American Journal of Law & Medicine (2023), 49: 4, 415–435
doi:10.1017/amj.2024.1

American Society of Law, Medicine & Ethics
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ARTICLE

How The "Great Resignation" and COVID Unemployment Have Eroded the Employer Sponsored Insurance Model and Access to Healthcare

Miriam F. Weismann

Florida International University College of Business, Miami, FL, USA
Email: mweisman@fiu.edu

Abstract

Pre-pandemic, employer-sponsored health insurance (ESI) covered 175 million workers and their dependents, the equivalent of 49% of the country's total population. ESI, a valuable tax preference to employer and employee alike, spurred worker job dependence on employers resulting in access to healthcare dependent upon continued employment. With the advent of the pandemic and the dramatic increase in unemployment, the number of uninsured increased by more than 2.7 million people. Then, unemployment proliferated further by an unprecedented exit from the workforce dubbed the "Great Resignation." Over 47 million Americans voluntarily quit their jobs in a movement characterized as a general labor strike. The pandemic opened the floodgates to workers' concerns about COVID safety in the workplace, wage stagnation despite increases in the cost of living, enduring job dissatisfaction, and increased demand for a remote-working environment. Data shows that the unemployed shifted to the Affordable Care Act marketplace or to the public payer option, Medicaid, for coverage. This shift signals a change, post-pandemic, away from the destabilizing system of access to care based on employment and unwanted job dependence and provides a policy argument favoring the more stabilizing influence of public insurance options in the health insurance market.

Keywords: employer-sponsored health insurance; great resignation; COVID; American Rescue Plan; Affordable Care Act

I. Introduction

The advent of employer-sponsored health insurance (ESI) as the primary system of access to healthcare in the United States, through the provision of group health insurance by employers to employees, has been the subject of continuing debate in the government and in the private sector.[1] For almost 70 years, employers have benefitted from dependence on job security created by the workers' need to remain employed in less-than-satisfying jobs and careers to maintain health insurance. Case in point, the story of former New York Times reporter Kurt Eichenwald who suffers from epilepsy. Mr. Eichenwald writes: "Health insurance rules my life. It decides my jobs, my aspirations, my retirement plans and, potentially, my citizenship."[2] Because of his chronic illness, Mr. Eichenwald could not obtain private insurance due to a pre-existing condition. His only hope was ESI and it was a severely limiting choice: "The only solution was employer-based group insurance. I wanted to be a newspaper reporter, but I could not be too picky. The basis of my career decisions rested almost solely on a potential employer's benefits

[1] *See The Tax Code and Health Insurance: Hearing Before the H. Comm. on Budget,* 110th Cong. (2007) [hereinafter *Hearing*]; *see also* Cong. Rsch. Serv., RL34767, The Tax Exclusion for Employer-Provided Health Insurance: Issues for Congress 9-10 (2011); Ellen O'Brien, *Employers' Benefits from Workers' Health Insurance,* 81 Milbank Q. 53 (2003).

[2] Kurt Eichenwald, *Held Hostage by Health Insurance,* N.Y. Times (Oct. 15, 2018), https://www.nytimes.com/2018/10/15/opinion/affordable-care-act-pre-existing-conditions.html [https://perma.cc/4YMT-6YMU].

package."[3] In his memoir, Mr. Eichenwald recounts the loss of job after job once his chronic condition became apparent to his employer. He was forced to leave a low-level editor's job to take a position as copy boy who ran errands and got coffee. Eventually after several years he was finally promoted to reporter.[4] He concludes: "For almost 40 years, my battle for insurance sent my life in directions I often didn't desire."[5] While the Affordable Care Act finally offered Mr. Eichenwald his first chance for relief, he became disillusioned as politics and litigation eviscerated much of its public value. His real fear was the possibility of having to leave the United States and seek foreign citizenship if the Affordable Care Act was finally repealed.[6] There are many more stories of the disaffected. Mr. Eichenwald's story is one that contextualizes the reality of unwanted job dependence due to ESI.

While some of the relative merits and disadvantages of ESI will be touched upon here, that is not the focus of the article. Instead, the article considers the change in employment dependence and healthcare access, post pandemic, through the increasing use of alternative public option sources of health insurance necessitated by job loss and layoffs due to the COVID-19 outbreak[7] [hereinafter the "pandemic"] and the Great Resignation. The data reflects that the erosion of ESI may be an inevitable consequence of the changes in job dependence post-pandemic.

II. The Simple Twist of Fate: The Tax Code and Employer-Sponsored Health Insurance

A. History of ESI

With the advent of the industrial revolution at the turn of the twentieth century, the link between health insurance and the workplace was formed in the United States.[8] By the end of World War II, ESI had greatly expanded into the workforce to attract employees to meet wartime production schedules.[9] At this time, the competition for a capable workforce was hindered by wartime wage controls.[10] However, employers competed to increase compensation without violating wage controls by simply offering health insurance as an employee benefit in lieu of cash wages.[11] Then, in 1943, the IRS ruled that employers' contributions to group health insurance would not violate wage controls and would not count as taxable income for employees.[12] That ruling was later codified by Congress in the Internal Revenue Code in 1954.[13] Post-1954 studies show that these changes in the tax law had an immediate impact in the insurance market resulting in a shift from individual plans to ESI.[14] By exempting ESI from taxation, it became economically cheaper to give and receive an untaxed dollar in health benefits, rather than a taxed

[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] *See* Bidisha Mandal et al., *Health Insurance Coverage During the COVID-19 Pandemic: The Role of Medicaid Expansion*, 57 J. Consumer Affs. 296, 296 (2022).
[8] Comm. on Emp.-Based Health Benefits, Inst. of Med., Employment and Health Benefits: A Connection at Risk 49 (Marilyn J. Field & Harold T. Shapiro eds., 1993).
[9] *Id.* at 66-71.
[10] 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 [https://perma.cc/8N94-FP9R].
[11] *Hearing*, *supra* note 1, at 9.
[12] IBP, Inc., US Healthcare Sector – Organization, Management and Payment Systems Handbook 1, 94 (2015) (citing I.R.S. Priv. Ltr. Rul. P-H 1943-44 (Aug. 26, 1943)); *see also* Cong. Budget Off., The Tax Treatment of Employment Based-Health Insurance 23 (1994) [hereinafter Tax Treatment].
[13] I.R.C. § 106(a) (1954) ("Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.").
[14] Melissa A. Thomasson, *The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance*, 93 Am. Econ. Rev. 1373, 1373 (2003).

dollar in salary.[15] As such, the ESI system that has been firmly rooted in the economy for almost 70 years sealed the institution of insurance in the United States as an employment-based system.[16]

This generous tax preference[17] accorded to ESI is a historical "twist of fate" that has increased in amount automatically over the decades without legislative authorization or appropriations.[18] It has become the unintentional foundation for a system which provides access to healthcare for 152 million workers aged 16 and older, meaning that approximately 175 million workers and their dependents had ESI coverage in 2019.[19] This follows an increasing trend. Earlier in 2007, the data showed that ESI was a source of coverage for 7 out of 10 American workers.[20] The unforeseen consequences of this tax preference included enduring worker job dependence on employment to maintain ESI, referred to as the condition of "job lock," and a small, dysfunctional insurance market for individual policies.[21] Notably, the ACA was legislatively designed, in part, to overcome some of the tax inequities in individual coverage created by this preference.[22] However, this and many other of the ACA provisions, as described in further detail below, were subsequently negated by Congress in the next administration.

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[15]Tax Pol'y Ctr., *Taxes and Health Care: How Might the Tax Exclusion for Employer-Sponsored Health Insurance (ESI) Be Reformed?*, *in* Tax Policy Center Briefing Book (2020), https://www.taxpolicycenter.org/briefing-book/how-might-tax-exclusion-employer-sponsored-health-insurance-esi-be-reformed-0 [https://perma.cc/TQN4-Q5Q3] (observing that "[t]he exclusion of employer-paid premiums for health insurance from federal income and payroll taxes is the single largest tax expenditure, costing the federal government an estimated $273 billion in fiscal year 2019. Further, because the employer-sponsored health insurance (ESI) exclusion reduces taxable income, it is worth more to taxpayers in higher tax brackets than to those in lower brackets, who are less likely to be covered by ESI in the first place.") [hereinafter TPC Briefing Book—Tax Exclusion].

[16]*Id.*

[17]*Options for Reducing the Deficit: Reduce Tax Preferences for Employment-Based Health Insurance*, Cong. Budget Off. (Dec. 8, 2016), https://www.cbo.gov/budget-options/2016/52246 [https://perma.cc/62KF-LRRB] [hereinafter *Tax Preference*]. Tax expenditures are exclusions, deductions, preferential rates, and credits in the tax system that have the same budget effect as direct federal spending in that they subsidize or provide financial assistance to specific activities, entities, or groups of people. *Id.* The favorable tax treatment of employment-based health benefits is the largest single tax expenditure by the federal government. Including effects both on income taxes and on payroll taxes, that exclusion is projected to equal 1.5% of gross domestic product over the 2017–2026 period. *Id.*

[18]*Hearing*, *supra* note 1, at 9.

[19]*Health Insurance Coverage of the Total Population*, KFF (2019), https://www.kff.org/other/state-indicator/total-population/?dataView=0&currentTimeframe=0&selectedDistributions=employer&sortModel=%7B%22colId%22:%22Employer%22,%22sort%22:%22desc%22%7D [https://perma.cc/6YED-Q3QN]. The Kaiser Family Foundation (KFF) data is based on the Census Bureau's American Community Survey (ACS) conducted by KFF. *Id.* The ACS Survey did not release the one-year estimates for 2020 due to significant disruptions to data collection brought on by the coronavirus pandemic. *Id. See also* Paul Fronstin & Stephen Woodbury, *How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?*, Commonwealth Fund (Oct. 7, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/how-many-lost-jobs-employer-coverage-pandemic [https://perma.cc/UVW2-HGCJ]; Vaugn Himber, *Employer Sponsored Health Insurance Statistics: What the Data Tells Us*, eHealth (Oct. 20, 2022), https://www.ehealthinsurance.com/resources/small-business/how-many-americans-get-health-insurance-from-their-employer [https://perma.cc/77J9-S7FM].

[20]*Hearing*, *supra* note 1, at 1.

[21]From a psychological standpoint, "job lock" refers to a circumstance in which a worker would like to retire or stop working altogether but perceives that they cannot due to needing the income, and/or health insurance. Gwenith G. Fisher et al., *Job Lock, Work, and Psychological Well-being in the United States*, 2 Work Aging & Ret. 345, 346 (2016); *see* David Blumenthal & Sara Collins, *Where Both the ACA and the AHCA Fall Short, and What the Health Insurance Market Really Needs*, Harv. Bus. Rev. (Mar. 21, 2017), https://hbr.org/2017/03/where-both-the-aca-and-ahca-fall-short-and-what-the-health-insurance-market-really-needs [https://perma.cc/KB6P-ZJH2] for the proposition that individual insurance markets have failed to meet the needs of the public for several reasons. Prior to the ACA, on average, individual insurance premiums were increasing more than 10% annually. These individual policies excluded consumers with pre-existing health conditions, charged higher premiums for the aged and young women, and placed limits on annual and lifetime benefits. Many policy applicants were simply turned down. In 2010, an estimated 9 million adults reported that in the prior 3-year period, they had been turned down for a policy, charged a higher premium or had policy exclusions due to pre-existing conditions. As a result, only health people who could afford an individual policy got insured and the rest remained uninsured.

[22]Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 782 (2010). For example, in terms of tax equity, ESI favors richer taxpayers who benefit more from favorable tax treatment than poorer workers. *See infra* note 26 and accompanying example. The Affordable Care Act's "Cadillac tax" was intended to limit the ESI exclusion for wealthy

B. The Debate Over ESI Efficacy

The ESI system is no panacea and has its fair share of critics in the government.[23] One reason is the adverse effect on job mobility. The Congressional Budget Office (CBO) found that tying health insurance to employment disadvantages workers.[24] Specifically, the CBO observed that "[w]orkers who develop health problems get trapped in their job because a new employer's insurance often will not cover preexisting conditions-or sometimes will not even cover such workers at all. And employment-based insurance is only as secure as the job it is tied to. If workers lose their jobs, they may lose their insurance; even if they keep their jobs, their employers may drop or change their health insurance coverage."[25]

In one example, a recent study found that loss of ESI during the pandemic directly contributed to a loss of prescription coverage and diminished access to medication.[26] Increases in unemployment during the pandemic resulted in a 2.6% reduction in medication adherence and 57.5 million fewer prescriptions filled in 2020, with prescriptions declining for many chronic conditions. Perhaps not surprisingly, post-job loss, the reduction in prescription fills and medication adherence were found to be highest in states without the backup safety net of expanded Medicaid eligibility.[27] A perfect storm of lost ESI benefits without a public option safety net protection.

The loss of ESI also creates other related economic challenges that eviscerate access to healthcare. Post-pandemic, about 64% of consumers surveyed said they were living paycheck to paycheck at the end of 2022.[28] This data implicitly raises the next question about how much people have in reserve to cover expenses once unemployed. In 2021, the Federal Reserve reported that 68% of adults could cover an unexpected expense up to $400; in terms of healthcare services, that is not much purchasing power.[29] For example, given that COBRA continuation coverage premiums equal the total cost of the premium under employer-sponsored health insurance, plus a 2% administration charge (102%), many Americans cannot afford the average monthly employer contribution to premiums needed to enroll.[30] Consider out of pocket medication costs. Singlecare provides a comparison of different types of insulin for a 30-day supply based on three vials or 10 pens per month.[31] The prices vary between $500-$1350 per month. [32] This does not include the costs of test strips, syringes, and pumps.[33] These examples of economic challenges underscore the point that ESI is an unsustainable mechanism to provide stable national access to healthcare.

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individuals receiving the most expensive coverage in lieu of otherwise increased taxable compensation starting in 2022. The Cadillac excise tax equaled 40% of the value of employer-provided health benefits exceeding certain thresholds. But the tax, which was originally scheduled to take effect in 2018, was twice delayed and ultimately repealed by legislation before ever taking effect. TPC Briefing Book—Tax Exclusion, *supra* note 15.

[23] *See* TPC Briefing Book—Tax Exclusion, *supra* note 15; *Hearing*, *supra* note 1; Cong. Rsch. Serv., *supra* note 1.

[24] *Tax Preference*, *supra* note 17, at 3, 20.

[25] Tax Treatment, *supra* note 12, at 3. Yet, the Tax Policy Center is constrained to observe that: "… repealing the exclusion would also reduce ESI coverage by an estimated 16 million people. While approximately half of this group would obtain coverage from other sources, (Medicaid and non-group coverage) the remaining 8 million would become uninsured."

[26] Amanda Nguyen et al., *The Impact of Job and Insurance Loss on Prescription Drug Use: A Panel Data Approach to Quantifying the Health Consequences of Unemployment During the Covid-19 Pandemic*, 52 Int'l J. of Health Servs. 312, 317-18 (2022).

[27] *Id.* at 317.

[28] Alexandre Tanzi, *Even on $100,000-Plus, More Americans Are Living Paycheck to Paycheck*, Bloomberg News (Jan. 30, 2023), https://www.bloomberg.com/news/articles/2023-01-30/even-on-100k-plus-more-americans-live-paycheck-to-paycheck?leadSource=uverify%20wall [https://perma.cc/PGV5-2FJL].

[29] Bd. of Governors of the Fed. Rsrv. Sys., Economic Well-Being of U.S. Households in 2021 35 (2022), https://www.federalreserve.gov/publications/files/2021-report-economic-well-being-us-households-202205.pdf [https://perma.cc/DG44-KWWS].

[30] *See Continuation of Health Coverage (COBRA)*, U.S. Dep't of Lab., https://www.dol.gov/general/topic/health-plans/cobra [https://perma.cc/M2BJ-FLM7] (last visited Feb. 28, 2023).

[31] SingleCare Team, *Insulin Prices: How much does insulin cost?*, SingleCare: The Checkup Blog (Feb. 8, 2023), https://www.singlecare.com/blog/insulin-prices/ [https://perma.cc/J785-UQ4W].

[32] *Id.*

[33] *Id.*

In addition, ESI creates an imbalance in tax savings favoring employer-insured workers and disfavoring the self-employed thereby undermining principles of tax equity.[34] Specifically, under current law, the tax exclusion provides tax savings when employers pay for the insurance, while coverage purchased in the individual market generally has marginal tax savings.[35] Critics argue that this limits workers' health plan choices and penalizes workers who might be able to work more productively elsewhere.[36] While there are two tax provisions that do provide tax savings to people who purchase insurance in the individual market, these provisions are fraught with tax complexity dissimilar to the ESI tax preference.[37,38] Also, the cost is increased for the self-employed who must purchase insurance with after tax dollars and do not share in the benefits of the tax preference afforded workers receiving ESI.[39]

Another criticism, in terms of tax equity, is that ESI favors richer taxpayers who benefit more from favorable tax treatment than poorer workers. Because the exclusion of premiums for ESI reduces worker taxable income, it is worth more to taxpayers in higher tax brackets than to those in lower brackets. Income tax savings from ESI depend upon a taxpayer's marginal tax rates. For low-income taxpayers, the savings on federal income taxes might be 10% or as little as none, depending on their income. For higher-income taxpayers, the income tax savings would be markedly greater because they have reported income available for offsetting deductions.[40]

Other criticism focuses on the adverse economic impact of ESI on healthcare utilization and the attendant consequence of increased healthcare costs. The tax exclusion from income subsidy reduces the after-tax cost of insurance to workers and results in workers buying more insurance coverage than they otherwise would. The exclusion thus contributes to what some economists consider an excess of

[34]*See* Tax Div., Am. Inst. of Certified Pub. Accts., Tax Policy Concept Statement 4: Guiding Principles for Tax Equity and Fairness (2007) ("The importance of tax equality, equity and fairness has long been recognized. Adam Smith established 'four maxims with regard to taxes,' one of which was the need for equality in a tax system."); Adam Smith, An Inquiry Into the Nature and Causes of the Wealth of Nations 224 (Jonathan Bennett ed., 2017).

[35]Cong. Rsch. Serv., *supra* note 1, at 15.

[36]*See supra* text accompanying note 1.

[37]Cong. Rsch. Serv., *supra* note 1, at 15; Treas. Reg. § 1.162(l)-1 (as amended in 2017). Deduction for health insurance costs of self-employed individuals. Under this section, a 100% deduction is allowed for self-employed taxpayers who buy policies for themselves and their family members; this applies only to a small number of people, less than 3% of all who file returns. One reason the percentage of filers is so small is the many rules attendant to the deduction. In addition to being self-employed, the taxpayer must meet a number of additional conditions. The deduction cannot exceed the net profit and any other earned income from the business under which the plan is established, less deductions taken for certain retirement plans and for one-half the self-employment tax. It is not available for any month in which the taxpayer or the taxpayer's spouse is eligible to participate in a subsidized employment-based health plan (i.e., one in which the employer pays part of the cost). These restrictions prevent taxpayers with little net income from their business, which is not uncommon for a new business, from deducting much if any of their insurance payments.

[38]I.R.C.§ 213.The other is the itemized deduction for unreimbursed medical expenses, which is available only to taxpayers who itemize their deductions and only to the extent the expenses exceed 7.5% of their adjusted gross income. *Id.* For most taxpayers, the standard deduction is larger than the sum of their potential itemized deductions, and of those who itemize, most do not have extensive unreimbursed medical expenses. In 2005, about 35% of all returns had itemized deductions, and of these, less than 21% (about 7% of all returns) claimed the medical expense deduction. Thus, most people who purchase insurance in the individual market cannot claim either of these deductions. *See* Cong. Rsch. Serv., *supra* note 1, at 15.

[39]Michael Morrisey, Health Insurance 275 (3d ed. 2020).

[40]Cong. Rsch. Serv., *supra* note 1, at 15. The Congressional Research Service provides the following tax calculation using 2008 tax brackets. In 2008, for example, a single tax filer generally will not have a regular tax liability until his or her income exceeds $8,950, the sum of the standard deduction and personal exemption. Until income exceeds $16,975, the taxable income (the difference between $16,975 and $8,950) would be taxed at 10%. Thus, if a single taxpayer with wage income of $13,000 was given employer-paid insurance worth $3,000, the savings from the income tax exclusion would be $300 (i.e., $3,000 x 10%). For single filers in the top tax bracket of 35%, the tax savings from the exclusion of $3,000 of coverage would be $1,050, appreciably more than the savings for low-income workers. Parenthetically, the analysis would be the same under the Tax Cuts Jobs Act which provides the current tax brackets.

insurance coverage and a significant welfare (or efficiency) loss for insured individuals and society as a whole.[41] The welfare loss from excess insurance, particularly insurance with low deductibles and copayments, occurs because people pay more for health care services than they would if everyone assumed more of the cost themselves.[42] This outcome is caused partly by the increased demand attributable to insurance (people generally use more services when they have coverage because their effective price at the time of service drops or a "more is better mentality")[43] and partly by the increase in market prices for services due to higher aggregate demand.[44] Increased market prices in turn encourage people to purchase more insurance in order to avoid or minimize the additional financial risk from higher prices.[45]

Finally, critics point to the severe adverse impact of ESI on revenue collection and the federal budget. For example, in 2019 the Tax Policy Center reported that various tax preferences for healthcare reduced income tax revenue by about $234 billion. Over $152 billion of that figure was attributable to the exclusion from taxable income of employers' contributions for medical insurance premiums and medical care.[46] Payroll tax revenue was substantially reduced by ESI. Combined, the ESI exclusion reduced income and payroll tax revenue by $273 billion in 2019.[47]

On the other side of the coin are those who argue that there is a business case to be made for ESI.[48] Supporters point out that ESI opened the door to healthcare access to many more workers than would otherwise have the financial ability to purchase insurance for themselves and their dependents.[49] Employers providing health insurance benefits to employees can benefit through reduced costs. These cost reductions are seen in areas such as workers' compensation, in the ability to recruit and retain workers, and increased productivity from reduced absenteeism.[50]

Additionally, workers and their dependents who were previously uninsured may experience greater access to medical care services and better health outcomes. To underscore the importance of this point, a study conducted at Harvard Medical School and Cambridge Health Alliance found that uninsured, working-age Americans have a 40% higher risk of death than their privately insured counterparts, up from a 25% excess death rate found in 1993.[51] The study concludes, based upon the data, that "uninsurance is associated with mortality."[52] Likewise, ESI offers the community a benefit from a healthier citizenry and a reduction in the tax burden associated with uncompensated care provided to the uninsured.[53]

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[41] Cong. Rsch. Serv., *supra* note 1, at 10; R. Douglas Scott II et al., *Applying Economic Principles to Health Care*, 7 Emerging Infectious Diseases 282, 283 (2001).

[42] Cong. Rsch. Serv., *supra* note 1, at 10.

[43] Miriam Weismann & Irving Jorge, *The Regulatory Vision of Universal Healthcare in the United States: Strategic, Economic, and Moral Decision-Making,* 213 U. Pa. J. Bus. L. 647, 666 (2019).

[44] For a more detailed account of the healthcare efficiency principle and its impact on healthcare spending, see *id.* at 660.

[45] William Hsiao & Peter S. Heller, *What Should Macroeconomists Know About Healthcare?* (Int'l Monetary Fund, Working Paper No. WP/07/013, 1, 6-8 (2007).

[46] Tax Pol'y Ctr., *Taxes and Health Care: How Much Does the Federal Government Spend on Health Care?*, *in* Tax Policy Center Briefing Book (2020), https://www.taxpolicycenter.org/briefing-book/how-much-does-federal-government-spend-health-care [https://perma.cc/E38Z-3R77].

[47] *Id.*

[48] For an in-depth discussion of the pros and cons of the business case supporting ESI, *see,* O'Brien, *supra* note 1.

[49] *Id.*

[50] *Benefits of Providing Coverage*, Small Bus. Majority, https://healthcarageguide.org/reference-guide/benefits-providers-and-costs/benefits-of-providing-coverage/ [https://perma.cc/R7CW-NFAX] (last visited Oct. 5, 2023).

[51] Andrew P. Wilper et al., *Health Insurance and Mortality in US Adults*, 99 Am. J. Pub. Health 2289, 2292 (2009).

[52] *Id.*

[53] *But see* Weismann & Jorge, *supra* note 43, at 673 for the proposition that: "Congress found that the 'cost of providing uncompensated care to the uninsured was $43 [billion] in 2008 [and] [t]o pay for this cost, health care providers pass[ed] on the cost to private insurers, which [was] pass[ed] on the cost to families.'"

C. The Call for Change

However, the Congressional Research Service[54] (CRS) counters that the demographic and community circumstances that merited ESI to achieve greater healthcare access in the past may still not exist today and that change is warranted.[55] The pandemic may be viewed as the precipitating national demographic event to introduce that change. The perfect storm of pandemic unemployment, layoffs and voluntary resignation may have set the stage to move the country toward a different post-pandemic labor market. Given that until the advent of the Affordable Care Act, there were fewer healthcare options or alternatives to ESI, the ground may be shifting under the historical debate over the relative benefits of ESI in the marketplace.

As explained in greater detail below, the Great Resignation was seen in part to be the liberation of workers feeling trapped in less satisfying jobs and careers. Pandemic layoffs left many others unsure of future ESI security.[56] But transitioning into unemployment and an uninsured status can risk the family's health and financial stability. To provide security for these unemployed, whether due to the pandemic or to the voluntary decision to resign, another source for health insurance coverage had to be found. Fueled in part by the tax and economic support provided during the pandemic by the American Rescue Plan,[57] the data in Section IV below shows that the unemployed shifted to the available public option plans including the Affordable Care Act marketplace (on-exchange or off-exchange)[58] or to the public payer option, Medicaid for coverage. To better understand the magnitude of this shift, it is helpful to understand the number of workers actually affected by unemployment during the pandemic.

III. The New Road to Unemployment in America: Get Laid off, Fired, or Just Quit!

A. Loss of ESI Due to Pandemic Layoffs and Unemployment

A 2020 Pew Research Center report stated that the economic downturn in the U.S. economy occasioned by the outbreak of the pandemic resulted in an increased unemployment rate among American workers by more than 14 million, from 6.2 million in February 2020 to 20.5 million in May 2020. [59] Subsequently, the U.S. unemployment rate increased from 3.8% in February 2020. This was among the lowest on record post-World War II – to 13.0% in May 2020.[60] The Pew Study included supporting data reported by the U.S. Bureau of Labor Statistics.[61]

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[54]"CRS works exclusively for the United States Congress, providing policy and legal analysis to committees and Members of both the House and Senate, regardless of party affiliation." *About the Congressional Research Service*, Congress.gov, https://constitution.congress.gov/about/congressional-research-service/ [https://perma.cc/AYR9-DMTZ] (last visited Nov. 1, 2023).

[55]Cong. Rsch. Serv., *supra* note 1, at 8. The report states:

> At the very least, it shows that tax policies currently at issue were largely shaped during a particular period in history, responding to what were perceived to be the needs at that time. An implication might be that current policies should be reviewed in light of today's needs, and that further changes might now be appropriate.
>
> *Id.*

[56]*See* Fronstin & Woodbury, *supra* note 19, at 1.

[57]American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4.

[58]For clarification purposes, health insurance acquired through a state health insurance exchange or through the federal health insurance market, HealthCare.gov, is described as an on-exchange plan. Off-exchange health insurance is a plan that is purchased directly from an insurance provider, or through a broker. Though considered private plans, off-exchange plans must comply with certain ACA compliance requirements, which ensure minimum coverage and essential health benefits (EHB). *See* Ryan Kennelly, *What's the Difference Between On-Exchange and Off-Exchange?*, iHealthAgents, (Sept. 2023), https://help.ihealthagents.com/hc/en-us/articles/115002945414-What-s-the-Difference-Between-On-Exchange-and-Off-Exchange- [https://perma.cc/B378-UXUS].

[59]Rakesh Kochhar, *Unemployment Rose Higher in Three Months of COVID-19 than it Did in Two Years of the Great Recession,* Pew Rsch. Ctr. (June 11, 2020), https://www.pewresearch.org/fact-tank/2020/06/11/unemployment-rose-higher-in-three-months-of-covid-19-than-it-did-in-two-years-of-the-great-recession/ [https://perma.cc/ENY5-6U2W].

[60]*Id.*

[61]*Id.*

Another contemporaneous study in 2020 set out to determine the number of the pandemic unemployed who lost ESI coverage.[62] Estimates show that approximately 7.7 million workers lost jobs with ESI as of June 2020 due to pandemic layoffs and unemployment.[63] ESI covered an additional 6.9 million of worker dependents, totaling approximately 14.6 million affected individuals.[64]

By August 2020, labor market data showed that the number of temporarily laid-off workers had fallen to 6.2 million as many workers returned to their jobs.[65] But during the same time, the number of permanently laid-off workers increased from 2.6 million to 4.1 million, and the number of workers unemployed for 15 or more weeks increased from 1.8 million to 8.1 million.[66]

Later in 2021, a group of researchers looked back at 2020 data to determine whether ESI was permanently lost when the pandemic unemployed slowly reentered the work force in the fall and winter of 2020.[67] The study separated the analysis into two time periods. The initial period from approximately March 2020 to August 2020 included data for the initial unemployment shock impact on the economy, followed by a second later period in 2020 when workers gradually returned to work.[68] The study concluded that rates of ESI declined throughout much of 2020, even after the initial shock to employment in March 2020. Interestingly, the study also found that ESI declined throughout both study time periods, even during the time when employment was increasing in late 2020.[69] The study hypothesizes that these results suggest either that ESI declines trailed job loss or that people who returned to work did not necessarily recover their employer-sponsored coverage.[70]

B. The Great Resignation Unemployment Data

Even after pandemic restrictions began to ease in the United States, the data shows that resignations persist among workers. Contrary to widespread predictions of a slowdown, the data demonstrates that people either continue to leave current employment in large numbers or plan to do so in the short term.[71] Fuller and Kerr observe that "[T]he Great Resignation was no anomaly; the forces underlying it are here to stay."[72]

The U.S. Bureau of Labor Statistics[73] reported over 47 million Americans voluntarily quit their jobs in 2021.[74] In the month of November 2021 alone, nearly 4.5 million people resigned from their jobs, an

[62]Fronstin & Woodbury, *supra* note 19, at 1.

[63]*Id.*

[64]*Id.*

[65]*Id.* at 2.

[66]*See The Employment Situation — August 2020, USDL-20-1650, tbls. A-11, A-12*, Bureau of Lab. Stats., Dep't of Lab. (Sept. 2020).

[67]M. Kate Bundorf, Sumedha Gupta & Christine Kim, *Trends in US Health Insurance Coverage During the COVID-19 Pandemic*, 2 JAMA Health F. 1, 1 (2021).

[68]*Id.* at 3.

[69]*Id.* at 6.

[70]*Id.*

[71]Kate Morgan, *Why Workers Won't Just Stop Quitting*, BBC (Aug. 18, 2022), https://www.bbc.com/worklife/article/20220817-why-workers-just-wont-stop-quitting [https://perma.cc/2BZ3-W38G].

[72]Joseph Fuller & William Kerr, *The Great Resignation Didn't Start with the Pandemic*, Harv. Bus. Rev. (Mar. 23, 2022), https://hbr.org/2022/03/the-great-resignation-didnt-start-with-the-pandemic [https://perma.cc/YBW5-HD82].

[73]*See Job Openings and Labor Turnover Survey*, *in* Handbook of Methods, U.S. Bureau of Lab. Stats. (2022), https://www.bls.gov/opub/hom/jlt/home.htm [https://perma.cc/92G2-JE9U]. (The U.S. Bureau of Labor Openings and Labor Turnover Survey publishes rates and levels of job openings, hires, quits, layoffs and discharges, other separations, and total separations (also known as turnover) for the nation as a whole and by state, by ownership (private verses public), region, and supersector and select sectors based on the North American Industry Classification System (NAICS)). *See also Job Openings and Labor Turnover Survey*, U.S. Bureau of Lab. Stats. (2023), https://www.bls.gov/jlt/ [https://perma.cc/NUU7-BHG2].

[74]Rick Penn & Eric Nezamis, *Job Openings and Quits Reach Record Highs in 2021, Layoffs and Discharges Fall to Record Lows,* U.S. Bureau of Lab. Stats.: Monthly Lab. Rev. (June 2022), https://www.bls.gov/opub/mlr/2022/article/job-openings-and-quits-reach-record-highs-in-2021.htm [https://perma.cc/97WU-P7P8].

all-time monthly high.[75] This tracking is done annually by the U.S. Bureau of Labor Statistics using the Job Openings and Labor Turnover Survey (JOLTS).[76] The trend continued into 2022 as well. The JOLTS survey reported approximately 4.3 million people quit their jobs in January 2022, followed by another 4.2 million in February.[77]

The pandemic apparently unleashed a labor sentiment akin to a general labor strike against unwanted job dependency. A Pew Research Center[78] survey found that low pay, a lack of opportunities for advancement and feeling disrespected at work were the top reasons why Americans quit their jobs during the Great Resignation.[79] The data includes surveyed labor sentiments: "Majorities of workers who quit a job in 2021 say low pay (63%), no opportunities for advancement (63%) and feeling disrespected at work (57%) were reasons why they quit… At least a third say each of these were *major* reasons why they left. Roughly half say childcare issues were a reason they quit a job (48% among those with a child younger than 18 in the household). A similar share point to a lack of flexibility to choose when they put in their hours (45%) or not having good benefits such as health insurance and paid time off (43%).[80] Roughly a quarter say each of these was a *major* reason."[81]

Given that most experts agree that the pandemic caused a shift in priorities that spurred the quitting wave,[82] many are searching for reasons that the quit rate continues after most pandemic restrictions have been lifted.[83] The behavioral reasons are varied and based on personal values and deeply rooted factors causing workers to quit which still need to be addressed.[84] Simply put, some experts observe that people are "looking at work and the role they want it to play in their lives in a different way, and switching to jobs that better align with their new values." [85]

Moreover, Fuller and Kerr attribute the behavioral changes, aggravated by the pandemic, to the 5Rs: retirement, relocation, reconsideration, reshuffling, and reluctance.[86] Based on data from academic studies and online surveys, they conclude workers are retiring in greater numbers but are not relocating in large numbers.[87] Workers are reconsidering their work-life balance and care roles.[88] Some are making localized switches among industries, or reshuffling, rather than exiting

[75] *Id.* ("The number of annual quits rose considerably, from 35.9 million in 2020 to 47.8 million in 2021, for an increase of 33 percent.").

[76] *Id.* ("Quits include employees who left their job voluntarily, excluding retirements or transfers to other locations.").

[77] *Id.*

[78] Pew Research Center is a nonpartisan "fact tank" that informs the public about the issues, attitudes and trends shaping the world. It conducts public opinion polling, demographic research, content analysis and other data-driven social science research. It does not publish policy positions. *See About Pew Research Center,* Pew Rsch. Ctr., https://www.pewresearch.org/about/ [https://perma.cc/4VUT-M6QW] (last visited Oct. 31, 2023).

[79] Kim Parker & Juliana Menasce Horowitz, *Majority of Workers Who Quit a Job in 2021 Cite Low Pay, No Opportunities for Advancement, Feeling Disrespected*, Pew Rsch. Ctr. (Mar. 9, 2022), https://www.pewresearch.org/fact-tank/2022/03/09/majority-of-workers-who-quit-a-job-in-2021-cite-low-pay-no-opportunities-for-advancement-feeling-disrespected/ [https://perma.cc/ERU6-24Y9].

[80] *But see* Maury Gittleman, *The "Great Resignation" in Perspective*, U.S. Bureau of Lab. Stats.: Monthly Lab. Rev. (July 2022), https://www.bls.gov/opub/mlr/2022/article/the-great-resignation-in-perspective.htm [https://perma.cc/VE4H-T8XC] (Gittleman is less certain regarding the reasons for the Great Resignation. The historical data examined in the article demonstrates that recent quit rates, while high for the 21st century, are not the highest historically. He concludes that the pace of resignations has more quickly resulted from labor market tightening alone. Gittleman posits that there is not enough current research to conclude the actual reasons for the quit rate evidenced by the Great Resignation. He also notes several questions regarding what is happening to workers who are resigning for the first time: are they leaving the labor force or moving on to better jobs, have yet to be fully explored).

[81] Parker & Horowitz, *supra* note 79.

[82] Morgan, *supra* note 71.

[83] *Id.*

[84] *Id.*

[85] *Id.*

[86] Fuller & Kerr, *supra* note 72.

[87] *Id.*

[88] *Id.*

the labor market entirely.[89] Because of pandemic-related fears, workers are exhibiting a reluctance to return to in-person jobs.[90] The authors conclude that "[i]n our view, five factors, exacerbated by the pandemic, have combined to yield the changes that we're living through in today's labor market."[91]

C. Past the Pandemic into the Present

Yet, the increase or decrease in unemployment statistics alone may not be the most important feature of the problem. By August 2023, employment rates increased by 3.8% in several combined industries.[92] These recent statistics reflect at some level an economy recovering after a global crisis.[93] However, the pandemic data does provide indelible proof that the national health crisis unmasked the inadequacy and inherent instability of ESI during an employment crisis.[94] It further underscored a real possibility of the crisis repeating itself during a future economic malaise. The current literature for the most part does not address the probability of this recurrence and expresses a sentiment of hopefulness that it does not happen again. [95] This may be wishful thinking although there is no crystal ball to predict. However, the current literature does provide a consensus that the ESI model is subject to instability and is no longer a resilient and predictable path to healthcare access.[96]

Yet, some may still argue that there is a role to be played by ESI in the healthcare system. For example, both France and Germany use the Bismarckian scheme for the organization and financing of their health care. There, medical doctors are paid on a fee-for-service basis, by the national sickness funds of which financial resources come from compulsory contributions of employers and employees.[97] However, the use of employer-based systems is only one method used in both countries to *finance* their respective universal healthcare systems. The United States is the only developed Western nation not to provide universal healthcare.[98] Accordingly, the loss of employment in either France or Germany does not cause the loss of healthcare access or coverage.[99]

The next section explores the various options pursued by the unemployed to replace the loss of ESI and the relative success of those options. The bottom line is that the newly uninsured migrated toward the public option. It is important to examine the current public option systems and whether the public option provides a meaningful substitute for ESI.

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[89] *Id.*

[90] *Id.*

[91] *Id.*

[92] *The Employment Situation — August 2023,* U.S. Bureau of Lab. Stats., Dep't of Lab. (Sept. 1, 2023, 8:30 AM), https://www.bls.gov/news.release/pdf/empsit.pdf.

[93] *See* Howard Schneider & Sarah Slobin, *The Post-Pandemic Workforce,* Reuters (June 12, 2023), https://www.reuters.com/graphics/USA-ECONOMY/OCCUPATIONS/znpnbrlwjpl/ [https://perma.cc/T7X6-9A2B].

[94] John Geyman, *The Future of Work in America: Demise of Employer-Sponsored Insurance and What Should Replace It*, 52 Int'l J. of Health Servs. 168, 168 (2022).

[95] *See* Allison Hoffman, *How a Pandemic Plus Recession Foretell the Post-Job Based Horizon of Health Insurance*, 71 DePaul L. Rev. 331, 359 (2022) ("Although such a dramatic concurrence of events will hopefully not recur anytime soon…").

[96] Geyman, *supra* note 94, at 168; *see also* Anna Sagan et al., *Strengthening Health System Resilience in the COVID-19 Era*, 28 Eurohealth 4 (2022) (discussing factors that improved European healthcare resilience during COVID-19).

[97] T.R. Reid, The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care 50-51, 74-75 (Penguin Books ed. 2010); *see also* Weismann & Jorge, *supra* note 42, at 703.

[98] Munira Z. Gunja et al., *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes*, Commonwealth Fund (Jan. 31, 2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022 [https://perma.cc/86YN-A4CG].

[99] Reid, *supra* note 97, at 51, 75. For a more in-depth comparison of global healthcare systems, *see* Weismann & Jorge, *supra* note 43, at 683-87.

IV. To the Rescue: The Public Option: The Affordable Care Act "Metal Markets," Medicaid and the American Rescue Plan

A. The Status Quo and ESI: No Constitutional Right to Healthcare

There is no shortage of scholarly articles asserting that access to healthcare *is* a fundamental right in the United States or *must be* a fundamental right or *should be* a fundamental right. In fact, the U.S. Constitution does not include a provision granting citizens any right to healthcare.[100] This fact has historically militated in favor of a fundamental change. Indeed, it is worth noting that in 1944, President Franklin D. Roosevelt, in his State of the Union address, advanced his idea of a "Second Bill of Rights" which would include "[t]he right to adequate medical care and the opportunity to achieve and enjoy good health."[101] Yet, the United States has fallen behind the other industrialized nations[102] where the right to healthcare is recognized in international law and guaranteed in the constitutions of those nations.[103] Thus, the early emergence of ESI served as a private sector substitute access point to healthcare and, concomitantly, created worker job dependency for a large percentage of Americans and their families.

Moreover, because healthcare operates in a heavily regulated environment that controls in large measure public access to healthcare, the regulatory reality of the current healthcare system dictates both what is and is not possible for the unemployed.[104] What follows is a discussion of the current regulatory options available to the those having lost ESI due to layoffs, unemployment, or quitting and the relative success of those options in terms of providing substitute access points to healthcare in lieu of ESI.

B. The American Rescue Plan to the Rescue: Implementing a Temporary Public Option

The U.S. Department of the Treasury observed that "[t]he current public health crisis [pandemic] and resulting economic crisis have devastated the health and economic wellbeing of millions of Americans."[105] In response to the crisis, Congress enacted The American Rescue Plan (ARPA) to provide temporary economic relief to families in crisis due in large measure to unemployment and layoffs caused by the pandemic.[106] Included in ARPA were provisions lowering or completely eliminating health insurance premiums for millions of lower- and middle-income families enrolled in ACA Health Insurance Marketplaces (HIM).[107] The idea of the HIM subsidy was to help over a million uninsured Americans gain and/or retain coverage[108] in the absence of ESI.

Additionally, ARPA provided a 100% federal continuation health coverage subsidy (COBRA) from April 1, 2021 through September 1, 2021 to ensure that those who lost their jobs or were laid off did not lose their COBRA entitlement.[109] However, the COBRA subsidy applies only to individuals who lost

[100] *See generally* U.S. Const; Weismann & Jorge, *supra* note 43, at 647.

[101] Franklin D. Roosevelt, President, U.S., State of the Union Address (Jan. 11, 1944).

[102] Org. for Econ. Coop. & Dev., Universal Health Coverage and Health Outcomes: Final Report (2016), https://www.oecd.org/els/health-systems/Universal-Health-Coverage-and-Health-Outcomes-OECD-G7-Health-Ministerial-2016.pdf [https://perma.cc/4MW3-LK4U].

[103] Timothy S. Jost, Disentitlement? The Threats Facing Our Public Health Care Programs and A Rights Based Response 24 (2003).

[104] *See* Robert Field, *Why Is Health Care Regulation So Complex?*, 33 P & T 607, 607 (Oct. 2008). ("[T]he present regulatory structure is neither uniform nor consistent. A broad range of regulatory bodies and programs apply in different ways to various aspects of the industry. Health care regulations are developed and enforced by all levels of government—federal, state, and local—and also by a large assortment of private organizations. At times, they operate without coordination.").

[105] *Fact Sheet: The American Rescue Plan Will Deliver Immediate Economic Relief to Families*, U.S. Dep't. of the Treasury (Mar. 18, 2021), https://home.treasury.gov/news/featured-stories/fact-sheet-the-american-rescue-plan-will-deliver-immediate-economic-relief-to-families [https://perma.cc/755V-SL68].

[106] *Id.*

[107] *Id.*

[108] *Id.*

[109] *American Rescue Plan*, White House (last visited Oct. 3, 2023), https://www.whitehouse.gov/american-rescue-plan [https://perma.cc/9QCT-E7YP].

their health care coverage due to involuntary termination[110] or a reduction in hours. Unlike the HIM subsidy, voluntary termination was not covered under the COBRA subsidy.[111]

Data shows that the results of the temporary HIM subsidy increased health insurance coverage in both on-exchange and off-exchange plans.[112] A Kaiser Family Foundation (KFF) paper concludes that that the majority of uninsured people (63%) satisfied eligibility requirements for financial assistance through the Marketplaces (HIM), Medicaid, or Basic Health Plans[113] as a result of ARPA.[114] The number of people eligible for an HIM subsidy to purchase coverages increased 20% from 18.1 million to 21.8 million people[115,116] resulting in more than 4 out of 10 uninsured people becoming eligible for a cost free or substantially cost reduced plan through one of these programs.[117] Thus, the data shows that ARPA financial subsidies helped to fuel the migration of the unemployed to the Affordable Care Act marketplace (on-exchange or off-exchange) or to the public payer option, Medicaid, for coverage during the pandemic by offering the unemployed an almost cost free option to purchase health insurance.[118]

As for the future, ARPA marketplace premium subsidies took effect in 2021 and remained in effect during 2022. The recently passed Inflation Reduction Act (IRA)[119] in 2022 extended ARPA's HIM subsidies for an additional three years, through 2025.[120] The HIM subsidies increased the ability of the laid off and unemployed to seek HIM alternatives, but these increases may turn around in 2025 if the subsidy is allowed to expire.[121] For example, Massachusetts expects that 300,000 people will be disenrolled from the Massachusetts Medicaid program, Mass Health, in May 2023.[122] Despite the

[110]Voluntary termination due to general concerns about workplace safety, a health condition of the employee or a family member, or other similar issues generally are not considered involuntary termination. This is because the actual reason for the termination is unrelated to the action or inaction of the employer. *See What Circumstances Are Considered "Involuntary Termination" for Purposes of Eligibility for COBRA Premium Assistance Under ARPA?*, NFP (May 25, 2021), https://www.nfp.com/insights/cc20210525faq/#:~:text=Involuntary%20termination%20includes%20when%20an,severance%20agreement%20or%20imminent%20termination [https://perma.cc/2QTM-V7T4].

[111]Kerry Notestine, Steve Friedman & Analiza Rodriguez, *IRS Issues Guidance on the American Rescue Plan Act COBRA Subsidy,* Littler (May 26, 2021), https://www.littler.com/publication-press/publication/irs-issues-guidance-american-rescue-plan-act-cobra-subsidy [https://perma.cc/G6Q8-82RE].

[112]*See* Matthew Ray et al., *How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured*, KFF (Mar. 25, 2021), https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/ [https://perma.cc/8DXN-HR67].

[113]*Id.* ("The ACA gives states the option to implement a Basic Health Program (BHP) that covers low-income residents through state-contracting plans outside the health insurance marketplace, rather than qualified health plans (QHPs).").

[114]*Id.*

[115]*Id.*

[116]*Id.* ("The study further estimated that the average savings under ARPA subsidies were about $70 per month for individual market purchasers, ranging from an average savings of $213 (39% of premiums after subsidies) per month for people with incomes between 400% and 600% of FPL to an average savings of $33 per month (100% of post-subsidy premiums) for people with incomes under 150% of FPL (who received zero-dollar premiums for silver plans with significantly reduced out-of-pocket costs).").

[117]*Id.*

[118]*See id.*

[119]Inflation Reduction Act of 2022, Pub. L. No. 117–169, 136 Stat. 1818.

[120]Lovisa Gustafsson & Sara Collins, *The Inflation Reduction Act Is a Milestone Achievement in Lowering American's Healthcare Costs*, Commonwealth Fund (Aug. 15, 2022), https://www.commonwealthfund.org/blog/2022/inflation-reduction-act-milestone-achievement-lowering-americans-health-care-costs [https://perma.cc/Q58Q-EG53].

[121]Joseph Choi, *Subsidies Have Boosted Affordable Care Act's Enrollment. It's Setting Up a Potential Fight*, Hill (Feb. 18, 2023, 6:00 AM), https://thehill.com/policy/healthcare/3863423-subsidies-have-boosted-affordable-care-acts-enrollment-its-setting-up-a-potential-fight/ [https://perma.cc/6X94-WE59]; Tami Luhby, *Special Affordable Care Act Subsidies Available for Unemployed Americans Starting July 1*, CNN (June 29, 2021, 1:00 PM), https://www.cnn.com/2021/06/29/politics/biden-obamacare-unemployed-assistance/index.html [https://perma.cc/DFF8-8XEV].

[122]Abby Patkin, *Healey: 300,000 People Will Likely Get Dropped from MassHealth This Year*, Boston.com (Mar. 2, 2023), https://www.boston.com/news/health/2023/03/02/masshealth-redetermination-maura-healey-300000-estimate/ [https://perma.cc/9V49-A6KC].

almost cost-free option offered by the HIM, as discussed in greater detail below, the pandemic enrollment trends were still greater in the public payer option, Medicaid, than in the HIM.

C. The Enrollment Trends Toward Public Options: The ACA and Medicaid

1. Affordable Care Act Enrollment

The 2010 Affordable Care Act (ACA)[123] created an online Health Insurance Marketplace (HIM), sometimes referred to as the "metal markets," providing individual health insurance coverage, as well as a system of income-based subsidies to make plan premiums more affordable.[124] Specifically, the law allows some consumers subsidies ("premium tax credits") lowering premiums for households with incomes between 100% and 400% of the federal poverty level (FPL).[125] For example, for a family of four, the FPL is earnings of $27,750 for 2022.[126] If the household income is at or below 150% FPL, consumers may qualify to enroll in or change HIM coverage through a special enrollment period.[127]

The HIM offers four levels of plans: bronze, silver, gold, and platinum.[128] These categories or "metal levels" are based on how the consumer and the insurance plan split costs between coverage and deductibles and have no connection to the quality of care.[129] Every health plan offers the same set of essential health benefits, including doctor visits, preventive care, hospitalization, prescriptions, and cover pre-existing conditions, and preventive services.[130]

The ACA also provides for states to expand Medicaid coverage to cover all adults with income below 138% of the FPL.[131] However, not all states have expanded their Medicaid programs.[132] The coverage gap resulting in states with no expansion is discussed in more detail below.

2. Limitations of the Affordable Care Act

The design of the ACA was a well-intentioned attempt to reform healthcare insurance in a partnership with the private insurance industry and the states. Its primary goal was to reduce the number of uninsured in the United States.[133] The approach included three critical prongs to guarantee success: the individual mandate, the employer mandate, and Medicaid expansion.[134]

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[123]Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010).

[124]*Marketplace*, HealthCare.gov (last visited Oct. 6, 2023), https://www.healthcare.gov/glossary/marketplace/ [https://perma.cc/K8GV-PRNT]; *About the Affordable Care Act*, U.S. Dep't of Health & Hum. Servs. (last visited Oct. 6, 2023), https://www.hhs.gov/healthcare/about-the-aca/index.html [https://perma.cc/G763-ACDL]; *The Health Plan Categories: Bronze, Silver, Gold & Platinum*, HealthCare.gov (last visited Nov. 1, 2023), https://www.healthcare.gov/choose-a-plan/plans-categories/ [https://perma.cc/KQ8N-LCT3].

[125]U.S. Dep't of Health & Hum. Servs., *supra* note 123.

[126]*Federal Poverty Level (FPL)*, HealthCare.gov, https://www.healthcare.gov/glossary/federal-poverty-level-fpl/ [https://perma.cc/676U-2HFG] (last visited Oct. 6, 2023).

[127]*Affordable Care Act (ACA)*, HealthCare.gov, https://www.healthcare.gov/glossary/affordable-care-act/ [https://perma.cc/W9ED-S7C3] (last visited Oct. 6, 2023).

[128]*See Health Plan Categories*, HealthCare.gov, https://www.healthcare.gov/glossary/health-plan-categories/ [https://perma.cc/EGG4-FZ2B] (last visited Oct. 4, 2023).

[129]*Id.*

[130]*Health Benefits and Coverage*, HealthCare.gov, https://www.healthcare.gov/coverage/what-marketplace-plans-cover/ [https://perma.cc/782T-8YCL] (last visited Oct. 4, 2023).

[131]Weismann & Jorge, *supra* note 43, at 670.

[132]*Id.*

[133]*See* 26 U.S.C. § 5000A(a) (2010) ("Requirement to Maintain Minimum Essential Coverage. An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.").

[134]Morrisey, *supra* note 39, at 29.

The individual mandate[135] required most U.S. citizens and legal residents to purchase health insurance.[136] The ACA imposed a penalty in the nature of a tax[137] for those not purchasing health insurance and a HIM subsidy for those who could not afford it.[138]

The legality of the individual mandate was subsequently tested. In 2012, the Supreme Court of the United States in the case of *National Federation of Independent Business v. Sebelius* upheld the health insurance mandate as a valid tax under the Taxing and Spending Clause of the Constitution.[139] To circumvent the Supreme Court ruling, on December 22, 2017, then President Trump signed the Tax Cuts and Jobs Act of 2017,[140] which reduced the individual mandate federal tax penalty to 0 for violating the provision, starting in 2019.[141] The tax change effectively nullified the individual mandate requirement.

The second legislative feature, the employer mandate, required employers with fifty or more fulltime workers to offer employee health insurance or pay a penalty.[142] The penalty was $2,000 per worker after the first thirty.[143] There are two types of penalties under the employer mandate.[144] One is for large employers that don't offer coverage at all, and the other is for large employers offering coverage that does not provide minimum value or is not considered affordable.[145] In both cases, the penalty is only assessed in the event that at least one full-time (thirty-plus hours per week) employee receives a premium tax credit in the marketplace.[146] The penalty for offering inadequate or unaffordable coverage can never be greater than the penalty for not offering coverage at all.[147] The implementation of this provision was delayed in 2015 and again until 2018.[148] It may be too soon to assess the effectiveness of the mandate or to determine how or if it changes the current ESI system.

The rationale of the employer mandate was to deter employers who already provided employee coverage from dumping workers into the HIM, either by dropping coverage completely or limiting

[135] *Id.* at 30. The reason for the Individual Mandate was two-fold. *Id.* First, to ensure that people had health insurance coverage, and second, to eliminate adverse selection in insurance risk pools. *Id.*

[136] *Id.*

[137] Jeremy Ashe, *Households Earning $75,000 or Less Paid Majority of Individual Mandate Penalties*, Tax Found. (July 21, 2021), https://taxfoundation.org/affordable-care-act-individual-mandate-penalties/ [https://perma.cc/G2PC-QZ43].

[138] Morrisey, *supra* note 39, at 30.

[139] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 542-69 (2012). The Supreme Court granted certiorari to three cases: *National Federation of Independent Business v. Sebelius* (which consolidated a part of *Florida v. Dept. of Health and Human Services*) on the issues of the constitutionality of the individual mandate and the severability of any unconstitutional provisions, *Dept. of Health and Human Services v. Florida* on the issue of whether review was barred by the Anti-Injunction Act, and *Florida v. Dept. of Health and Human Services* on the matter of the constitutionality of the Medicaid expansion. *Id.*

[140] Tax Cuts and Jobs Act, Pub. L. No. 115–97, § 11001, 131 Stat. 2054.

[141] Christine Eibner & Sarah Nowak, *The Effect of Eliminating the Individual Mandate Penalty*, Commonwealth Fund (July 11, 2018), https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors [https://perma.cc/U6YP-595G].

[142] Morrisey, *supra* note 39, at 41.

[143] *Id.*

[144] *What Is an Employer Mandate?*, HealthInsurance.Org, https://www.healthinsurance.org/glossary/employer-mandate/ [https://perma.cc/3ZZU-9SX6] (last visited Oct. 6, 2023).

[145] *Id.*

[146] *Id.*

[147] *Id.* As of 2022, the employer mandate penalties are as follows:

For a large employer that doesn't offer coverage at all: $2,750 multiplied by 30 less than the total number of full-time employees. For a large employer that offers coverage that isn't considered affordable and/or doesn't provide minimum value: $4,120 multiplied by the number of full-time employees who receive a premium tax credit in the marketplace. However, this penalty will not exceed the amount of the other penalty, so that will be used instead if it is less.

Id.

[148] Kip Piper & Randy Vogenberg, *Implications of the Employer Mandate Delay on the Healthcare Marketplace*, 6 Am Health & Drug Benefits 303, 305 (2013); Timothy Jost, *ACA Round-Up: Employer Responsibility Penalties, Enrollment Policies*, Health Affs. Forefront (Nov. 7, 2017), https://www.healthaffairs.org/content/forefront/aca-round-up-employer-responsibility-penalties-enrollment-policies.

benefits, forcing workers to buy insurance elsewhere.[149] For that reason, the penalty is only triggered if at least one full-time (thirty-plus hours per week) employee receives a premium tax credit in the HIM.[150] Otherwise, as noted above, the penalty does not apply.

Finally, the third feature was Medicaid expansion. The purpose of the expansion was to provide Medicaid coverage to all adults with income below 138% of the FPL.[151] In the case *National Federation of Independent Business v. Sebelius*,[152] the Supreme Court concluded, among other things, that the federal government could not condition the receipt of Medicaid funding by the states on the states' agreement to expand Medicaid coverage under the ACA.[153] Instead, any program expansion must be a voluntary choice by each state.[154] As of 2023, forty-one states have expanded Medicaid, including DC, and nine have not.[155]

In those states where Medicaid has not been expanded, it has the effect of creating a coverage gap under the ACA for low-income persons.[156] As part of the three pronged legislative design, the assumption was that those below the federal poverty level would be covered by the state Medicaid program and thus, rendered ineligible for federal subsidies in the HIM whereas those other uninsured above the poverty level would be required pursuant to the individual mandate to purchase insurance.[157]

The individual mandate provided that if those required to purchase insurance failed to do so, then a tax penalty would be imposed by the IRS.[158] However, if those below the poverty level live in a state that has refused to expand Medicaid eligibility under the ACA, they may not be eligible for HIM subsidies either. That leaves the uninsured in an odd gap in which they are living in poverty but also ineligible for HIM subsidies and state Medicaid without any financial assistance to purchase health insurance.[159]

While laudable in its purpose, getting everybody insured by some plan of insurance, subsequent litigation and legislation combined to marginalize several key provisions of the ACA legislation.[160] It is for these reasons in part that millions of Americans remained uninsured under the ACA before the pandemic.[161]

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[149]David Blumenthal & David Squires, *The Employer Mandate*: *Essential or Dispensable*, Commonwealth Fund, (June 4, 2014), https://www.commonwealthfund.org/blog/2014/employer-mandate-essential-or-dispensable [https://perma.cc/4ZNF-BWJ9].

[150]*See id.*

[151]Morrisey, *supra* note 39, at 22.

[152]Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 606 (2012).

[153]*Id.* at 522; *see also* 42 U.S.C. § 18091(2)(D) (2010) (describing how the employer mandate achieves near-universal coverage by strengthening the private employer-based health insurance system).

[154]Sara Rosenbaum & Timothy Westmoreland, *The Supreme Court's Surprising Decision on Medicaid Expansion: How Will the Federal Government and the States Proceed?*, 31 Health Affs. 1663, 1665 (2012) (Twenty-six states joined the suit opposing the mandatory expansion of Medicaid. The reasons were for the most part tied to the economic uncertainty that the new burden of coverage would place on the states. The immense size of the program was problematic as the states would now be required to insure one in four Americans. While the costs of covering the newly eligible was supposed to be covered by the federal government, paying 100% of medical assistance costs associated with the expansion group in most states for the first three years (2014–16) and declining annually to 95% in 2017–19 and to 90% in 2020, states would still incur costs. By 2020 the states were "expected to contribute 10[%] toward the cost of medical assistance for the newly" enrolled group. The federal contribution was also to remain at its then current level in the case of medical assistance for the existing vulnerable groups covered under Medicaid which ranged from 50% to 83% "of total medical assistance costs. Most states were barely able to cover those costs).

[155]*Status of State Medicaid Expansion Decisions: Interactive Map*, KFF (Oct. 4, 2023), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ [https://perma.cc/75UP-MJG8].

[156]Morrisey, *supra* note 39, at 46.

[157]Weismann & Jorge, *supra* note 43, at 678.

[158]Ashe, *supra* note 137.

[159]*See* Weismann & Jorge, *supra* note 43, at 678; Morrisey, *supra* note 39, at 46.

[160]*See* David Bernstein, *Let's Recall Why the Affordable Care Act Is So Messed Up*, Wash. Post (June 25, 2015), https://www.washingtonpost.com/news/volokh-conspiracy/wp/2015/06/25/lets-recall-why-the-affordable-care-act-is-so-messed-up/?noredirect=on [https://perma.cc/K5SR-9VS7].

[161]Rachel Garfield et al., KFF, The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid 2 (2020), https://files.kff.org/attachment/Issue-Brief-The-Coverage-Gap-Uninsured-Poor-Adults-in-States-that-Do-Not-Expand-Medicaid [https://perma.cc/D5LU-PJYX].

3. Access to the ACA by the Independent Workforce

Despite several setbacks, the ACA did provide some support for an increasingly independent workforce during the pandemic, again, fueled by ARPA subsidies. The data shows that before the ARPA passed in 2021, the ACA had not achieved the goal of reducing the uninsured.[162] For example, as of 2016, only five states saw improved coverage reducing the uninsured; however, in twenty-two states those uninsured increased in number.[163]

However, other data shows that the HIMs, during the same period, were particularly supportive of entrepreneurs and freelancers.[164] The number of insured freelance workers increased from 64% in 2013 (the year before ACA plans were first available on the federal exchanges) to 83% in 2016.[165] Concomitantly, the number of at least part-time freelance workers increased 11% to 59 million between 2014 and 2020.[166] It is anticipated that freelancers in the United States will increase to 86.5 million people, or just over half of the total labor pool, by 2027.[167]

Yet, unlike the situation with freelancers, the decrease in the uninsured population during the pandemic was more pronounced under Medicaid rather than from purchases in the HIM. The choice was there. Four out of ten people without insurance pre-pandemic became eligible to receive free healthcare insurance coverage — either through Medicaid or a zero-premium bronze plan on the exchange.[168] However, most people chose the Medicaid option. While there is still a lack of dispositive data, a Kaiser Family Foundation study concluded that in 2021, the decrease of the population numbers of people without health insurance resulted from an increase in Medicaid coverage with a less substantial increases in non-group coverage including coverage in the HIM.[169] The gains are interpreted as the effort by the federal government to stabilize insurance coverage during the pandemic particularly through Medicaid.[170] The increase in Medicaid enrollment numbers during the pandemic are significant. Total Medicaid/CHIP enrollment increased to 90.9 million in September 2022. This was an increase of 19.8 million or more than 27.9% from enrollment in February 2020.[171]

However, these gains may be on shaky ground. When the continuous enrollment Medicaid assistance ends, millions of people could lose coverage reversing these gains in coverage.[172] As part of an end-of-the-year spending bill, signed into law on December 29, 2022, Congress set an end to the continuous enrollment provision on March 31, 2023, and phased down the enhanced federal Medicaid matching

[162] *See* Kelsey Waddill, *How COVID-19 Impacted Employer-Sponsored Health Plan Coverage*, HealthPayerIntelligence (Sept. 8, 2021), https://healthpayerintelligence.com/news/how-covid-19-impacted-employer-sponsored-health-plan-coverage [https://perma.cc/B7G8-3V4S].

[163] *Id.*

[164] Brent Messenger & Noah Lang, *Healthcare Access Will Fuel the Great Resignation – and That Is a Good Thing*, Fortune (Nov. 27, 2021), https://fortune.com/2021/12/27/healthcare-access-will-fuel-the-great-resignation-health-insurance-aca-affordable-care-freelancers-careers-personal-finance/ [https://perma.cc/Z3CU-HDSV]. A freelancer is an independent contractor who earns wages on a per-job or per-task basis, typically for short-term work. Lucas Downey, *What Is a Freelancer: Examples, Taxes, Benefits, and Drawbacks*, Investopedia (Nov. 2, 2022), https://www.investopedia.com/terms/f/freelancer.asp [https://perma.cc/PPX6-HQK4].

[165] Messenger & Lang, *supra* note 164.

[166] *Id.*

[167] *Id.*

[168] Daniel McDermott et al., *How Has the Pandemic Affected Health Coverage in the U.S.?*, KFF (Dec. 9, 2020), https://www.kff.org/policy-watch/how-has-the-pandemic-affected-health-coverage-in-the-u-s/ [https://perma.cc/YTE2-6LE6].

[169] Jennifer Tolbert et al., *Key Facts About the Uninsured Population,* KFF (Dec. 19, 2022), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/ [https://perma.cc/QP2U-6X5X].

[170] *Id.*

[171] Bradley Corallo & Sophia Moreno, *Analysis of National Trends in Medicaid and CHIP Enrollment During the COVID-19 Pandemic*, KFF (Apr. 4, 2023), https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/ [https://perma.cc/EBM7-5WPV].

[172] Jennifer Tolbert & Meghana Ammula, *10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision*, KFF (Jun. 9, 2023), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/ [https://perma.cc/EBM7-5WPV].

funds through December 2023.[173] States that accepted the enhanced federal funding could begin disenrollment as early as April 2023.[174] The next section examines the relative merits of Medicaid enrollment for the unemployed and low wage workers pre- and post-pandemic.

4. Enrollment in Medicaid

Medicaid enrollment and the number of the uninsured were both expected to increase at the beginning of the pandemic as people became unemployed losing ESI benefits.[175] As discussed above, under the ACA, states have the option to voluntarily extend Medicaid's eligibility to those with incomes up to 138% of the FPL.[176] A recent study concluded that those who lost income or jobs resulting from the pandemic and residing in Medicaid expansion states, were more likely to enroll in Medicaid and less likely to be uninsured than those living in non-expansion Medicaid states.[177]

But Medicaid coverage has been no panacea for the unemployed in states that have chosen not to expand benefits under the ACA pre-pandemic. As noted previously, Congress intended to legislate a variation of universal healthcare by requiring all states to expand Medicaid coverage to include all individuals with incomes below 138% of the poverty level. It was then assumed that those below the federal poverty level would be absorbed into the state Medicaid program. As such they would be rendered ineligible for federal subsidies in the insurance marketplace where other uninsured above the poverty level would be required by law to purchase insurance.[178] After the *Sebelius*[179] decision struck down mandatory state Medicaid expansion, those below the poverty level who did not fit into the list of vulnerable groups covered by Medicaid were dropped into a "gap" of the uninsured under the ACA.[180] Not only did the below poverty individuals not qualify for Medicaid, they were also ineligible to obtain premium subsidies in the insurance market exchanges making coverage unaffordable.[181]

Moreover, data shows that pandemic unemployment rates increased the disparity between insured and uninsured in expanding and non-expanding Medicaid states, respectively. Bundorf, Gupta & Kim's study concluded that in no expansion states, "rates of any coverage declined by 0.23 percentage points weekly; rates of ESI declined by 0.32 percentage points per week, while rates of other coverage increased by 0.09 percentage points." In expansion states the overall decline in coverage was not "statistically significantly different from zero — the combination of a smaller decline in ESI (0.16 percentage points per week) and a similarly sized increase in other coverage as in no expansion states."[182] The study further determined that the decline in insurance in no expansion states was correlated with a large decline in ESI, relative to expansion states, which was not fully offset by increases in non-ESI. The data further showed that increases in non-ESI represented 28% and 63% of the decline in ESI in no expansion and expansion states, respectively. In both expansion and no expansion states, Medicaid coverage was the primary source of coverage gains.[183]

In fact, several studies have confirmed that enrollment in public programs, rather than private insurance such as COBRA or on-or off-exchange ACA individual coverage, increased throughout the pandemic.[184] A large increase in Medicaid enrollment was consistent with rising Medicaid enrollment

[173] *Id.*

[174] *Id.*

[175] Joseph Benitez & Lisa Dubay, *COVID-19-Related Medicaid Enrollment in Expansion and Non-Expansion States*, 57 Health Servs. Rsch. 1321, 1322 (2022).

[176] Alison Mitchell, Cong. Rsch. Serv., R43564, The ACA Medicaid Expansion (2014).

[177] Benitez & Dubay, *supra* note 175, at 1322.

[178] Weismann & Jorge, *supra* note 43, at 678.

[179] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 585 (2012).

[180] Garfield et al., *supra* note 161, at 1.

[181] *Id.*

[182] Bundorf et al., *supra* note 67, at 5.

[183] *Id.*

[184] *See, e.g.*, Sumit Agarwal & Benjamin Sommers, *Insurance Coverage After Job Loss—The Importance of the ACA During the Covid-Associated Recession*, 383 New Eng. J. Med. 1603, 1604 (2020).

during the pandemic, as well as pre-pandemic evidence that the ACA's coverage options have alleviated the negative effect of unemployment on insurance coverage.[185]

Congruous with these findings, The Center on Budget and Policy Priorities suggests that post-pandemic, states should offer continuous Medicaid coverage.[186] Continuous coverage allows people to keep Medicaid enrollment for a set time-period, irrespective of changes in their financial circumstances. States can also elect to provide continuous eligibility to adults through a Medicaid waiver.[187] Providing continuous coverage appeals to many states largely because it helps eligible people stay covered and avoids enrollment churning.[188] However, without future individual state action, when the federal continuous enrollment Medicaid assistance ends, millions of people could lose coverage reversing these gains in coverage for the unemployed (see Appendix A, Coverage Gap).

V. Public Option Proposals

The data collected during the pandemic showed that the uninsured generally chose the Medicaid public option as an alternative to ESI.[189] However, the impending expiration of federal pandemic subsidies may eviscerate the stabilization of insurance coverage achieved during the pandemic. Another policy solution to address impending instability, freedom from unwanted job dependency and loss of ESI, would be the creation of a new form of public option coverage. "A public option is a health insurance plan (or plans) sold by the government and available to all Americans, regardless of income, age, or other personal characteristics. It competes with private insurance, rather than supplanting it."[190] There are several different proposals for a public option.

A. What is a Public Option Plan?

"Traditionally, a 'public option' has been envisioned as a government insurance plan offered to compete against private health insurance. Under this model, the government administers the plan and bears the risk of any claims."[191] The ACA is one example of a public option plan involving the use of government subsidies as discussed above. But there are other models as well at both the federal and state levels.

B. Legislative Proposals: Federal and State

Post-pandemic, some legislators introduced an alternative proposal to create a federally administered health insurance plan, known as a public option plan, in the category of nongroup HIMs under the Affordable Care Act.[192] The focus is on the individual insurance market only. The federal government

[185]Peggah Khorrami & Benjamin Sommers, *Changes in US Medicaid Enrollment During the COVID-19 Pandemic*, 4 JAMA Network Open 1, 1, 3 (2021).

[186]Judith Solomon et al., Ctr. on Budget & Pol'y Priorities, Medicaid Protections in Family First Act Critical to Protecting Healthcare Coverage 1 (2020).

[187]*Id.* at 1.

[188]*Id.* at 2 ("[L]ow-income people often experience frequent fluctuations in income that can lead them to become temporarily ineligible for Medicaid but then regain eligibility within a few months. Continuous coverage reduces the churn from these frequent changes in eligibility").

[189]*See* Bundorf et al., *supra* note 67, at 4-5.

[190]Rosemarie Day, *Post-Pandemic Solutions: A Public Option for Universal Healthcare*, Health Care Blog (May 21, 2020), https://thehealthcareblog.com/blog/2020/05/21/post-pandemic-solutions-a-public-option-for-universal-healthcare/ [https://perma.cc/ZR2R-24XH].

[191]Christine Monahan & Madeline O'Brien, *States Move Forward with Public Option Programs, but Differ in How They Select Insurance Carriers*, Commonwealth Fund (Jan. 24, 2023), https://www.commonwealthfund.org/blog/2023/states-move-forward-public-option-programs-insurance-carriers [https://perma.cc/F5GE-W25S].

[192]Cong. Budget Off., 57020, A Public Option for Health Insurance in the Non-Group Marketplaces: Key Design Considerations and Implications 1 (2021), https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf [https://perma.cc/GGA9-CJSU].

would bear the insurance risk of the public meaning that the federal government would have the financial responsibility to cover medical claims under the plan.[193] Critics observed this public option proposal raises many more questions than it answers. To provide clarification, the Congressional Budget Office (CBO) evaluated the public option proposal and prepared a rendering of the "Design Considerations for A Federally Administered Public Option"[194] (see Appendix B). In summary, the content of an individual plan would be tied to the current design of the HIM and include the possibility of subsidies.[195] Thus, the plan would provide another competing product option similar to existing metal plans provided by private insurers in the HIM.

The CBO specifically examined the question of how this form of public option would affect insurance coverage. The conclusion was not a ringing endorsement for this type of plan due, in part, to the current tax preferences that make ESI still more attractive than even the public option. The CBO concludes that for those currently covered by ESI "[a] low-premium public option would also attract some people who currently have employment-based coverage: Some of those people would forgo their employer's offer of insurance, and some employers would choose to no longer offer health insurance. That effect would be small, relative to the total number of people with employment-based coverage, because employers' and most employees' premium contributions are excluded from taxable compensation and because people with affordable offers of employment-based coverage are ineligible for marketplace subsidies under current law."[196]

As for the uninsured, the CBO concludes that "[a]mong other groups of uninsured people, the entry of a public option into the nongroup marketplaces would have only a small effect on coverage" because "[i]n 2019, 11 percent of the uninsured population, or 3.2 million people, had income that was too low to qualify for marketplace subsidies and lived in states where Medicaid had not been expanded under the Affordable Care Act."[197] Without a subsidy eligibility adjustment, the plan would end up being too costly.[198]

Another possibility for a public option plan is a Medicaid buy-in plan.[199] Both Medicare and Medicaid already have limited buy-in options for certain demographics such as age and disability.[200] There have been many legislative proposals in favor of this option for the unemployed.[201] These legislative proposals are generally separated in 5 categories: (1) Medicare-for-all, a universal coverage plan for all U.S. residents; (2) a national health insurance program with the choice to opt out for qualified coverage; (3) an individual public plan option through the ACA marketplace (similar to the proposal considered above); (4) a Medicare buy-in option for those not yet age eligible for the Medicare program; and, (5) a Medicaid buy-in option for individuals that states can chose to offer through the ACA marketplace.[202]

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[193] *Id.*

[194] *Id.* at 2.

[195] *See id.* at 5.

[196] *Id.* at 3.

[197] *Id.* at 31.

[198] *Id.*

[199] For examples of Medicare buy-in legislation, see the Expanding Health Care Options for Early Retirees Act, S. 2236, 117th Cong. (2021), the Medicare Buy-In and Health Care Stabilization Act of 2019, H.R. 1346, 116th Cong. (2019), and the Medicare at 50 Act, S. 470, 116th Cong. (2019). For an example of Medicaid buy-in legislation, see the State Public Option Act, S. 489, 116th Cong. (2019).

[200] *Medicaid Buy-In Opens Doors to Employment for People with Disabilities*, Admin. for Cmty. Living: ACL Blog (May 6, 2020), https://acl.gov/news-and-events/acl-blog/medicaid-buy-opens-doors-employment-people-disabilities [https://perma.cc/C2G9-QY5H].

[201] *See Compare Medicare for All and Public Option Plans,* KFF (May 15, 2019), https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/ [https://perma.cc/X88Q-ZTDY].

[202] *Id.* For more detail showing the side-by-side comparison charts *see Side-by-Side Comparison of Medicare-for-all and Public Plan Proposals Introduced in the 116th Congress*, KFF (May 15, 2019), https://files.kff.org/attachment/Table-Side-by-Side-Comparison-Medicare-for-all-Public-Plan-Proposals-116th-Congress [https://perma.cc/4NHV-YQT8].

Another option is for each individual state to design and implement a public option plan. Washington state has already done so.[203] Nevada and Colorado also recently added public option plans, but Nevada's launch has been delayed to 2026.[204] (A comparison of the three-state format option plans is attached in Appendix C.)

Washington State uses a "selective procurement approach.[205] At its launch, Washington State contracted with private carriers to administer its plan and accepted all qualified bidders to increase the availability of option plans. However, the contract carriers limited their geographic range to a few counties each and the plans were not popular with some hospitals opting out of these networks because the state caps how much public option plans can pay providers in the aggregate.[206] Because hospitals did not join the networks there were substantial gaps in plan availability. As a result, the state required hospitals participating in other state programs to partner with at least one public option plan if public option plans were not available statewide by 2022. Subsequently, for the 2023 plan year, seven carriers submitted bids to offer public option plans. Washington contracted with three carriers offering plans in thirty-four of thirty-nine counties, giving the plan networks access to 98% of marketplace consumers.[207]

Colorado has opted for a "mandatory participation approach."[208] Colorado Option plans must satisfy certain premium rate reduction targets and health equity-focused network requirements.[209] Under the law, insurance carriers are required to offer gold, silver, and bronze tier public option plans in the same counties where they offer individual or small-employer plans. As a result of this program, public option plans are accessible to consumers in all sixty-four Colorado counties.[210] Due to carrier financial difficulties, the total number of plans decreased in both markets compared to 2022.[211]

Nevada is structuring a public option program with an intended start date in 2026. Like Washington, Nevada's plan includes contracting with private carriers. Nevada law also requires all carriers bidding on public option programs to offer Medicaid managed care plans as an additional option.[212] To simplify network building among bidders, Nevada also will require providers to join a public option network if they participate in Medicaid or other state plans.

C. Prospects for Success

The prospect of success for a public option plan is mixed. The idea of a public option for health insurance became increasingly politicized and was strongly opposed by insurance companies, the pharmaceutical industry, and powerful hospital systems, all groups that profit from the status quo, during negotiations for the ACA.[213] However, as noted above, three states have opted for some form of Medicaid buy-in programs.

[203] *See* James C. Capretta, *Washington State's Quasi-Public Option*, Milbank Q. (Mar. 2020), https://www.milbank.org/quarterly/articles/washington-states-quasi-public-option/ [https://perma.cc/KQZ6-TARN].

[204] Christine Monahan et al., *State Public Option-Style Laws: What Policy Makers Need to Know*, Commonwealth Fund (July 23, 2021), https://www.commonwealthfund.org/blog/2021/state-public-option-style-laws-what-policymakers-need-know [https://perma.cc/69YU-D56W].

[205] Monahan & O'Brien, *supra* note 191.

[206] *Id.*

[207] *Id.*

[208] *Id.*

[209] *Id.*

[210] *Id.*

[211] *Id.*

[212] *Id.*

[213] *See* Jane Norman & John Reichard, *Senate Democrats Drop the Public Option to Woo Lieberman, and Liberals Howl*, Commonwealth Fund (Dec. 15, 2009), https://www.commonwealthfund.org/publications/newsletter-article/senate-democrats-drop-public-option-woo-lieberman-and-liberals-howl [https://perma.cc/3HD4-THN5]; *see also* John Gregory, *Hospital, Insurer, Pharma Lobbyists Push Back Against Public Option*, HealthExec (Oct. 24, 2016), https://healthexec.com/topics/healthcare-policy/hospital-insurer-pharma-lobbyists-push-back-against-public-option [https://perma.cc/TL3S-8Z9A].

Until such time as the expected disenrollment occurs, it will remain difficult to predict what other states or the federal government may do to prevent an increase in the uninsured population.[214]

Parenthetically, another suggestion that has cropped up is to simply repeal the ESI tax preference to disincentivize employer provided insurance and provide financing alternatives such as refundable tax credits or limiting excise taxes on certain types of insurance.[215] At least one study considered the distributional effects on workers if a flat tax credit was provided in lieu of ESI.[216] The study concluded that lower income workers would benefit the most with no net effect on the middle worker quintile.[217] A tax credit could produce net gains for the fourth quintile of the income distribution and above.[218] In short, a tax solution alone, without other plan options to compete with ESI, does not appear to be practicable. Thus, the prospects for success of any increase in worker independence may rest on first finding a workable alternative to ESI.

VI. Conclusion: Substituting the Public Option and the Future of ESI Work Dependency

The pandemic and Great Resignation combined to undermine the dynamic of ESI, revealing weaknesses and inflexibility in the current health insurance structure. In many respects this is not surprising given that the predominance of ESI in the marketplace is a twist of fate unrelated to healthcare infrastructure but rather entirely dependent on U.S. tax law. But this unintentional system of coverage has had the unanticipated and collateral effect of tying some workers to unwanted and unproductive employment.

With the aid of ARPA, providing an influx of federal subsidies into the insurance markets, more unemployed workers and their dependents became insured, at least temporarily, severing the bond between employment and health insurance coverage. The data showed a preference in migration to public option plans. Post-pandemic, there has been a proliferation of legislative proposals, at both the state and federal levels, to create government administered health insurance plans, known as public option plans, to create an affordable and workable alternative to ESI (see Appendix B). Three states have already opted into some hybrid form of public option and Medicaid buy-in to keep the increased insured rate of the unemployed stable (see Appendix C).

If the data is correct and a large number of freelancers and entrepreneurs will swell the labor market by 2027, an alternative to ESI will be required to cover an otherwise uninsured population of workers and their dependents. The proverbial handwriting may be on the wall.

Supplementary material. To view supplementary material for this article, please visit http://doi.org/10.1017/amj.2024.1.

Miriam F. Weismann JD LLM is a professor of business law and tax at Florida International University. She is also the Academic Director of the FIU Healthcare MBA program. She was previously appointed by President George Bush as The United States Attorney for the Southern District of Illinois (Dept. of Justice) and served as a special supervisory counsel on the WACO Commission under Senator John Danforth. Her publications in the field of healthcare focus on health equity and healthcare economics.

[214]The question of the prospects of success for the public option is best left to explore after the expected disenrollment from Medicaid occurs. It is possible that many more states will follow suit and construct some form of Medicaid buy-in or other public option to avoid a dramatic increase in the state uninsured population. If not, an even more compelling case for a public option will arise in the ensuing uninsured crisis.

[215]*Tax Preference*, *supra* note 17.

[216]Eric J. Toder et al., *Distributional Effects of Tax Expenditures*, Tax Notes (July 1, 2009), https://www.taxnotes.com/research/federal/other-documents/washington-roundup/tax-policy-center-reviews-distributional-effects-of-large-tax-expenditures/wtkl [https://perma.cc/A8ME-REXX].

[217]*Id.*

[218]*Id.*

Cite this article: Weismann, M.F. (2023), 'How The "Great Resignation" and COVID Unemployment Have Eroded the Employer Sponsored Insurance Model and Access to Healthcare', *American Journal of Law & Medicine*, **49**, pp. 415–435. https://doi.org/10.1017/amj.2024.1