/11/15/20966674/elizabeth-warren-medicare-for-all-plan-public-option. Presumably many higher-income workers would choose an employer plan that would end up cheaper for them. For example, an individual who makes $200,000 would pay $10,000 in premiums under Warren's plan, but might pay much less for an employer plan. DeLauoro's plan offers subsidies to individuals up to 600% of the poverty line, and caps monthly premiums for individuals above that threshold at 8% of monthly income. *The Medicare for America Act of 2019*, DELAURO.HOUSE.GOV, https://delauro.house.gov/sites/delauro.house.gov/files/Medicare%20for%20America%20of%202019%20Summary.pdf (last visited May 6, 2020). That same individual with $200,000 of annual income would pay an annual premium of $16,000 for DeLauro's Medicare for America coverage.

[195] Elizabeth Warren, *My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All,* ELIZABETHWARREN.COM, https://elizabethwarren.com/plans/m4a-transition [https://perma.cc/L3LW-W4JJ] (last visited Mar. 5, 2020) ("critical benefits like audio, vision, full dental coverage, and long-term care benefits will be added to Medicare, and we will legislate full parity for mental health and substance use services.")

the government-sponsored insurance.[196] That way, employees will not choose between employer-sponsored and government-sponsored simply based on the coverage available.

However, while DeLauro's plan mandates that the benefits must match, she does not discuss whether the cost to procure the benefits or the quality of the benefits must match. While an employer must allow you to access care for the same kinds of conditions, the DeLauro plan does not state that the out-of-pocket cost must be the same, or that the same exact doctors be accessible. That could mean that an employer could cover dental services, with a $100 out-of-pocket deductible, without running afoul of this provision. Yet under that circumstance, if the government-sponsored insurance provided dental care with no out-of-pocket expenses, employees who expected to use dental care services would certainly be expected to opt for the government-sponsored plan. Additionally, the employer-sponsored option might have one doctor available for certain types of expensive procedures, meaning quality of care may be lower, or waiting time for the service may be longer. If the government option had more doctors available, employees needing that service would presumably opt for the government insurance instead.

Allowing choice between employer-sponsored and government-sponsored coverage will likely lead to imbalanced and unpredictable risk pools, with the government pool almost certain to be a higher-risk, and therefore more expensive pool to insure. Greater uncertainty about the risk pool will require the government-sponsored plan to build in larger margins to accommodate uncertain risks, leading to increased cost overall.[197] The increased number of claims that the

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[196] *The Medicare for America Act of 2019*, DELAURO.HOUSE.GOV, https://delauro.house.gov/sites/delauro.house.gov/files/Medicare%20for%20America%20of%202019%20Summary.pdf (last visited May 6, 2020) ("Large employers can continue to provide insurance, if it is gold-level coverage with benefits comparable to Medicare for America.")

[197] DRIVERS OF 2016 HEALTH INSURANCE PREMIUM CHANGES 7, (Amer. Acad. of Actuaries Aug. 2015), available at https://www.actuary.org/sites/default/files/files/Drivers_2016_Premiums_080515.pdf

government-insured pool will have to pay out, due to higher-risk participants, would either lead to increased premiums for those who don't qualify for subsidies, and/or a larger contribution from the government to prevent premiums from going above unsustainable levels.[198] Warren's plan guarantees that no one would pay more in premiums than 5% of their income[199] (and Sanders promises no premiums at all)[200] but this promise would be hard to sustain if the pool ended up being much riskier than an average pool because of the abovementioned adverse selection.[201] Conversely, when employers run insurance programs covering all of their employees the adverse selection problem disappears, as individuals get health insurance as a result of their employment, not their relative health needs.[202]

History has taught healthcare reformers different lessons about the connection between adverse selection and uncertain risk pools. When New York State experimented with various healthcare reforms in the 1990s, indeterminate risk pools led to increased premiums and fewer

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[198] Amy Monahan and Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees*, 97 VA. L. REV. 125, 173 (2011), http://virginialawreview.org/sites/virginialawreview.org/files/125.pdf ("If employers dump a substantial number of disproportionately high risk employees on to individual markets, then premiums for all policyholders will rise to reflect the worse-than-average risk pool… Individuals would not bear the burden of the resulting rate increases alone: so too would the federal government, whose statutory obligations to subsidize health insurance premiums increase in lock step with increases in overall premiums.")

[199] Elizabeth Warren, *My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All,* ELIZABETHWARREN.COM, https://elizabethwarren.com/plans/m4a-transition [https://perma.cc/L3LW-W4JJ] (last visited Mar. 5, 2020) ("For individuals above 200% FPL, premiums will gradually scale as a percentage of income and are capped at 5.0% of their income.")

[200] *Bernie Sanders on Healthcare,* FEELTHEBERN.ORG, https://feelthebern.org/bernie-sanders-on-healthcare/ [https://perma.cc/TGZ9-QPBV] ("No premiums, deductibles or copays for any medical services...")

[201] DRIVERS OF 2016 HEALTH INSURANCE PREMIUM CHANGES 1 (Amer. Acad. of Actuaries Aug. 2015), available at https://www.actuary.org/sites/default/files/files/Drivers_2016_Premiums_080515.pdf ("If a risk pool disproportionately attracts those with higher expected claims, premiums will be higher on average for that pool.")

[202] David A. Hyman and Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 23, 32

insurance providers as high-risk pools became increasingly difficult to sustain.[203] On the other hand, the ACA public exchanges also had uncertain risk pools but fewer issues with adverse selection. In the case of those exchanges, the individual mandate combined with generous federal premium subsidies meant that many young people opted into buying insurance on the exchanges and the subsequent risk pool was not as high-risk as some had feared.[204] Additionally, other risk management provisions of the ACA, including the risk adjustment program and risk corridors reduced the impact of adverse selection of the exchanges.[205]

Of course, many do not agree that a choice between employer- and government-sponsored insurance would destabilize the economics of a government-sponsored insurance plan. Proponents of Medicare for All or an improved public option tout their plan to lower the cost of the overall system. Lowering overall costs would help counter the increase costs from adverse selection in the government pool. Warren's plan includes promises to reduce drug prices,[206]

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[203] Mark A. Hall, *An Evaluation of New York's Health Insurance Reform Law*, 25 J. HEALTH POL., POL'Y & L. 1, 2-3 (2000) ("Prices in the individual market have increased substantially more than in other portions of the market, due to adverse selection… It seems likely that New York's individual market will become essentially a widely dispersed high risk pool funded by HMOs and Blue Cross plans in which enrollment will continue to shrink and rates will continue to rise faster than medical inflation.")

[204] Thomas Beaton, *How to Curb Adverse Selection in the Individual Health Plan Market*, HEALTH PAYER INTELLIGENCE (Aug. 31, 2018), https://healthpayerintelligence.com/news/how-to-curb-adverse-selection-in-the-individual-health-plan-market ("Policies within the Affordable Care Act, such as the individual mandate, risk adjustment program, and risk corridor program, were intended to prevent payers and consumers from unbalancing risk pools or tweaking plan designs to encourage favorable enrollment patterns."). *But see*, Robert Laszewski, *Joe Biden's Health Care Plan Would Fix the Individual Health Insurance System*, FORBES (Dec. 22, 2019), https://www.forbes.com/sites/robertlaszewski2/2019/12/22/joe-bidens-health-care-plan-would-fix-the-individual-health-insurance-system/#cda8eb81f932 ("The fundamental reason the Obamacare individual market policies have seen a long succession of more and more unaffordable rate increases is because of "anti-selection"—as the prices increase more, and more healthy people find the coverage unaffordable, and as a result take the risk of dropping out, leaving the sickest participants behind, and the prices even higher.")

[205] *See* note 204*, supra*

[206] Elizabeth Warren, *Ending the Stranglehold of Health Care Costs on American Families*, ELIZABETHWARREN.COM, https://elizabethwarren.com/plans/paying-for-m4a [https://perma.cc/SY74-TA2C] (last visited Mar. 6, 2020) ("My administration will use a suite of aggressive policy tools to set a net savings target that will bring down Medicare prices for brand name prescription drugs by 70% and prices for generics by 30%, with an initial focus on more expensive drugs.")

decrease administrative overhead,[207] decrease reimbursements for specialist doctors,[208] and a movement away from fee-for-service[209] (discussed above in Part I as one reasons the AMA lobbied against government-sponsored insurance in the first half of the 20th century.)[210]

If healthcare reform manages to take these cost-cutting measures and dramatically reduce the costs of operating a government plan even as adverse selection sends higher-risk people into the government plan, adverse selection could end up as a feature and not a bug. As discussed above in §II.B.1.a.i, higher-risk and therefore higher-cost individuals would migrate into a quality government plan that is able to provide care at a relatively low price. Employer plans would end up saving insurance costs, since those remaining in the pool would be lower-risk.

At least a handful of these aggressive cost-cutting measures are likely to meet massive lobbying resistance, however, from medical associations such as the AMA, the pharmaceutical industry, and insurance companies currently administering plans. Doctors and hospitals would also likely oppose a move towards Medicare reimbursement rates, as those are historically much

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[207] *Id*. ("Medicare for All will save money by bringing down the staggering administrative costs for insurers in our current system. As the experts I asked to evaluate my plan noted, private insurers had administrative costs of 12% of premiums collected in 2017, while Medicare kept its administrative costs down to 2.3%. My plan will ensure that Medicare for All functions just as efficiently as traditional Medicare by setting net administrative spending at 2.3%.")

[208] *Id*. ("Under my approach, Medicare for All will sharply reduce administrative spending and reimburse physicians and other non-hospital providers at current Medicare rates. My plan will also rebalance rates in a budget neutral way that increases reimbursements for primary care providers and lowers reimbursements for overpaid specialties.")

[209] *Id*. ("Instead of paying providers for each individual service, bundled payments reimburse providers for an entire "episode" of care and have been shown to both improve outcomes and control costs.")

[210] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 256 (Basic Books, Inc., 1982)

lower than current reimbursement rates from private insurers[211] and sometimes do not even cover the cost of care.[212] Part I of this article showed that controversial cost-saving measures such as fee-for-service can lead to the death of well-meaning healthcare reform,[213] and more recently, when the ACA attempted to take on Big Pharma and introduce drug cost-cutting measures, pharmaceutical lobbyists succeeded in removing drug controls from the bill.[214] Additionally, the current Medicare system does not have a great track record with cost-effectiveness. While the administrative costs are indeed low, as highlighted in Warren's plan,[215] Medicare does not do a great job determining which treatments deliver the best value. For example, a 2018 report to Congress by The Medicare Payment Advisory Commission reported "up to one-third of Medicare beneficiaries received some kind of low-value treatment in 2014, costing the program

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[211] Clarrie Feinstein & Joseph Zeballos-Roig, *Bernie Sanders Just Cemented his Frontrunner Status with a Huge Victory in Nevada. Here's How his Medicare for All Plan Would Remake the $3.6 Trillion US Healthcare Industry*, BUSINESS INSIDER (Feb. 23, 2020), https://www.businessinsider.com/how-medicare-for-all-would-affect-us-healthcare-system-2019-8 ("Private insurers typically pay more for physician services than Medicare… according to the Congressional Budget Office [CBO]. If Medicare for All was implemented, doctors would get paid government rates for all their patients. "Such a reduction in provider payment rates would probably reduce the amount of care supplied and could also reduce the quality of care," the CBO report said.")

[212] Robert Pear, *Health Care and Insurance Industries Mobilize to Kill 'Medicare for All'*, N.Y. TIMES (Feb. 23, 2019), https://www.nytimes.com/2019/02/23/us/politics/medicare-for-all-lobbyists.html ("Doctors and hospitals say Medicare generally pays less than private insurance, and hospitals say the payments frequently do not cover the costs of providing care to Medicare patients.")

[213] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 256 (Basic Books, Inc., 1982)

[214] Brett Norman and Sarah Karlin-Smith, *The One That Got Away: Obamacare and the Drug Industry*, POLITICO (July 13, 2016), https://www.politico.com/story/2016/07/obamacare-prescription-drugs-pharma-225444 ("We needed 60 votes in the Senate; we got 60. We needed 218 votes in the House; we got 219..."Had structural changes to pharmaceutical pricing been in the bill, the Affordable Care Act would not have been enacted.")

[215] Elizabeth Warren, *My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare for All,* ELIZABETHWARREN.COM, https://elizabethwarren.com/plans/m4a-transition [https://perma.cc/L3LW-W4JJ] (last visited Mar. 5, 2020) ("Medicare for All will save money by bringing down the staggering administrative costs for insurers in our current system. As the experts I asked to evaluate my plan noted, private insurers had administrative costs of 12% of premiums collected in 2017, while Medicare kept its administrative costs down to 2.3%. My plan will ensure that Medicare for All functions just as efficiently as traditional Medicare by setting net administrative spending at 2.3%.")

billions of dollars."[216] Lowering the cost of the overall health care system, like many of Medicare for All's lofty promises, is much easier said than done.

Even if the public option does not manage to implement aggressive cost-cuts, there are other ways to manage the risk of and costs of adverse selection. Policymakers can look to the successes of the ACA in avoiding adverse selection and offer generous enough subsidies that incentivize younger and healthier people to opt into the public option. Alternatively, healthcare reform could follow DeLauro's proposal mandating that employer-sponsored insurance must have coverage comparable to the government-sponsored insurance, so that individuals do not make choices based on breadth of coverage. Adopting this proposal would raise overall costs of insurance for employers, however, who may end up passing along some of those costs to their employees in the form of increased premiums or other forms of cost sharing.

Almost all of the proposals for Medicare for All and public option proposals allow for coexistence of employer-sponsored and government-sponsored insurance programs, either temporarily or permanently. This coexistence means that the connection between employment and healthcare will remain strong, even though there will be an alternative path to receiving coverage beyond simply through one's employer.

In addition to continuing the employment-health nexus, maintaining this choice also opens up regulatory compliance and behavioral economic complexities. Employers looking to be strategic about whom to keep in their pool may bump up against ACA nondiscrimination regulations and they will have to navigate complex coordination of benefits issues. Employees looking for the best plan to serve their specific health needs may end up self-selecting into a

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[216] Austin Frakt & Elsa Pearson, *A Question Rarely Asked: What Would Medicare for All Cover?*, N.Y. TIMES (July 29, 2019), https://www.nytimes.com/2019/07/29/upshot/medicare-for-all-coverage-question.html

government pool that becomes increasingly high-risk because of its comprehensive coverage and subsidized premiums. Such a high-risk government pool will see increased costs due to increased claims. These costs may or may not be offset by controversial cost-cutting measures which will attract the same kind of lobbying that killed previous reform proposals, such as lowering reimbursements for doctors and capping the pharmaceutical industry's ability to set drug prices. If the cost-cutting measures are successful, however, adverse selection could end up as a feature of a two-track insurance system, rather than a bug.

III. Managing the Employment-Health Nexus in a Healthcare-for-All System

It seems that none of the currently proposed healthcare reforms can succeed in completely severing the connection between employment and health. As much of the coronavirus pandemic illuminates the problems with tying healthcare coverage to employment status, the relationship between employers and health insurance will likely continue to exist. Medicare for All or a more robust public option can help to cushion the blow of unemployment on health care coverage, however, by providing a safety net program for people who lose their coverage if they lose their job. While the detailed plans hammered out in the 2019-2020 presidential primaries still allow for a lot of room for employers to administer and fund health care, they would also increase the financial and health security of Americans by providing alternative means to procuring insurance if you cannot, or chose not to, receive it from an employer. At the same time, many of these plans would also allow Americans to continue to receive their health insurance from their employer as long as they choose to. This compromise, of providing government coverage for those who want or need it, while allowing Americans to continue to receive coverage from their employer if they so choose, seems to provide an optimal balance. Companies

can continue to recruit and retain top talent and the American people can access comprehensive health care coverage not tied to their employment status. Additionally, a robust public option plan could save costs by adopting regulations banning employers from shifting high-cost employees to a government plan and mandating that the public option cannot function as a secondary insurance for those who choose an employer option.

If American politicians and policymakers do end up adopting a Warren or Sanders-style Medicare for All, possibly spurred to action by the coronavirus pandemic, there will still be room for employer provision of health care benefits. As is the case in other countries, employers will likely continue to provide health insurance as an employee benefit, only it would be supplemental coverage that would layer on top of a government-sponsored universal health insurance program. Supplemental coverage should continue to receive the same sort of beneficial tax treatment that employer-sponsored health insurance receives today, both as a cost-saving measure and a concession to employers looking to use benefits to recruit and retain top talent.

Continuing the tax deduction for employer healthcare costs may also help limit health care inflation. If companies can deduct health care expenses, it means that companies are deducting a higher amount when their health care costs are higher. If health care costs remain high, the government will see decreased tax revenue, as companies can write off higher health care costs. If the government does manage to bring down the costs of healthcare, as discussed above in Section II.B.2, companies will be able to write off smaller and smaller amounts of healthcare spending in response to those government cost-cutting measures. This would be a win-win: companies would spend less on providing healthcare benefits to their employees, and the government would see increased tax revenue as healthcare deductions decrease.

CONCLUSION

While this paper identifies and teases out regulatory complexities that naturally arise in a choice-based healthcare regime, I do not mean to suggest that healthcare reform should eliminate choice. On average Americans are happy with the coverage they receive from their employers,[217] and reformers should beware the practical barriers that may arise out of disrupting consumer satisfaction. Additionally, maintaining a strong employer-sponsored option will help manage the size and cost of a more robust government-sponsored option.

Rather than eliminate choice, policymakers should plan for the complexities that will naturally arise from allowing choice to continue. Sponsors of health insurance, whether a company or the federal government, will need to carefully assess the regulations to plan for nondiscrimination and coordination of benefits issues that are certain to arise. Additionally, when sponsors of insurance programs price their premiums, they should account for the adverse selection that will inevitably take place in a regime that allows for consumer choice. These barriers should not scare policymakers away from providing choice. Choice will reap benefits-for companies, by preserving their ability to garner employee satisfaction in a tax-efficient manner, and for the government, by decreasing costs and increasing popular support for a system that does not necessarily disrupt current satisfaction with insurance coverage.

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[217] Justin McCarthy, *Most Americans Still Rate Their Healthcare Quite Positively*, GALLUP (Dec. 7, 2018), https://news.gallup.com/poll/245195/americans-rate-healthcare-quite-positively.aspx ("...solid majorities of Americans rate the coverage (69%) and quality (80%) of the healthcare they personally receive as "excellent" or "good."”); Karen Pollitz, et. al, *What's The Role of Private Health Insurance Today and Under Medicare-for-all and Other Public Option Proposals?*, THE KAISER FAMILY FOUNDATION (July 30, 2019), https://www.kff.org/health-reform/issue-brief/whats-the-role-of-private-health-insurance-today-and-under-medicare-for-all-and-other-public-option-proposals/ ("...nearly seven in ten (68%) people with job-based coverage give their plan a grade of "A" or "B" and use words like "grateful" (72%) or "content" (69%) in describing how they feel about their insurance.")