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Employers and Health Insurance Under the Affordable Care Act

Arnold J. Rosoff & Anthony W. Orlando***

The healthcare system of the United States has historically stood apart from the systems of other major nations in two very important respects. First, as has been widely noted and often decried, we are the only major nation that has not committed to Universal Health Care (“UHC”).¹ Second, and closely related, our system is built on a foundation of voluntary employment-based health insurance (“EBHI”), meaning most people in the U.S. who have health insurance obtain it through their employer or the employer of a member of their household.² The Patient Protection and Affordable Care Act (herein “the ACA” or the colloquial “Obamacare”)³ has undertaken to move us toward UHC—*i.e.*, adequate health insurance coverage for all citizens—and has provisions that could substantially change the employment-based nature of our health insurance system.

This paper offers an evolutionary view of our employment-based system: how we came to have the current system, how the ACA changes things, and how employers and others are likely to respond to the ACA and other factors at play in our nation’s contemporary economic and social environment with regard to EBHI. Section I reviews the history of health insurance in the U.S., emphasizing how our system came to be so heavily based on voluntary employer action. Section II assesses the consequences

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1. Bruce Vladeck, *Universal Health Insurance in the United States: Reflections on the Past, the Present, and the Future*, 93 AM. J. PUB. HEALTH 16, 16-19 (2003).

2. As of May 2014, 55 percent of firms offer health benefits to their workers, and 90 percent of workers are in a firm that offers health benefits to at least some of its employees. THE KAISER FAMILY FOUND., 2014 EMPLOYER HEALTH BENEFITS SURVEY 8, *available at* <http://kff.org/report-section/ehbs-2014-summary-of-findings/>.

3. Patient Protection and Affordable Care Act, Pub L. No. 111-148, 124 Stat. 141 (2010) (codified as amended in scattered sections of 42 U.S.C.).

of placing EBHI at the center of our nation's healthcare system. Section III examines how the ACA undertakes to change the EBHI environment, and how the Obama Administration, the Internal Revenue Service ("IRS") and the U.S. Department of Health and Human Services ("HHS") are implementing the relevant provisions. Section IV attempts to project how employers will respond to these changes, and how the U.S. healthcare system will evolve as a result. This prognostication is very difficult because of the diversity and complexity of the factors bearing on this evolution. Consequently, the paper's contribution lies not in offering a definitive conclusion and prediction but, rather, in setting out an analytical framework by which readers can better understand what may happen over the next decade and beyond. Section V summarizes the above and sets forth the authors' overall conclusions.

I. THE HISTORY OF EMPLOYMENT-BASED COVERAGE IN THE U.S.

The United States was not the first country to build a health insurance system on a foundation of employer responsibility. That distinction belongs to Germany, where workers in the mid-1800s pooled their resources to pay the healthcare expenses of workers who got sick or injured and had been regularly paying their monthly contribution to the cooperative.⁴ In an attempt to counter the working class's attraction to the trendy allure of communism, Chancellor Otto von Bismarck turned this *ad hoc* arrangement into a national system with his *Imperial Insurance Order*, issued in 1883, which required all workers and employers across the country to pay into "sickness funds."⁵ To this day, employment-based health care is widely known as the "Bismarck model."⁶

The United States started from a similar grassroots premise, but moved in a more voluntary, incentive-based direction. First came the institution of health insurance itself. In 1929, Baylor University Hospital began offering

4. See Anne Underwood, *Health Care Abroad: Germany*, N.Y. TIMES (Sept. 29, 2009), <http://prescriptions.blogs.nytimes.com/2009/09/29/health-care-abroad-germany/> (chronicling the history of Germany's employment-based health insurance system.) Today, Germany's "sickness funds", as these cooperatives came to be called, are financed through a payroll tax levied on employers and employees. Albert DiPierro, *Universal Problems & Universal Healthcare: 6 Countries- 6 Systems*, OR. FUTURE, 31 (2004), available at http://libmedia.willamette.edu/xmlui/bitstream/handle/10177/4551/countries_healthcare-27.pdf?sequence=1.

5. Underwood, *supra* note 4; accord SOC. SEC. ADMIN., *Otto von Bismarck*, <http://www.ssa.gov/history/ottob.html> (last visited Apr. 27, 2015) (discussing Bismarck's influence on social insurance in Germany).

6. Lorraine S. Wallace, *A View of Health Care Around the World*, 11 ANNALS FAM. MED. 84, 84 (2013); Olga Khazan, *What American Healthcare Can Learn From Germany*, THE ATLANTIC (Apr. 8, 2014), <http://www.theatlantic.com/health/archive/2014/04/what-american-healthcare-can-learn-from-germany/360133/>.

local schoolteachers a prepaid plan of hospital and medical care in exchange for a regular monthly payment.⁷ In 1932, the “Baylor Plan” was expanded to whole communities, allowing them to choose among multiple hospitals.⁸ To distinguish these plans from other emerging health insurance arrangements, hospitals and other healthcare providers began using blue crosses or blue shields as brand logos.⁹ These “Blue Cross” (hospital service) and “Blue Shield” (medical care) plans, colloquially termed “The Blues,” grew during the Great Depression through state-by-state adoption of enabling statutes that gave special concessions—typically in the form of tax exemptions—to nonprofit plans that sold insurance on a “community-rated” basis.¹⁰

A. *World War II and the Postwar Years: Employers Take the Lead*

Labor strife in the early years of the Great Depression spurred a tremendous push for unionization, which led to the passage of the National Labor Relations Act (the Wagner Act, or “NLRA”) in 1935, securing the right of workers to unionize and bargain collectively.¹¹ Under the NLRA, unionization continued apace through the latter half of the 1930s.¹² By the

7. See David J. Ballard et al., *Health Care Quality Improvement Across the Baylor Health Care System: The First Century*, 17 BAYLOR U. MED. CTR. PROC. 277, 279 (2004) (stating that the vice president of Baylor University proposed that Dallas school teachers contribute 50 cents a month to guarantee them up to 21 days of hospital care in a semi-private room); see also CAROL F. O’NEILL, AM. C. OF MED. PRAC. EXECUTIVES, HOW DID WE GET HERE? A HISTORICAL REVIEW OF PAYMENT SYSTEMS IN THE UNITED STATES 6 (2006), available at <https://hcahomework.files.wordpress.com/2008/03/how-did-we-get-here-a-historical-review-of-payment-systems-in-the-us.pdf>.

8. Ballard et al., *supra* note 7, at 279.

9. Marc Lichtenstein, *Health Insurance from Invention to Innovation: A History of the Blue Cross and Blue Shield Companies*, BLUE CROSS BLUE SHIELD, <http://www.bcbs.com/blog/health-insurance.html> (last visited Apr. 27, 2015).

10. D. ANDREW AUSTIN & THOMAS L. HUNGERFORD, CONG. RESEARCH SERV., THE MARKET STRUCTURE OF THE HEALTH INSURANCE INDUSTRY 3 (2009), available at <https://www.fas.org/sgp/crs/misc/R40834.pdf>; Melissa Thomasson, *Health Insurance in the United States*, EH.NET, <http://eh.net/encyclopedia/health-insurance-in-the-united-states/> (last visited Apr. 27, 2015); STEPHANIE KELTON, CENTER FOR FULL EMP. AND PRICE STABILITY, AN INTRODUCTION TO THE HEALTH CARE CRISIS IN AMERICA: HOW DID WE GET HERE? 14-15 (2007), available at <http://www.cfeps.org/%5C/health/chapters/pdf/Chapter%201%20Introduction.pdf>. Under “community rating,” insurers put all insureds into a common risk pool, disregarding differences in individual or work-group risk characteristics. Since insurance relies on “the law of large numbers” to damp out fluctuations and yield a more predictable and stable risk and premium structure, community rating, the pooling arrangement closest to social insurance, is the ultimate mechanism for dealing with societal risks.

11. See generally National Labor Relations Act, 29 U.S.C.A. §§ 151-169 (West, WestlawNext through P.L. 113-294, excluding P.L. 113-235, 113-283, 113-287, 113-291).

12. See Claude Fischer, *Labor’s Laboring Effort*, BERKELEY BLOG (Sept. 9, 2010), <http://blogs.berkeley.edu/2010/09/09/labor%E2%80%99s-laboring-effort> (indicating that

time the U.S. was drawn into World War II (“WWII”), unions had a high penetration into the national workforce.¹³ When a wartime anti-inflation presidential Executive Order froze wages,¹⁴ the unions had to come up with something else to push for their workers or union membership would plummet.¹⁵ While it blocked wage increases, the law allowed unions to negotiate for fringe benefits, such as pensions and health insurance, and the unions largely focused on the latter.¹⁶ Given the labor shortages of the War years, employers responded to the unions’ pressure by offering health benefits, and competition among employers for the scarce labor supply fueled an escalation in those benefits over time.

By the end of WWII, the unions’ push for health insurance was well embedded, as was the trend toward employers providing health benefits.¹⁷ Employers, continuing their competition for manpower in the post-war “boom” economy, used the strength and attractiveness of their health insurance plans to recruit and retain employees.¹⁸ In 1943, the IRS ruled that employers could deduct the cost of health insurance as a business expense but that employees (and their dependents) did not have to recognize the monetary value of the health insurance benefits as income.¹⁹ This exemption from taxation meant that employer-provided health insurance is purchased with before-tax dollars. If the employer did not provide insurance, but simply paid the employee more, the employee would have to pay tax on the additional income and then buy the insurance with reduced, after-tax dollars.²⁰ In effect, the exemption amounts to a federal

unionization increased during the Great Depression, the New Deal Era, and the early post-war period).

13. See *id.* (referencing the union density chart). In just one decade, from 1935 to 1945, the percentage of employed workers belonging to a union more than tripled, from approximately one-tenth to one-third of the U.S. workforce.

14. Exec. Order No. 9328, 8 Fed. Reg. 4681 (1943).

15. Union members naturally lost a key incentive to pay dues when the union’s primary function—to negotiate for higher wages—was blocked.

16. David A. Hyman & Mark Hall, *Two Cheers For Employment-Based Health Insurance*, 2 YALE J. HEALTH POL’Y L. & ETHICS 23, 25-26 (2002) (explaining that “[t]he freezing of cash wages forced employers to compete for scarce labor by enhancing their fringe benefit packages” and “[d]uring the late 1940s and 1950s, unions aggressively bargained for richer benefit packages, with health insurance at the top of their list.”). For more on this excellent article and its authors, see notes 94-100 *infra* and accompanying text.

17. *Id.* at 26.

18. *Id.* at 25; Thomasson, *supra* note 10.

19. Hyman & Hall, *supra* note 16, at 25.

20. See I.R.C. § 106 (West, WestlawNext through P.L. 113-294 (excluding P.L. 113-235, 113-283, 113-787, 113-291)) (amended 2014 by P.L. 113-295, 128 Stat. 4010) (“Gross income of an employee does not include employer-provided coverage under an accident or health plan.”); see also I.R.C. § 162(a) (allowing a deduction for “other compensation,” which includes health expenditures furnished by employers).

subsidy for the purchase of health insurance and was clearly intended to incentivize such purchase.²¹ Congress enshrined the employees' tax shelter for employer-provided health benefits in the Internal Revenue Code of 1954, an approach that has persisted to the present day.²² The tax shelter was a substantial incentive and a major reason why the move toward EBHI accelerated in postwar years.²³

B. Health Care Costs Begin Their Rise

From its beginnings, health insurance in the United States developed with little regard for cost-containment. Up to and through the 1960s, the insurance system mostly paid for health services on a "fee-for-service" ("FFS") basis, giving physicians and hospitals an incentive to over-provide or over-utilize expensive services and inflating the cost of health care.²⁴ Elsewhere, in countries such as the United Kingdom, the government strictly regulated prices and/or utilization to contain these costs; but the U.S. healthcare system developed without these cost controls.²⁵ When Congress created Medicare and Medicaid in 1965 to assure access to health care for the elderly, disabled, and poor, political pressures dictated that government payment for hospital and medical services would be provided essentially on a "blank check" basis.²⁶ Under Medicare Part A, hospitals were paid retroactively adjusted cost-based reimbursements—essentially what it cost the provider to render the services, determined after the fact.²⁷

21. Note that, as discussed below, note 183 *infra*, that subsidy is greater—in absolute dollar terms, at least—for higher-income employees, who are in a higher income tax bracket.

22. See Hyman & Hall, *supra* note 16, at 25 ("Ten years later . . . Congress amended the Internal Revenue Code in 1954 to expressly exclude employment-based coverage from taxable income.").

23. AUSTIN & HUNGERFORD, *supra* note 10, at 5; Thomasson, *supra* note 10; see also Hyman & Hall *supra* note 16, at 25 ("The result is a substantial financial incentive for employees to obtain coverage through their employer if at all possible."); see also KELTON, *supra* note 10, at 17 ("This preferential tax treatment for 'fringe' benefits gave business an incentive to offer health insurance to their employees.").

24. KELTON, *supra* note 10, at 18. Under FFS, one unit of service — *e.g.*, each day of hospitalization or doctor office visit — earns the provider one unit of pay; thus the more units rendered the greater the provider's income. The cost of health care is the product of the number of units provided (the "utilization") times the price per unit.

25. A single-payer health system with strong government controls does not, however, assure that there will not be troublesome cost concerns. See, *e.g.*, TONY WHITE, A GUIDE TO THE NHS 74 (2010) (explaining that in 1948, England's government founded the National Health Service Act, which established "a free, comprehensive healthcare service, available to the entire population" and by 1953, the Guillebaud Committee Report "called for better information and analytical services to resolve financial difficulties in the NHS").

26. For an excellent and comprehensive analysis of the political wrangling over Medicare and the medical establishment's vigorous opposition, see THEODORE MARMOR, THE POLITICS OF MEDICARE, 2D ED. (Transaction Publishers, 2000).

27. When cost-reimbursement is figured on a retroactively-adjusted basis, it removes

plus a modest profit.²⁸ Under Part B, physicians were paid whatever was “usual, customary, and reasonable” (“UCR”) in the geographic medical community—that is, whatever the area’s doctors customarily charged for a particular service.²⁹ Largely because of these policies and the FFS structure of private insurance, overutilization led to rapid cost inflation.³⁰ Importantly, the separation of providers from payers meant that providers could over-provide services and overcharge for services provided without sufficient constraint from patients, who were insulated by their insurance from the effects of the cost escalation.³¹

By the 1970s, employers and government officials alike were seeking reforms to address the growing problem of healthcare cost escalation.³² Many policymakers, including President Richard Nixon, considered creating a national health insurance system.³³ However, by that time, the employment-based system was deeply entrenched, with powerful constituencies committed to maintaining it.³⁴ Corporate human resources

much of the incentive of the provider to try to live within its budget, since any additional cost gets passed on the government.

28. See SHANNON BROWNLEE, *OVERTREATED: WHY TOO MUCH MEDICINE IS MAKING US SICKER AND POORER* 31-32 (2007). In the case of nonprofit hospitals the correct term would be “margin.”

29. Avik Roy, *Saving Medicare from Itself*, 8 NAT. AFF. 35, 39 (2011), available at <http://www.nationalaffairs.com/publications/detail/saving-medicare-from-itself> (last visited Mar. 22, 2015); Thomasson, *supra* note 10; see also Thomas L. Greaney, *Transforming Medicare Through Physician Payment Reform: An Introduction to the Symposium Issue*, 34 ST. LOUIS U. L.J. 749, 752-54 (1990) (discussing how reasonable cost was an accepted principle from 1961 to 1965). The UCR fee screen system was also utilized by Medicaid and other third party insurers. O’NEILL, *supra* note 7 at 10.

30. See BROWNLEE, *supra* note 28, at 33 (“Every time individual physicians raised their fees, Medicare and private insurers were forced to raise reimbursements, and soon physician payments were in an inflationary spiral.”).

31. See Michael H. Bernstein & John T. Seybert, *Everyone Pays the Price When Healthcare Providers Waive Patients’ Co-Insurance Obligations*, 21 HEALTH L. 20, 24 (2008) (indicating how providers seek more treatment for a patient than necessary, focusing on their personal profits and not necessarily the best interests of the patient). Patients often have to pay deductibles and co-payments, which are supposed to induce cost-consciousness on the consumer side as well as help to defray the cost of services; but it is generally acknowledged that these patient payments do little to counter overutilization. *Id.*

32. See KELTON, *supra* note 10, at 19 (“Throughout the 1970s, sharp increases in medical costs spawned various forms of legislation aimed at slowing the pace of health care inflation. For example, in August 1971, President Nixon imposed wage and price controls in an effort to contain inflationary pressures.”).

33. See MARIE GOTTSCHALK, *THE SHADOW WELFARE STATE: LABOR, BUSINESS, AND THE POLITICS OF HEALTH CARE IN THE UNITED STATES* 68 (2000) (indicating that in 1971, the Nixon administration proposed to establish an employer mandate which “would require employers to pay 65 percent of the cost of insurance premiums for employees working 25 hours or more per week,” but the proposal was met with strong opposition to what would essentially establish a national health insurance system).

34. *Id.*

("HR") executives, for example, stood to lose much accumulated power, and possibly their jobs, if there was a transition away from EBHI. In the early postwar years, employers' provision of health insurance had been simpler, with most employers choosing Blue Cross/Blue Shield ("BC/BS") coverage. Unlike "the Blues," which were limited by their enabling statutes, for-profit insurers ("the commercials") could "experience-rate" their group business.³⁵ That is, they could assess the risk exposure of a given company (or group of companies, such as an industry sector) and offer to that company or group a lower premium reflecting its better health risk and healthcare cost experience.³⁶ The commercials sought out, aggressively marketed to, and, with their lower premiums, successfully wooed away companies with better risk exposure and cost statistics, leaving BC/BS plans' community-rated risk pools with poorer risks and higher costs.³⁷ As more and more companies with favorable risk characteristics migrated away from the community-rated pools, the quality of those pools decreased and their premiums increased, prompting a further migration. Significantly disadvantaged by the competition from experience-rated group insurance, the Blues campaigned for and eventually won, on a state-by-state basis, the right to experience-rate their group insurance business.³⁸ As community rating gave way to experience rating across the nation, the era of early idealism in private insurance had ended. The natural tendency for companies (and people generally) to pursue their own self-interest at the expense of the interest of the larger collective is, on a broader scale, as good an explanation as one can give for our country's long-term inability to

35. CONSUMERS UNION, BLUE CROSS BLUE SHIELD A HISTORICAL COMPILATION 5-6 (2007), available at http://consumersunion.org/wp-content/uploads/2013/03/yourhealthdollar.org_blue-cross-history-compilation.pdf (citing ROBERT CUNNINGHAM III AND ROBERT M. CUNNINGHAM JR., *THE BLUES: HISTORY OF THE BLUE CROSS AND BLUE SHIELD SYSTEM*, (1997), and defining experience rating as "the practice of setting insurance premiums on the basis of the actual loss experience of a given employee group," as distinct from community rating, which is the "concept of creating rates for a large pool of subscribers").

36. See Jessica L. Roberts, "Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform, 2012 U. ILL. L. REV. 1159, 1168-69 (2012) (defining experience rating as examining "the actual claims histories of the individual groups" and then using that information to calculate future risk and make a premium adjustment based on the claims history).

37. See *id.* at 1170 (discussing how group and individual markets are disadvantaged by health insurance practices that cause individuals with chronic health conditions to increase their out-of-pocket expenses by 70 percent). See also NYS Health Maint. Org. Conference. v. Curiale, 64 F.3d 794, 796 (2d Cir. 1995) (stating that the disintegration of nonprofit insurance organizations is due to the experience rating utilized by commercial insurers to price insurance premiums, leaving nonprofit insurers with the sickest members of the population and very few healthy subscribers to offset the costs).

38. Katherine Pratt, *Funding Health Care with an Employer Mandate: Efficiency and Equity Concerns*, 39 ST. LOUIS U. L.J. 155, 205 (1994).

achieve Universal Health Care.

As time went on and the insurance market became more diverse and competitive, employers, especially the larger companies, developed HR staffs with specialists who were better at shopping for coverage and negotiating with insurers.³⁹ These company experts had a stake in maintaining the system they knew. They campaigned for EBHI in part because they believed in it but also, one may assume, because their job security was tied to it. The largest companies had the biggest stake in the employment-based system because – under “experience rating” – they had more stable risk pools and the most market clout and therefore could secure and offer the best health benefits to recruit the best employees, giving them a competitive advantage in the labor market.⁴⁰ Such companies, of course, also had the most influence in lobbying Congress, influence they used to maintain the *status quo*, the EBHI system.⁴¹

C. Late Twentieth Century: The Managed Care Movement

Employers were not entirely comfortable with the *status quo*, however, because healthcare costs continued to rise annually, usually at a rate higher than costs in general.⁴² Reflecting the cost concerns of many American businesses, General Motors complained that it spent more for health care than it did for steel.⁴³ Healthcare costs were increasingly seen as a factor jeopardizing American companies’ global competitive position, a problem

39. David Blumenthal, *Employer-Sponsored Health Insurance in the United States – Origins and Implications*, 355(1) N. ENG. J. MED 82, 83-85 (2006), available at <http://people.umass.edu/econ340/nejm-ebhi.pdf>.

40. See John R. Graham, *Why Do Employers Want to Control Their Employees’ Health Benefits?*, NATIONAL CENTER FOR POLICY ANALYSIS – HEALTH POLICY BLOG (Sep. 15, 2014), available at <http://healthblog.ncpa.org/why-do-large-employers-want-to-control-their-employees-health-benefits/>.

41. See NAT’L BUS. COAL. ON HEALTH, EMPLOYERS COMMIT TO STATUS QUO FOR HEALTH BENEFITS, OFFER CLEAR REJECTION OF PRIVATE EXCHANGES: RESULTS FROM THE 2014 INSIDE BENEFITS COMMUNICATION SURVEY (2014), available at <http://www.nbch.org/nbch/files/ccLibraryFiles/Filename/000000003480/IBCSurvey%20one%20page%20report.pdf> (stating that despite health care reform, HR and benefits practitioners intend to maintain the *status quo*).

42. See Michelle Andrews, *Health Premiums and Costs Set to Rise for Workers Covered at Work*, NAT’L PUB. RADIO (Oct. 14, 2014), <http://www.npr.org/blogs/health/2014/10/14/356097499/health-premiums-and-costs-set-to-rise-for-workers-covered-at-work> (“[E]mployers say they’re making changes to their health plans in 2015 to rein in cost growth: 68 percent said they plan to do so in 2015, compared with 55 percent just two years earlier.”).

43. Ali Frick, *GM CEO: Serious Health Care Reform ‘Undoubtedly Would Help Level the Playing Field’*, THINKPROGRESS Dec. 5, 2008, <http://thinkprogress.org/politics/2008/12/05/33286/gm-health-care-reform/>.

that had to be corrected.⁴⁴ Consequently, employers supported the “managed care” movement—a complex of reforms intended to restrain cost inflation while preserving the EBHI system.⁴⁵

A foundational element of the managed care movement was the Health Maintenance Organization (“HMO”).⁴⁶ HMOs provided a comprehensive set of health services to a defined subscriber population for a predetermined amount, transferring to providers the risks of overutilization and excessive costs.⁴⁷ In theory, and generally in practice as well, the HMO model brought the delivery of care and the payment for care together, presumably inducing a desirable cost-consciousness in all parties involved.⁴⁸ The paradigmatic HMO was the nonprofit prepaid group practice (“PPGP”) model, best represented by the Kaiser Health Plans;⁴⁹ but in broader sweep the HMO movement took in a variety of models in which the providers were mostly paid a predetermined amount and had to provide all needed care within this fixed budget.⁵⁰

The managed care movement came into public prominence in 1970 with the issuance of the “HMO White Paper” by the Department of Health, Education, and Welfare (“HEW”).⁵¹ It was further propelled by the passage

44. Expert Guidance: Implications of The Changing Nature Of Society, HUM. RESOURCES COMPLIANCE LIBR. (CCH) ¶ 54,062 (West 2013).

45. See generally, Ronald Lagoe, Deborah L. Aspling and Gert P. Westert, *Current and Future Developments in Managed Care in the United States and Implications for Europe*, HEALTH RES. POL’Y & SYS. 1, 2 (Mar. 17, 2005), available at <http://www.health-policy-systems.com/content/3/1/4> (discussing the history of managed care in the United States).

46. The term “Health Maintenance Organization” and the acronym HMO were coined by Dr. Paul M. Ellwood, Jr., whose healthcare think tank, Interstudy, championed the concept and worked with missionary zeal to promote the spread of HMOs. See Bradford H. Gray, *The Rise and Decline of the HMO: A Chapter in U.S. Health-Policy History*, in HISTORY & HEALTH POLICY IN THE UNITED STATES: PUTTING THE PAST BACK IN 309, 316 (Rosemary A. Stevens et al. eds., 2006).

47. Brian P. Battaglia, *The Shift Toward Managed Care and Emerging Liability Claims Arising from Utilization Management and Financial Incentive Arrangements Between Health Care Providers and Payers*, 19 U. ARK. LITTLE ROCK L.J. 155, 174-75 (1997); see generally Gray, *supra* note 46.

48. See Gray, *supra* note 46, at 318-22 (discussing the history of HMOs).

49. *Id.* at 318-19.

50. See Arnold J. Rosoff, *Phase Two of the Federal HMO Development Program: New Directions After a Shaky Start*, 1 AM. J.L. & MED. 209, 210 (1975) (discussing alternative types of HMOs, including “open panel” or “foundation-type” plans). In 1979 HEW was reorganized and became today’s HHS (Department of Health and Human Services). http://simple.wikipedia.org/wiki/United_States_Department_of_Health_Education_and_Welfare.

51. See *id.* at 210-214 (discussing the efforts HEW made to promote HMOs, referencing the prediction in their White Paper that by 1980 there would be 1,700 HMOs in operation and discussing the progress of the HMO movement after HEW made this prediction).

of the federal Health Maintenance Organization Act of 1973,⁵² which offered federal funds for feasibility studies, HMO development costs, and initial operating expenses.⁵³ The law was intended to have a nationwide network of HMOs in place by 1980 that would afford ninety percent of Americans the option of getting their health care through an HMO.⁵⁴ Not only did HMOs' early penetration into the health insurance market fail to meet these projections, but HMOs' promised economies failed to materialize. In fact, the managed care movement generally did not deliver on its initial hype, and public enthusiasm for it waned.⁵⁵ Managed care is still a significant part of the U.S. healthcare scene today but has proved no panacea. Complex problems of cost, access, and quality of care still remain.

*D. The Current Predicament:
Employers Find New Ways to Avoid Rising Costs*

Going into the decade of the 1970s, despite the best efforts of insurers

52. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914-36 (1973); see *Rosoff*, *supra* note 50, at 214 (explaining the passage of the HMO Act).

53. See SOC. SEC. ADMIN., NOTES AND BRIEF REPORTS: HEALTH MAINTENANCE ORGANIZATION ACT OF 1973 37 (1974), available at <http://www.ssa.gov/policy/docs/ssb/v37n3/v37n3p35.pdf>. The Act authorized \$375 million for a five-year period in grants and contracts for "(1) surveys or other activities to determine the feasibility of developing and operating or expanding the operation of an HMO, (2) planning projects to establish HMO's or to expand the membership of an HMO or the area that it serves, and (3) projects to initially develop HMO's."

54. U.S. DEP'T OF HEALTH, EDUC., AND WELFARE, TOWARDS A COMPREHENSIVE HEALTH POLICY FOR THE 1970'S: A WHITE PAPER 37 (1971), available at https://ia601006.us.archive.org/7/items/towards_comprehen00unit/towardscomprehen00unit.pdf. A key part of the legislative scheme was the so-called "Dual Choice" mandate, which required employers of 25 or more employees who provided health insurance coverage to offer their employees at least one federally qualified HMO plan in addition to whatever traditional insurance coverage was offered. *Rosoff*, *supra* note 50, at 229. One effect, then, of the HMO movement in the 1970s was to require employer companies to have more knowledgeable HR staff to administer their health benefits. See Blumenthal, *supra* note 1. The HMO Act fell far short of its goal for penetration by 1980, but HMO development and growth continued through the 1980s and HMOs, both non-profit and for-profit, have become a common part of the U.S. healthcare landscape. See "A Quarter Century of Health Maintenance," 280 (24) J.A.M.A. 2059 (Dec. 23/30, 1998), available at <http://jama.jamanetwork.com/article.aspx?articleid=188296>.

55. See, e.g., Robert J. Blendon, Mollyann Brodie, John M. Benson, Drew E. Altman, Larry Levitt, Tina Hoff and Larry Hugick, Understanding the Managed Care Backlash, 17(4) Health Aff. 80-94 (1998). A widely noted reflection of the American public's disaffection with HMOs' attempts at economizing on health care is the classic scene in the 1997 movie *As Good as It Gets* in which Helen Hunt rails against the refusal of her HMO to cover needed health care. See <https://www.google.com/#q=as+good+as+it+gets+hmo+quote> and <http://movie-sounds.org/comedy-movie-sounds/as-good-as-it-gets-1997/fucking-hmo-bastard-pieces-of-shit>.

and employers alike, costs continued to rise,⁵⁶ and still a large segment of the U.S. population was uninsured or underinsured.⁵⁷ Senator Edward ("Ted") Kennedy, who was widely expected to be the Democratic nominee for president in 1972, made UHC a central plank of his platform and strongly advocated adoption of a single-payer national health insurance ("NHI") system.⁵⁸ The Nixon Administration countered in 1971 with a pluralistic, market-based NHI plan built on the existing framework of private insurance and EBHI.⁵⁹ Kennedy did not become the Democrats' 1972 presidential candidate, Nixon's NHI proposal went nowhere,⁶⁰ and health care costs continued to rise.

Some larger employers, those who had a large enough number of employees to constitute a sufficiently balanced risk pool, moved to self-insurance.⁶¹ With the assistance of a strong in-house HR staff or good outside support, such employers could run their own health insurance program at a lower cost.⁶² The Employee Retirement Income Security Act

56. See Christina H. Park, *Prevalence of Employer Self-Insured Health Benefits: National and State Variation*, 57 MED. CARE RES. & REV. 340, 341 (2000) (discussing self-insurance as a way to combat the soaring cost of health care throughout the 1970s and 1980s).

57. See Robin A. Cohen et al., *Health Insurance Coverage Trends, 1959-2007: Estimates from the National Health Interview Survey*, 17 NATIONAL HEALTH STATISTICS REPORTS (2009).

58. See Congressional Quarterly, *Health Insurance: Hearings on New Proposals*, 27 CONGRESSIONAL QUARTERLY ALMANAC, 92ND CONGRESS 1ST SESSION 541-544 (saying Kennedy proposed the Kennedy-Griffiths bill in Jan. 1971).

59. Nixon's Comprehensive Health Insurance Plan (CHIP) was drafted and circulated as a proposal from 1971 on but was not formally introduced before Congress until February 6, 1974. See President Richard Nixon, Special Message to the Congress Proposing a Comprehensive Health Insurance Plan (transcript available at <http://www.presidency.ucsb.edu/ws/index.php?pid=4337>). See also STUART ALTMAN & DAVID SHACTMAN, POWER, POLITICS AND UNIVERSAL HEALTH CARE: THE INSIDE STORY OF A CENTURY-LONG BATTLE 42 (2011); Nixon insisted on an employer mandate under which employers would purchase health insurance coverage for their employees from private insurers; however, Kennedy was unwilling to support this and the proposal failed. *Id.* at 55. See also Michael Meyer, *Nixon and the PPACA*, 22 ANNALS OF HEALTH L. ADVANCE DIRECTIVE 33, 37 (2012).

60. Note, however, that the basic architecture of the Nixon proposal, maintaining EBHI and achieving UHC through employer-provided coverage, private insurance, and managed competition carried forward as a foundational part of the ACA. See, e.g., Robert Reich, "Nixon Proposed Today's Affordable Care Act" (2013), http://www.salong.com/2013/10/29/nixon_proposed_todays_affordable_care_act_partner/; see also, <http://www.forbes.com/sites/peterubel/2014/02/04/another-early-obamacare-supporter-richard-nixon/>.

61. See Timothy Stoltzfus Jost & Mark A. Hall, *Self-Insurance for Small Employers under the Affordable Care Act: Federal and State Regulatory Options*, 68 N.Y.U. ANN. SURV. AM. L. 539, 540 (2013) (stating that, generally, self-insured plans are found among large employers, since small groups are less capable of bearing risks associated with self-insured plans).

62. They still used health insurers to handle claims on an "administrative services only"

of 1974 ("ERISA") provided further impetus for self-insurance by shielding employee benefit plans from state insurance regulations, such as those mandating certain costly benefits.⁶³ However, there were so many factors and forces causing healthcare cost increases that, even for self-insured companies, costs continued to rise, increasing employers' incentive and desire to get out from under the growing burden.⁶⁴

With managed care and self-insurance not getting the cost-containment job done, some employers began to back away from the EBHI system they had long supported and defended. Starting in the 1980s, a significant proportion of employers began raising the employees' share of the cost through higher co-payments and less generous cost-participation formulas.⁶⁵

("ASO") basis. *Id.* at 546. These insurers were known as "third-party administrators" ("TPAs"). *See id.* at 557-58 (discussing how "North Carolina prohibits insurers from serving as third-party administrators for small employers."). Sometimes insurers also provided back-up insurance ("stop-loss reinsurance"). *See Park, supra* note 56, at 354 (explaining that "stop-loss coverage" helps employer's minimize risk); *see also Jost & Hall, supra* note 61, at 546 (comparing self-insured plans with "stop-loss" coverage to insured plans).

63. Employee Retirement Income Security Program, 29 U.S.C. §§ 1001-1461 (1974); *Park, supra* note 56, at 341. Under the McCarran-Ferguson Act of 1945, states are empowered to regulate "the business of insurance." 15 U.S.C.A. § 1011 (West 2014). However, ERISA preempts most state-level laws and regulations mandating inclusion of benefits, such as mental health and alcohol and drug abuse treatments, which are expensive and particularly problematic with regard to utilization control. *Park, supra* note 56, at 341, 346.

64. KAISER FAMILY FOUND., *Employer-Sponsored Family Health Premiums Rise a Modest 4 Percent in 2013, National Benchmark Employer Survey Finds* (Aug. 20, 2013), <http://kff.org/private-insurance/press-release/employer-sponsored-family-health-premiums-rise-a-modest-4-percent-in-2013-national-benchmark-employer-survey-finds/>. Self-insurance also created a conflict of interest by putting the employer in a middleman position between its employees, to whom the employer owed a duty to negotiate for the best quality treatments, and the insurer, with whom it was trying to bargain for lower costs. *See Christine Eibner, et al., TECHNICAL REPORT: EMPLOYER SELF-INSURANCE DECISIONS AND THE IMPLICATIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AS MODIFIED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (ACA), 1(2) RAND HEALTH QTLY* (Summer 2011) 29-30, *available at* <http://www.rand.org/pubs/periodicals/health-quarterly/issues/v1/n2/07.html> (discussing the potential conflict of interest between employers and employees during claims adjudication); *see also* U.S. DEP'T OF HEALTH & HUMAN SERVS. & U.S. DEP'T OF LABOR, *REPORT TO CONGRESS ON A STUDY OF THE LARGE GROUP MARKET 6* (2011), *available at* <http://www.dol.gov/ebsa/pdf/LGMStudy.pdf>.

65. *See generally*, Timothy Jost, *HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT* 67 (2007). Historically, it was common for employers to have "defined benefit" health plans, in which the covered benefits were defined and whatever it cost to provide that package of benefits was divided between the employer and the employee, often on an 80/20 basis. If the insurance premium for the covered benefit package rose by \$100, the employer would bear \$80 of that increase. Some companies began putting dollar limits, or caps, on the amount of the increase they would bear, saying, for example, that regardless of how much the premium increased for the following year the employer would only cover a given amount, say \$60, of the increase. An increasingly common arrangement is for an

Many companies that previously provided coverage to employees' families, regardless of the number of dependents, started charging an additional premium to cover family members.⁶⁶ Other companies adopted wellness programs, designed to decrease healthcare costs by improving the health of their employees.⁶⁷ These programs, while commendable in their intent, fell short of delivering proven benefits in terms both of health outcomes and cost savings.⁶⁸ In short, employers increasingly sought ways to get out from under the burden they had taken on themselves and were increasingly frustrated by their inability to do so.

During the years when EBHI was on the rise, employers were loath to skimp on healthcare benefits for fear of losing valuable workers to a strong labor market in which they could easily be lured away by a competitor with a better health plan. Nowadays, with weakened labor power, an evolving labor market,⁶⁹ and the threat of global outsourcing, the positions are reversed: employees are wary of asking for too much. With more workers looking for a job, employers no longer need to offer the most lavish benefits. If they continue to offer good healthcare coverage, it is most likely because of inertial forces. The managerial class may be satisfied with the *status quo*, for example, and employers may be reluctant to upset their settled expectations. Perhaps not yet a complete anachronism, the employment-based system for providing health insurance is on uncertain ground. This brings us to the big question: In today's world, do the benefits of EBHI outweigh the costs? The next section addresses that question:

employer to offer a "defined contribution" plan, whereby the employer says how much it will contribute for the employee in a given period and the employee must bear whatever cost, and cost increase, goes beyond the employer's contribution. AM. ACAD. OF ACTUARIES, ISSUE BRIEF: UNDERSTANDING DEFINED CONTRIBUTION HEALTH PLANS (2002), http://www.actuary.org/files/dc_june02.4.pdf/dc_june02.4.pdf.

66. KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS: 2014 SUMMARY OF FINDINGS 1 (2014) *available at* <http://files.kff.org/attachment/ehbs-2014-abstract-summary-of-findings> (discussing how employers charge higher premiums for family coverage).

67. See SOEREN MATTKE ET AL., WORKPLACE WELLNESS PROGRAMS STUDY, RAND HEALTH 1-2 (2013), *available at* <http://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinal.pdf> (discussing that employers have started wellness programs to combat chronic disease).

68. See Austin Frakt & Aaron E. Carroll, *Do Workplace Wellness Programs Work? Usually Not*, N.Y. TIMES (Sept. 11, 2004), <http://www.nytimes.com/2014/09/12/upshot/do-workplace-wellness-programs-work-usually-not.html> (explaining why workplace wellness programs usually do not work); *but see* MATTKE ET AL., *supra* note 67, at xiii (explaining that these programs have been found to impact employees' "long-term health trajectory").

69. In this evolving labor market, jobs have become less secure and careers more volatile. The political scientist Jacob S. Hacker has famously termed this transformation "The Great Risk Shift." In such a constantly changing environment, companies are less likely to make efforts and expenditures to tie employees to them for the long term. See JACOB S. HACKER, THE GREAT RISK SHIFT: THE NEW ECONOMIC INSECURITY AND THE DECLINE OF THE AMERICAN DREAM (2006).

focusing for the most part on the contributions of EBHI in the pre-ACA world. How the ACA changes things and might affect this analysis will be dealt with in Section III.

II. PROS AND CONS OF THE EMPLOYMENT-BASED SYSTEM

While many, including the authors, believe that EBHI is not the best foundation for our nation's healthcare system, it has served a valuable function throughout much of the twentieth century and, even in today's changed and changing world, it may still make sense to continue its use in selected applications.⁷⁰ A key point to remember is that in designing a system for the U.S., we are not starting with a clean sheet of paper. What we have in place now, and the commitment of people and institutions to maintaining the *status quo*, are powerful determinants of what we can hope to achieve as we seek the ideal solution.

Key hallmarks of an employment-based system, at least as it has evolved in our country, are diversity, complexity, and cost. Almost by definition, an employment-based system is decentralized, depending on many employers to negotiate with many insurers, who in turn must negotiate with many hospitals, physicians, and other providers of healthcare goods and services.⁷¹ The result is a myriad of insurance products, prices, and relationships that in its diversity and complexity goes well beyond what exists anywhere else in the world.⁷² It is uniquely "American." The case against EBHI is not open-and-shut, however; and, even if it were clear-cut in substantive terms, it would still be a daunting challenge to change settled thinking and move toward new structures and arrangements. Just as large ships can't turn in their own length, decentralized social systems don't change overnight, or even in a decade.

70. This is the view of David Hyman and Mark Hall, whose excellent article, *Two Cheers for Employment-Based Health Insurance*, supra note 16, was an important guide through this analysis.

71. See Uwe E. Reinhardt, *Employment-Based Health Insurance: A Balance Sheet*, 18 HEALTH AFF. 124, 126 (1999), available at https://www3.nd.edu/~wevans1/class_papers/reinhardt_employer_health_insurance_health_affairs.pdf (explaining the decentralization of the employment-based system). Note that one can posit a national healthcare system that relies heavily on employer initiatives, actions and financing and yet is much more tightly constrained in its structure and operation than ours is. Germany, Argentina and Japan offer good examples. See generally T. R. REID, *THE HEALING OF AMERICA: A GLOBAL QUEST FOR BETTER, CHEAPER, AND FAIRER HEALTH CARE* (2010).

72. See U.S. DEP'T OF LABOR, Report of the Working Group on Challenges to the Employment-Based Healthcare System (Nov. 14, 2001), http://www.dol.gov/ebsa/publications/AC_1114b01_report.html ("[A] large employer can wield clout in the market place by virtue of the sheer number of employees and hence the dollars it brings to the insurer Employers can demand things from the insurer that individual buyers could not.").

A. *The Presumed Benefits of Choice*

Americans are accustomed to an environment that offers unparalleled choice in all aspects of their consuming behavior. Although it lacks a Constitutional basis, we tend to regard freedom of consumer choice as a right, much like freedom of speech or the right to own a gun. We love choice and believe in it deeply. Considered from the viewpoint of neoclassical economics, an abundance of choices is highly positive. In theory, having many competitors vie to provide the best quality goods and services at the lowest cost in order to win the business of the most consumers is a key strength of our economy and an assurance of the public's satisfaction. In the healthcare context, however, the benefits of choice are harder to realize. Consumers rarely have the knowledge, ability, time, or patience to fully explore and understand all their options and make an optimal decision. Thus, in health care, as in some other technical areas, an overabundance of choice and the complexity it introduces can lessen consumers' ability to make good choices and to engage the force of competition to constrain price inflation.⁷³

There is also a significant transaction cost to offering consumers alternatives and bringing those alternatives to their attention. As an example, compare the "medical loss ratio" of Medicare with that of private insurance, meaning how much of each dollar goes to running the insurance plan as opposed to providing care. Medicare generally operates at a loss ratio of approximately 97%; that is, roughly 97 cents of every Medicare dollar go to pay providers for care and only about 3 cents are used for administrative costs of the program. Historically, the loss ratios of private insurance plans have been much lower, in the range of 68-88% for individual coverage, somewhat higher but still below 90% for group coverage.⁷⁴ There are many reasons for the higher administrative expenses

73. SUSAN M. FINLEY, *THE GREAT AMERICAN RIP-OFF: A CONSUMER'S PERSPECTIVE ON HEALTHCARE* 25 (2007). Psychological studies have shown that having too many choices can lead to confusion and stress, potentially causing consumers to make worse decisions than they would have made in a more restricted setting. *See, e.g.*, BARRY SCHWARTZ, *THE PARADOX OF CHOICE: WHY MORE IS LESS* 3 (2005), ("...there is a cost to having an overload of choice.").

74. *See, e.g.*, Health Affairs, *Health Policy Brief on Medical Loss Ratios* (Nov. 17, 2010), available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=31 (last visited Apr. 27, 2015). The ACA, attempting to assure that insurance purchasers get good value for their money, imposes minimum loss ratios on insurers. Insurers of individuals and small (less than 100) groups must maintain a loss ratio of at least 80%, while insurers of larger groups must have a loss ratio of 85% or more. *Id.* *See also* <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html>. While the medical loss ratio is widely used as a metric to assess the efficiency and value of a health insurer's plans, this complex measure must be used carefully to avoid drawing invalid conclusions about a plan's worth. *See* James C. Robinson, *Use and*

of private insurance, but one of the principal factors is how much it costs to offer consumers a wide range of choices.⁷⁵ If there were good evidence that allowing such a range of choice paid off in terms of better competition, greater consumer satisfaction, etc., the higher cost would be worth it; but such evidence is lacking, so the American public's addiction to free choice must be seriously questioned.

B. Does EBHI Assure Choice?

Critics of the ACA, and of government intervention in the healthcare sector generally, emphasize the benefits of choice and complain about how the law limits free choice; but EBHI does not assure—or even support—consumer choice to the extent that many assume. In the pre-ACA world, employers were free to choose what health coverage, if any, to provide their employees. Some companies used that freedom of choice knowledgeably and benevolently for the employees' welfare; but choice at the corporate level does not equate to choice at the level of the individual employee. While some employers, especially larger ones, may offer their employees a range of health benefit options—often termed a “cafeteria plan”—others make a company-wide selection of a single health plan and the employees' only “choice” is to take or leave it. The chosen plan may be ideal for some of the company's employees and not so good for others;⁷⁶ thus, the systemic choice offered by EBHI on the macro (healthcare system or company/firm) level may be a mere illusion of choice on the micro (individual insured) level.

Moreover, EBHI may interfere with job choice in the labor market. The variability in health plans from one employer to another makes it difficult to

Abuse of the Medical Loss Ratio to Measure Health Plan Performance, 16(4) HEALTH AFFAIRS 176-187 (July-Aug. 1997), available at <http://content.healthaffairs.org/content/16/4/176.full.pdf>.

75. To explain just one dimension of this, consider the marketing costs involved when an employer seeks or accepts bids from several insurance companies. Each company must employ salespeople to market its product(s) to the employer. The sales costs necessarily add to the price of the insurance. If the employer offers several different insurers' policies, each insurer must also sell at the individual employee level, with the costs of brochures, websites, call-center operators, etc., again adding to the price of the coverage. At the corporate level, the insurer's activity is termed “marketing”; at the individual level it is called “enrollment.” Both levels of activity generate significant cost, which raises the price of the product.

76. A company that offers a very generous health insurance, for example, may be serving well the interests of its middle-aged, high-tax-bracket managerial class who like and can afford “gold” coverage, while a healthy young assembly-line employee might find that level of coverage to be overkill. He or she might be better served by a less expensive, less generous “bronze” level plan and more dollars in the pay envelope. Yet, if the company follows a “one size fits all” health benefits policy, the “choice” that the employer enjoys at the corporate level is no choice at all for the young employee.

compare employment opportunities when one is looking for a job or thinking about changing jobs. The specifics and richness of the insurance benefit is much harder to assess than salary levels or other terms and conditions of employment. A job-seeker who tries to use health coverage as a factor in deciding which job to take or keep is likely to be confounded by the many variables in health plan details. Many of these details are not transparent to prospective employees—or even to current employees, for that matter. It's not just the policy language that varies but also how the insurer interprets and applies that language in practice, something that insurance shoppers find very difficult, if not impossible, to assess before the fact. As will be discussed in the following section, one of the advantages the ACA offers is the establishment of the Insurance Exchanges, which are rationalized and standardized retail markets designed to facilitate comparison-shopping.

Prior to the ACA's guarantees of coverage and insurability,⁷⁷ employees were often reluctant to change jobs, even when that was the right thing to do on other grounds, because they did not want to disrupt their insurance coverage.⁷⁸ Even if the new employer provided a good insurance package, the employees, or their dependents, might be subject to exclusions of pre-existing health conditions and/or a waiting period for full vesting of benefits. This phenomenon of sticking with one's current job for fear of the side-effects of making a switch, known as "job lock," takes away an important dimension of personal choice and interferes with the dynamic functioning of the labor market, which compromises the nation's economic strength.⁷⁹

77. 42 U.S.C.A. §§ 300gg, various subsections (2010) (sub. 3, prohibiting pre-existing condition exclusions; sub. 4., prohibiting discrimination based on health status; sub. 6, mandating coverage of "essential health benefits"; and sub. 7, prohibiting excessive waiting periods before coverage begins).

78. The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), 29 U.S.C. §§ 1161-1168, tried to ameliorate this problem by facilitating bridge coverage for workers transitioning from one job to another, but it relied on the very expensive individual market, which is unaffordable for many, if not most, consumers. See Michelle Andrews, *For Workers Leaving Their Jobs, Health Exchanges Offer Insurance Choices beyond COBRA*, KAISER HEALTH NEWS (Sept. 16, 2013), <http://khn.org/news/091713-michelle-andrews-cobra-and-health-exchanges/> (discussing COBRA as a "transitional type of coverage").

79. See Anna Sanz-de-Galdeano, *Job-Lock and Public Policy: Clinton's Second Mandate*, 59 INDUS. & LAB. REL. REV. 430, 430 (2006) (identifying some situations in which job-lock may arise, e.g., if a person has a preexisting health condition). Job lock may be a positive feature for employers who use health benefits to recruit and retain employees, although this approach is less likely to work in a world of labor scarcity. See David S. Caroline, Comment, *Employer Health-Care Mandates: The Wrong Answer to the Wrong Question*, 11 U. PA. J. BUS. L. 427, 435 (2009) ("An individual who needs better insurance might change jobs, even if he or she otherwise is quite content and productive, which in turn causes an unnecessary loss in efficiency."). In today's world, where the "surplus army of the

The complexity and diversity of the EBHI system, with its multitude of different plans, providers, and payment regimes, doesn't just affect insurance purchase choices and the dynamics of the labor market; it can also affect the delivery and quality of health care.⁸⁰ For patients, it can result in less continuity and coordination of care than patients enjoy in some other countries.⁸¹ That lack of coordination is linked to higher rates of medical errors, greater rates of infection during hospital stays, and lower quality of care generally.⁸² For physicians, it results in more paperwork and payment headaches than doctors face in other developed nations.⁸³ For insurers, it results in significantly higher administrative costs than public insurance systems. That doesn't necessarily mean, however, that insurers would rather be part of a public system. Lower efficiency and higher cost aren't necessarily bad if you're on the receiving end of the cost chain. One man's expense is another's revenue and, sometimes, profit.⁸⁴

unemployed" is so large and capital so much more powerful than labor, it seems unlikely that many employers would *need* health benefits to recruit and retain employees. See ANTHONY W. ORLANDO, LETTER TO THE ONE PERCENT 43-44 (2013) (referencing Karl Marx's phrase "surplus army of the unemployed" and reminding that when "unemployment is high, workers are negotiating from a weak position.").

80. The negative effects of discontinuous and uncoordinated health care can be found in any type of health system, not just an employment-based one, but these two elements are so tightly interwoven in the United States that it is impossible to keep their effects strictly separate.

81. See Cathy Schoen et al., *New 2011 Survey of Patients with Complex Care Needs In Eleven Countries Finds That Care is Often Poorly Coordinated*, 30 HEALTH AFF. 1, 1-3 (2011) (referring to chart comparing coordination of care in eleven countries and stating how in the United States "89 percent of total national health spending is concentrated on the sickest 30 percent of the population. Because these patients typically see multiple clinicians at different locations, care coordination is imperative. Without effective communication among providers, these patients are at risk for experiencing delays, errors, and ineffective care.").

82. See Elizabeth Docteur & Robert A. Berenson, *How Does the Quality of U.S. Health Care Compare Internationally? Timely Analysis of Immediate Health Policy Issues*, URBAN INST. 8 (2009), available at http://www.urban.org/uploadedpdf/411947_ushealthcare_quality.pdf (stating that patients in the U.S. may be at a greater risk of safety problems such as medical error).

83. See Cathy Schoen et al., *Access, Affordability, and Insurance Complexity Are Often Worse in the United States Compared to Ten Other Countries*, 32 HEALTH AFF. 1, 8 (2013) ("The United States also stood out in the 2012 survey of physicians in 11 countries for time-consuming insurance-related complexity. Fifty-four percent of US primary care physicians said that the amount of time that they and their staff spent dealing with coverage restrictions was a 'major problem,' a significantly higher percentage than that in any other country.") Surely, though, some U.S. physicians would rather deal with a complex and fragmented system than one with tighter governmental controls. If this weren't so it's much more likely that the U.S. would have a governmental system. From the beginning in this country, what doctors want, or are comfortable with, has been a key determinant of the architecture of our healthcare system.

84. See Diane Archer, *Medicare Is More Efficient Than Private Insurance*, HEALTH

This imbalance of negotiating power plagues not only insurers in negotiating with hospitals and physicians over reimbursement rates,⁸⁵ but also consumers in negotiating with insurers.⁸⁶ In public insurance systems, the government generally has significant negotiating power as the representative for most, if not all, of the country's health insurance customers. In some cases it has the legal authority to set prices without negotiation.⁸⁷ While large employers in the U.S. may have and exercise significant bargaining power when dealing with insurers and health plans, certainly much more than small businesses do, they are clearly at a disadvantage in negotiating for lower insurance premiums and better coverage when compared with their counterparts abroad, who essentially outsource such negotiations to the government.⁸⁸ This difference in bargaining power is an important reason why both employers and employees in the U.S. face significantly higher costs for health care⁸⁹

Matters are even worse for individuals who attempt to purchase health

AFF. BLOG (Sept. 20, 2011), <http://healthaffairs.org/blog/2011/09/20/medicare-is-more-efficient-than-private-insurance/?view=full> (explaining that Medicare is more efficient than private insurance and has less administrative cost).

85. Hospitals often have a geographic monopoly, forcing insurers to pay the rates they demand if they want to insure patients in that locality. See Avik Roy, *Hospital Monopolies: The Biggest Driver of Health Costs That Nobody Talks About*, FORBES (Aug. 22, 2011), available at <http://www.forbes.com/sites/theapothecary/2011/08/22/hospital-monopolies-the-biggest-driver-of-health-costs-that-nobody-talks-about/>.

86. See Christopher M. Pope, *Legislating Low Prices: Cutting Costs or Care?* BACKGROUNDERS 1, 2–3 (Heritage Found. No. 2834, Aug. 9, 2013), available at http://thf_media.s3.amazonaws.com/2013/pdf/bg2834.pdf (explaining how the monopoly hospitals have over the health care system leads to higher costs for consumers).

87. *Id.* Japan is one such country where the government sets standardized fees for physician fees and other cost elements. See, e.g., Naoki Ikegami, *Japanese Health Care: Low Cost Through Regulated Fees*, 10 HEALTH AFFAIRS 87–109 (Fall 1991). See also Naoki Ikegami & Gerard Anderson, *In Japan, All-Payer Rate Setting Under Tight Government Control Has Proved to Be an Effective Approach to Containing Costs*, 31 HEALTH AFFAIRS 1049–1056 (May 2012); See also Pope, *supra* note 86 at 5–8.

88. See, e.g., ALYSSA KIM SCHABLOSKI, HEALTH CARE SYSTEMS AROUND THE WORLD, INSURE THE UNINSURED PROJECT 31 (2008), available at http://www.itup.org/Reports/Fresh%20Thinking/Health_Care_Systems_Around_World.pdf (providing that the United Kingdom's central government sets health priorities under the National Health Service Act of 1946 and controls the overall pool of funds). By contrast, in the U.S., employers must fend for themselves in their dealings with insurers. This particularly puts small businesses at a disadvantage. Essentially, they must choose between insurance that is less generous and higher priced than their larger competitors' insurance or no insurance at all.

89. See Uwe E. Reinhardt, *Why Does U.S. Health Care Cost So Much? (Part II: Indefensible Administrative Costs)*, N.Y. TIMES (Nov. 21, 2008), <http://economix.blogs.nytimes.com/2008/11/21/why-does-us-health-care-cost-so-much-part-ii-indefensible-administrative-costs/> (explaining why health care costs are high).

insurance in the non-group market.⁹⁰ They have negligible negotiating power because they cannot pool their risks with others into a group that insurers have to take together.⁹¹ The result is — or, at least, *was* before the ACA — that insurers underwrite and cherry-pick to get the best risks, leaving consumers with health problems, those who need insurance most, with the choice of paying exorbitant costs or going uninsured.⁹² This has been the most widely acknowledged shortcoming of our EBHI system—a lack of access for millions of Americans, translating into an uninsured rate that dwarfs all other developed nations combined.⁹³ Section III below examines how the ACA attempts to address these issues, but they remain the primary challenges of a private, employment-based system.

Despite its limitations and failings, the EBHI system in the U.S. has made a profound contribution. In the absence of a comprehensive national health insurance system, employer-provided insurance has made a generally good level of coverage available to a substantial majority of our citizens, and has funded the development of a highly sophisticated and successful healthcare system. In a world where private insurers can pick and choose which persons to insure, based in significant part on their personal and family health history, current health status, and anticipated future healthcare needs, many more Americans would be without adequate coverage if it weren't for EBHI.⁹⁴ Employers can pool risks, covering both the healthier and the less healthy within their employee “families” and creating something akin to a community rating system in which the low-risk insureds help to subsidize the needs of higher-risk consumers.⁹⁵ For these reasons, EBHI deserves “two cheers” (not the full three), as Professors David Hyman⁹⁶ and Mark Hall,⁹⁷ two of the most knowledgeable and

90. See U.S. DEP'T OF LABOR, *supra* note 72 (noting that an employer has more leverage than an individual when it comes to negotiating discounts on premiums).

91. *Id.*

92. But see David Blumenthal, *The Three R's of Health Insurance*, COMMONWEALTH FUND (Mar. 5, 2014), <http://www.commonwealthfund.org/publications/blog/2014/mar/the-three-rs-of-health-insurance> (explaining how risk adjustment under the ACA attempts to deter insurance plans from cherry-picking enrollees while at the same time protecting companies that attract sicker-than-average customers); *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors*, KAISER FAM. FOUND. 1 (Jan. 22, 2014), <http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/> (discussing how insurers are no longer allowed to deny insurance or charge higher premiums for people with pre-existing conditions).

93. See *Health at a Glance 2013: OECD Indicators*, OECD 138 (2013), <http://www.oecd.org/els/health-systems/Health-at-a-Glance-2013.pdf> (discussing coverage and costs of health care for other countries).

94. Hyman & Hall, *supra* note 16, at 32.

95. *Id.*

96. David A. Hyman, M.D., J.D., is Professor of Law and Medicine at the Univ. of Illinois, where he directs the Epstein Program in Health Law and Policy. See <https://>

perceptive scholars in this field, proclaim in their thorough and insightful 2002 article chronicling the history of EBHI and critically evaluating it.⁹⁸ Because of its failings and the possibility of reforming our nation's healthcare system to assure adequate coverage for all without the discriminatory practices of a free-market private insurance market, Hyman and Hall reserve their "third cheer." The Affordable Care Act affords a solution to the main problems that EBHI evolved to address,⁹⁹ and upon successful implementation of the ACA's insurance exchanges, should offer the freedom of choice and the benefits of free-market competition that EBHI was intended to deliver but never quite did. For this reason the third cheer for EBHI may never come.¹⁰⁰ To explore that possibility, the next section considers how the ACA has changed the environment in which EBHI exists and operates.¹⁰¹

III. HOW THE AFFORDABLE CARE ACT CHANGES THE GAME

The ACA's approach to EBHI, like so many parts of the Act, is the product of political compromise. In the debates preceding the ACA's passage, many UHC advocates and various stakeholders favored a national healthcare system that was not employment-based.¹⁰² However, both politically and practically it was not feasible to toss out the existing system and replace it with something else.¹⁰³ A "clean slate" approach simply was not feasible; a large segment of the public had a strong commitment to the existing EBHI system. For this reason, EBHI was retained as a foundational element of the ACA, at least on an optional basis.¹⁰⁴

www.law.illinois.edu/faculty/profile/davidhyman.

97. Mark Hall, J.D., is Professor of Law at Wake Forest Univ. School of Law and directs the University's Center for Bioethics, Health & Society. See <http://law.wfu.edu/faculty/profile/hallma/bio/>.

98. Hyman and Hall, *supra* note 16, at 24.

99. *Id.* at 32.

100. *Id.* at 32-33.

101. Patricia C. Flynn, *Health-Care Reform and ESI: Reconsidering the Relationship Between Employment and Health Insurance*, 115 BUS. & SOC'Y REV. 311, 313 (2010) (discussing how EBHI began during World War II and how federal policies helped to expand this coverage).

102. See, e.g., Ronald Bailey, *Ending Employment-based Health Insurance Is a Good Idea – But Do We Really Need a New Regressive Health Insurance Tax?*, REASON (October 16, 2007), available at <http://reason.com/archives/2007/10/16/ending-employment-based-health-i>. See also Ezekiel J. Emanuel, *The Problem with Tax-Exempt Health Insurance*, N.Y. TIMES (October 10, 2008), <http://campaignstops.blogs.nytimes.com/2008/10/10/the-problem-with-tax-exempt-health-insurance/>.

103. See Hyman & Hall, *supra* note 16, at 35-38 (discussing problems that could occur with reform and a shift away from EBHI).

104. See Angie Drobnic Holan, *Obama Statements on Single-Payer Have Changed a Bit*, POLITIFACT (July 16, 2009, 3:39 PM), <http://www.politifact.com/truth-o-meter/>

Campaigning for the ACA's passage, President Obama stated on several occasions that Americans who were satisfied with their healthcare plans would be able to keep their current plans.¹⁰⁵ In broad concept, that may have been the ACA's objective; but it's not easy to make major changes to a highly complex, deeply embedded system and still keep wholly intact a key element of it.¹⁰⁶ The President undoubtedly regrets making this "promise" without the necessary qualifiers,¹⁰⁷ but the underlying rationale made sense: keep what is good and valued in the system, strengthen it where necessary, and build in options for alternatives. This section explores how the ACA accomplishes these goals, starting with an overview of a key concern with free-market insurance systems, "Adverse Selection".

A. The Adverse Selection Problem

For the ACA's promise of universal coverage to be attainable and sustainable, the whole population must be enrolled in the system because of the perils of "adverse selection," an economic phenomenon well known in the insurance industry.¹⁰⁸ If people are allowed to choose whether to participate in a risk pooling arrangement, the ones who know or believe themselves to be at low risk will opt out and withhold their premiums, leaving the risk pool overpopulated with the poorer health risks who will require more care and, thus, drive up the cost of the insurance.¹⁰⁹ To make

statements/2009/jul/16/barack-obama/obama-statements-single-payer-have-changed-bit/ ("Obama says he supports the idea of universal health care but does not think a single-payer government system is feasible . . . He has said he is reluctant to switch to a 'single-payer' national health insurance system because of the difficulty in making a quick transition from the employment-based private system.").

105. See, e.g., Obama: 'If You Like Your Health Care Plan, You'll Be Able to Keep Your Health Care Plan', POLITIFACT, <http://www.politifact.com/obama-like-health-care-keep/> (last visited Mar. 16, 2015); see also Washington Free Beacon, *36 Times Obama Said You Could Keep Your Health Care Plan*, YOUTUBE (Nov. 5, 2013), <https://www.youtube.com/watch?v=qpa-5JdCnmo> (compiling 36 times that President Obama stated "if you like your health care plan, you can keep your health care plan").

106. The story behind why Obama and other Administration spokespeople made this claim so strongly and unequivocally, without the limitations, caveats, and qualifiers needed to make it fully accurate is interesting and bears importantly on the question of the future of employment-based health care. However, it is too lengthy and complex to be adequately covered here. For a fuller explication, see Matthew O'Brien, *Everything You Need to Know About Obama's New 'You Can Keep Your Plan' Policy*, ATLANTIC (Nov. 16, 2013), <http://www.theatlantic.com/business/archive/2013/11/everything-you-need-to-know-about-obamas-new-you-can-keep-your-plan-policy/281522/>.

107. Ashley Killough, *Obama Apologizes for Insurance Cancellations due to Obamacare*, CNN (Nov. 7, 2013), <http://www.cnn.com/2013/11/07/politics/obama-obamacare-apology/>.

108. Mark Pauly & Sean Nicholson, *Adverse Consequences of Adverse Selection*, 24 J. HEALTH POL. POL'Y & L. 921 (1999).

109. Hyman & Hall, *supra* note 16, at 31-32.

matters worse, as this causes insurance premiums to rise, reflecting the deteriorating quality of the risk pool, the higher cost will drive the next tier of relatively good risks out of the risk pool. This step-wise degradation of the pool makes it less and less viable.¹¹⁰ If the risk mix gets bad enough the pool goes into what some term a “death spiral.”¹¹¹ Insurers can protect themselves from this situation if allowed to “underwrite” applicants¹¹² – *i.e.*, initially exclude those who are poor risks, limit their benefits, and/or charge them higher premiums – or to drop people from coverage when they prove themselves to need too much care. Historically, U.S. health insurers, operating in a free-market regime, have been able to manage their risk exposure this way, in some cases “cherry-picking” only the very best risks; and they have done so, yielding an unfortunate segment of the population who, prior to the ACA, either could not get coverage or had to pay excessively high premiums.¹¹³ In the interest of achieving universal coverage and assuring non-discrimination, the ACA guarantees insurability by forbidding insurers to exclude those with pre-existing health conditions, impose waiting periods before such conditions become covered, raise premiums on those who turn out to be poor risks, and drop such insured individuals from coverage.¹¹⁴ Given these “patient protections,” it is essential that the entire population be covered all of the time. If they were not, prospective insureds could stay out of the risk pool until they needed care and then come forward and demand their guaranteed insurability. That would be tantamount to requiring fire insurance companies to issue policies to homeowners when they come running in shouting that their houses are ablaze.¹¹⁵

To assuage the opposition of health insurers to the above-mentioned “patient protections” and to combat adverse selection, which would otherwise expose insurers to its destructive effects, the ACA contains both

110. BERNADETTE FERNANDEZ & ANNIE L. MACH, CONG. RESEARCH SERV., R42663, HEALTH INSURANCE EXCHANGES UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) 24 (2013), available at <https://www.fas.org/sgp/crs/misc/R42663.pdf>.

111. Yuval Levin, *An Insurance Death Spiral?*, NAT'L REVIEW, THE CORNER (Oct. 25, 2013), <http://www.nationalreview.com/corner/362215/insurance-death-spiral-yuval-levin> (explaining that a “death spiral” is a progressively deteriorating risk pool that has gotten so bad that it’s no longer sustainable).

112. See Larry Levitt & Gary Claxton, *Is a Death Spiral Inevitable if There is No Mandate?*, KAISER FAM. FOUND. (June 19, 2012), <http://kff.org/health-reform/perspective/is-a-death-spiral-inevitable-if-there-is-no-mandate/>.

113. Leigh Page, *Why ‘Cherry-Picking’ Patients is Gaining Ground*, MEDSCAPE (Dec. 19, 2013), <http://www.medscape.com/viewarticle/818079>.

114. 42 U.S.C.A. §§ 300gg-3–7 (West, WestlawNext current through P.L. 113-296 (excluding P.L. 113-235, 113-287, 113-291, and 113-295)) (2010).

115. See Levitt, *supra* note 112.

individual¹¹⁶ and employer mandates.¹¹⁷ The “Individual Shared Responsibility” provision requires individuals to have coverage that provides at least the “minimum essential coverage” the ACA prescribes, and imposes a tax penalty if they do not.¹¹⁸ Likewise, employers of fifty or more full-time equivalent (“FTE”) employees must provide coverage that meets the law’s requirements or pay a penalty, which the ACA euphemistically terms an “Employer Shared Responsibility (“ESR”) fee.”¹¹⁹ These penalties are meant to induce individuals and employers to do the right thing and, to a limited extent, to provide funds to the government to help defray the additional expenses it will incur providing needed care to uninsured or underinsured individuals.¹²⁰ However, the penalties are set well below the cost of the insurance that the mandate requires.¹²¹ Thus, in many cases, it would cost less for an employer to violate the mandate and pay the penalty than to comply with it.¹²² This statement, however, takes account only of the dollars directly expended under each alternative; it doesn’t consider what might be very substantial costs in terms of employer-

116. 26 U.S.C.A. §5000A (West, WestlawNext current through P.L. 113-296 (excluding P.L. 113-235, 113-287, 113-291, and 113-295)) (2010); see *Individual Shared Responsibility Provision – Minimum Essential Coverage*, INTERNAL REVENUE SERV., <http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Minimum-Essential-Coverage> (last updated Mar. 13, 2015).

117. 26 U.S.C.A. §4980H (West, WestlawNext current through P.L. 113-296 (excluding P.L. 113-235, 113-287, 113-291, and 113-295)) (2010); see *Employer Shared Responsibility Provisions*, INTERNAL REVENUE SERV., <http://www.irs.gov/Affordable-Care-Act/Employers/Employer-Shared-Responsibility-Provisions> (last updated Feb. 18, 2015). Note that although both the individual and employer responsibility provisions are widely referred to as “mandates,” as reflected in many of the articles hereinafter cited, the ACA does not use that word and the law’s requirements are structured so as to not be absolutely prescriptive. Therefore, as explained below, it would be more precise to speak of the provisions as strong incentives rather than “mandates.” See generally Fitzgerald, note 121 *infra*.

118. 26 U.S.C.A. §5000A (2010). See Annie L. Mach, *INDIVIDUAL MANDATE UNDER ACA* (Cong. Research Service Report R41331, Aug. 12, 2014) available at <https://www.fas.org/sgp/crs/misc/R41331.pdf>. The penalty starts low but increases between 2014 and 2016 and is indexed to inflation thereafter. *Id.* at 1-4.

119. *Employer Mandate*, U.S. CHAMBER OF COM., <https://www.uschamber.com/health-reform/employer-mandate> (last visited Mar. 19, 2015).

120. Bob Semro, *The Role of the ‘Employer Mandate’ in the Affordable Care Act*, HUFFPOST DENVER (July 12, 2013), http://www.huffingtonpost.com/bob-semro/the-role-of-the-employer-mandate_b_3575041.html.

121. See Beth Fitzgerald, *Employers Could Opt to Pay ACA Penalty Rather than Provide Mandated Coverage*, NJBIZ (Nov. 26, 2014), <http://www.njbiz.com/article/20141126/NJBIZ01/141129821/Employers-could-opt-to-pay-ACA-penalty-rather-than-provide-mandated-coverage>; See also CIGNA, *EMPLOYER MANDATE FACT SHEET 3* (2014), available at <http://www.cigna.com/assets/docs/about-cigna/informed-on-reform/employer-mandate-fact-sheet.pdf> (listing the penalties applied to employers).

122. Fitzgerald, *supra* note 121.

employee relations, a company's public image, its ability to attract and retain employees, and other non-quantifiable side effects of a decision to violate the mandate. As discussed in Section IV below, the considerations and calculations needed to decide what is the best course are complex and can vary depending on an individual's or employer's particular situation.

B. Employer Shared Responsibility

A full exposition of the employer mandate and its many details is beyond this paper's scope; it is sufficient for present purposes simply to understand the basics. The ACA defines FTE employees as those who work thirty hours or more per week¹²³ and applies the mandate basically to those employers who have fifty or more FTEs.¹²⁴ It defines "minimum essential coverage" of health insurance in terms of what is covered, guarantees of insurability and maintenance of coverage, and criteria of premium equity and affordability.¹²⁵ The ESR provisions require employers to provide at least 95% of their employees with this minimum insurance and contribute at least 60% to its cost.¹²⁶ The insurance must cover the employee and any dependents under the age of twenty-six, not including the employee's spouse.¹²⁷

Employers are treated differently depending on their size, as measured

123. 26 U.S.C.A. § 4980H.

124. *Id.* Opponents of the ACA intent on limiting its reach have proposed amending the law to define FTE employees as those who work 40 or more hours per week and to apply the mandate only to larger employers. See Paul N. Van de Water, *Health Reform Not Causing Significant Shift to Part-Time Work*, CTR. ON BUDGET & POLICY PRIORITIES, <http://www.cbpp.org/cms/?fa=view&id=4028> (Jan. 6, 2015) (last visited June 22, 2015).

125. 26 U.S.C.A. § 5000A (West, Westlaw through P.L. 113-296 (excluding P.L. 113-235, 113-287 and 113-291) approved Dec. 19, 2014). See generally, *Individual Shared Responsibility Provision - Minimum Essential Coverage*, *supra* note 116 (detailing the requirements for minimum essential coverage).

126. 26 C.F.R. § 54.4980H-4 (West, Westlaw through Apr. 23, 2015) ("[f]or purposes of this paragraph (a), an applicable large employer member is treated as offering such coverage to its full-time employees (and their dependents) for a calendar month, if for that month, it offers such coverage to all but five percent (or, if greater, five) of its full-time employees"); See also *Questions and Answers on Employer Shared Responsibility Provisions under the Affordable Care Act*, INTERNAL REVENUE SERV., <http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act> (last updated Feb. 18, 2015) [hereinafter *Questions and Answers*]; see also CIGNA, *supra* note 121, at 1-2.

127. See 26 U.S.C.A. § 4980H (West, Westlaw through P.L. 113-296 (excluding 113-235, 113-287, and 113-291) approved Dec. 19, 2014) (requiring dependents, not including spouses, to be included in coverage. The ACA assumes that spouses will obtain insurance either through their employer or by purchasing it on an exchange); 42 U.S.C.A. § 300gg-14 (West, Westlaw through P.L. 113-296, excluding P.L. 113-235, 113-287, 113-291), approved Dec. 19, 2014) (extending coverage for dependents until they attain the age of 26).

principally by their number of employees.¹²⁸ Their responsibilities under the ACA vary substantially and the requirements applicable to them now are set to begin at different times.¹²⁹ In 2015, the mandate applies only to firms with 100 or more FTEs; starting in 2016 it applies as well to firms with fifty to ninety-nine employees.¹³⁰ Smaller firms are eligible for tax credits to encourage and enable them to provide insurance.¹³¹ The size of the firm and the wage levels of its employees also affect the penalties for non-compliance.¹³²

As noted above, the ACA doesn't speak of employer payments as a penalty; rather, it uses the less provocative term "ESR fee".¹³³ For employers subject to the mandate, the fee is \$2,000 per employee per year, calculated and prorated on a monthly basis.¹³⁴ Thus, if an employer of 100 or more employees chooses not to provide its employees with insurance in 2015, and if at least one of those employees shops on an insurance exchange and is eligible for a federal premium subsidy, the employer would normally have to pay through the IRS a \$2,000 ESR fee for each of its 100 employees—\$200,000 in aggregate. The ACA's phase-in provisions will soften the impact somewhat through 2016 by granting exemptions for some number of an employer's employees, but the rules regarding the exemptions vary by year and company size and are complicated to compute, putting an unappealing administrative burden on employers.¹³⁵

128. Juliet Eilperin & Amy Goldstein, *White House Delays Health Insurance Mandate for Medium-size Employers Until 2016*, WASH. POST (Feb. 10, 2014), http://www.washingtonpost.com/national/health-science/white-house-delays-health-insurance-mandate-for-medium-sized-employers-until-2016/2014/02/10/ade6b344-9279-11e3-84e1-27626c5ef5fb_story.html. The wage levels of the employees are also taken into account in calculating the employer's obligations and available subsidies. See CIGNA, *supra* note 121, at 1-2.

129. Eilperin & Goldstein, *supra* note 128.

130. CIGNA, *supra* note 121, at 1; Eilperin & Goldstein, *supra* note 128. Starting in 2016, large employers will be considered those with an average of 50 or more employees, while small employers will be those with less than 50 employees. *Id.*

131. 26 U.S.C.A. § 45R (West, Westlaw through P.L. 113-296 (excluding P.L. 113-235, 113-287, 113-291) approved Dec. 19, 2014); 26 C.F.R. §1.45R-3 (West, Westlaw through Apr. 23, 2015); 26 C.F.R. §1.45R-5 (West, Westlaw through Apr. 23, 2015); see also *Small Business Health Care Tax Credit for Small Employers*, INTERNAL REVENUE SERV., <http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers> (last updated May 24, 2015). Small firms are defined not just on the number of employees but also on the employees' average earnings. See *id.*

132. See 26 U.S.C.A. § 4980H (West, Westlaw through P.L. 113-296 (excluding 113-235, 113-287, and 113-291) approved Dec. 19, 2014).

133. *Id.*

134. *Id.*

135. Shared Responsibility for Employers Regarding Health Coverage, 79 Fed. Reg. 29, 8576 (Feb. 12, 2014) (to be codified at 26 C.F.R. pts. 1, 54 & 301); see 26 U.S.C.A. § 4980H (West, Westlaw through P.L. 113-296 (excluding 113-235, 113-287, and 113-291) approved

The process steps and calculations an employer must engage in to assure it is meeting its ACA obligations are very onerous; many, especially those responsible for compliance, have bemoaned their complexity.¹³⁶ Surely, this has an effect on employers' reaction to the ACA and their decision process about how to deal with it. Figuring out the optimum approach for dealing with the ACA's requirements is (a) very complicated, (b) subject to widely varying interpretations, thus controversial, and (c) uneven, and perhaps inequitable, in its application to different stakeholders. Given all of this, it is no surprise that the ACA has been so controversial that it is impossible to make confident predictions as to what will happen going forward.

C. *How Essential is the Employer Mandate?*

As discussed above, a core tenet of the ACA was to build upon the existing healthcare financing structure, including EBHI. The law was designed to motivate employers who do not currently provide insurance to do what the substantial majority of U.S. employers were already doing, while imposing on all employers coverage and affordability requirements to assure that the insurance provided is adequate in terms of coverage and affordability to the insured individuals.¹³⁷ The so-called employer

Dec. 19, 2014) (after 2015, large employers have an exemption for only 30 of those employees); *see also* CIGNA, *supra* note 121. Thus, if the employer had 100 employees, its ESR fee for 2015 would be \$40,000 in aggregate or \$2,000 for each of the remaining 20 employees. If the employer provided its employees ACA-qualifying insurance for 9 months of 2015 it would owe the ESR fee for only 3 months, that is for $3/12 \times \$2,000$ (\$500) \times 20 employees, or a total of \$10,000. If that same employer provided coverage to its employees and one or more of them purchased insurance on an exchange and got a federal subsidy, the employer would owe an ESR fee that is the lesser of \$2,000 for each of its employees (over 80 in 2015) or \$3,000 for each employee whose employer's provided insurance did not meet the ACA's minimum standards for coverage and affordability and who also received a federal subsidy when purchasing insurance on an exchange. In 2015, the same 80-employee exemption and per month proration would apply to this calculation; and the same question as in note 136, *infra*, about which type of exchange the employee(s) purchased on would also apply. In 2016 and thereafter, the exemption for a large (>99 employee) firm drops from 80 employees to 30 employees. *See* 26 U.S.C.A. § 4980H (West, Westlaw through P.L. 113-296 (excluding 113-235, 113-287, and 113-291) approved Dec. 19, 2014).

136. *See* Paul Demko, *Companies Still Struggling to Comply with ACA's Employer Mandate*, MODERN HEALTHCARE (Jan. 20, 2015), <http://www.modernhealthcare.com/article/20150120/BLOG/301209978/companies-still-struggling-to-comply-with-acas-employer-mandate>; *see also* Lisa Chau & Joshua Schiefelbein, *Obamacare's Achilles Heel*, U.S. NEWS (Mar. 10, 2014), <http://www.usnews.com/opinion/economic-intelligence/2014/03/10/the-obamacare-mandate-is-still-bad-news-for-employers> (last visited June 22, 2015).

137. *See* *Obamacare and You: If You Have Job-Based Coverage*, KAISER FAM. FOUND. (Oct. 2013), <https://kaiserfamilyfoundation.files.wordpress.com/2013/10/8495-obamacare-if-you-have-job-based-coverage.pdf> ("The law encourages employers to offer health insurance."); *but see* Suja Thomas & Peter Molk, *Employer Costs and Conflicts under the Affordable Care Act*, 99 CORNELL L. REV. 56, 59–60 (2013) (arguing that the ACA

“mandate” was not intended to be an absolute requirement;¹³⁸ if it were, the penalties for non-compliance would be set considerably higher. Given the flexibility and choice allowed, employers will have to think carefully and make tough choices about how they will handle their newly imposed responsibilities.

While allowing flexibility may have been the better thing to do objectively—and was probably politically required to get the law passed—the many variables designed into the law to accommodate different employers’ particular situations and predilections make their decision processes very complex. As with previous governmental regulatory initiatives, such as the Health Insurance Portability and Accountability Act (“HIPAA”),¹³⁹ the ACA has spawned a whole industry of compliance consultants and has required employers to choose among them, deal with them, pay them, and in many cases adopt new policies and procedures to accommodate the law.¹⁴⁰ Understandably, this has generated considerable unhappiness and resistance in the business community.¹⁴¹ Some employers are unhappy about what the law actually requires, some are unhappy about what they misperceive the law requires, and some are unhappy because they do not know or understand what the law requires and resent the effort and expense needed to find out.¹⁴² Overhanging all of this is the general inclination of American businesses to distrust government and resist

incentivizes employers to either minimize the number of employees who accept “adequate” employer-sponsored coverage or to minimize the number of employees who obtain individual subsidized coverage from an exchange as an alternative to “inadequate” employer-sponsored coverage).

138. See *Summary of Coverage Provisions in the Patient Protection and Affordable Care Act*, KAISER FAM. FOUND. (July 17, 2012), <http://kff.org/health-costs/issue-brief/summary-of-coverage-provisions-in-the-patient/> (stating that there is no employer mandate; however, there are penalties associated with failure to offer coverage).

139. Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936 (codified in scattered sections of 42 U.S.C. and 29 U.S.C.); see also CHARLES R. MCCONNELL, *THE EFFECTIVE HEALTH CARE SUPERVISOR* 470 (Jones and Bartlett Publishers, 6th ed. 2007) (discussing how complicated HIPAA compliance is and how it affects healthcare providers’ feelings about governmental regulation).

140. See Japsen, *infra* note 151; see Demko, *supra* note 136 (expressing the general feeling that companies have of unpreparedness in the face of the requirement to comply with the employer mandate).

141. See *The Employer Mandate: Examining the Delay and Its Effect on Workplaces*, GALEN INST. (July 23, 2013), <http://www.galen.org/topics/the-employer-mandate-examining-the-delay-and-its-effect-on-workplaces/> (“Now, employers are more confused than ever about their responsibilities and liabilities, including whether delay of the reporting requirements does in fact also absolve them of the mandate itself.”).

142. See *Barack Obama’s Message to Business: Stop Whining, I’m Your Friend*, THE ECONOMIST (Aug. 9, 2014), <http://www.economist.com/node/21611140/print> (addressing Obama’s awareness of the business community’s “grumbling about the burden of regulation” and complaints about “over-regulation”).

regulation.¹⁴³ Some employers will devote substantial attention and effort to avoiding or minimizing compliance with the ACA's requirements, e.g., by limiting the number of FTEs and cutting back on some employees' weekly hours to avoid triggering more extensive requirements.¹⁴⁴ These attempts to avoid or skirt the law are a big part of what opponents of the ACA have in mind when they speak of the law as a "job-killer."¹⁴⁵ Although some would disagree, there is nothing inherent in the ACA that makes it a job-killer or would drag down the U.S. economy. Many other nations have UHC and strong economies — Germany, for example — and the U.S. could achieve this easily if it had the national consensus and will. Sadly, as President Obama has observed, it is difficult to make a major reform succeed when so many want it to fail.¹⁴⁶

Whatever views parties at both ends of the political spectrum might have had of the employer mandate, either in principle or with regard to practical implications, another dimension has been added to the debate by the Obama Administration's delay of the mandate's implementation. The ACA as enacted called for the employer mandate to go into effect on January 1, 2014.¹⁴⁷ However, because of the complexity of the employer provisions and the business community's complaints that it could not gear up fast enough to meet that deadline, the Administration announced in July 2013 that implementation would be delayed one year, until January 2015.¹⁴⁸ Then, in February 2014, a further postponement was announced: the requirements for companies with fewer than 100 employees were deferred until January of 2016.¹⁴⁹ For companies with 100 or more FTEs, some

143. *See id.*

144. *See* Chau & Schiefelbein, *supra* note 136.

145. Glenn Kessler, *Is Obamacare a Job-Killer?*, WASH. POST (Feb. 26, 2014), <http://www.washingtonpost.com/blogs/fact-checker/wp/2014/02/26/is-obamacare-a-job-killer/>.

146. *Full Transcript: President Obama Speaks Exclusively to George Stephanopoulos on 'This Week.'* ABC NEWS (Sept. 15, 2013), <http://abcnews.go.com/blogs/politics/2013/09/full-transcript-president-obamas-exclusive-interview-with-george-stephanopoulos/>; *See also* Deirdre Walsh, *House Votes - Again - to Repeal Obamacare*, CNN (Feb. 3, 2015), <http://www.cnn.com/2015/02/03/politics/obamacare-repeal-vote-house>.

147. 26 U.S.C.A. § 4980H (West, Westlaw through P.L. 113-296 (excluding 113-235, 113-287, and 113-291) approved Dec. 19, 2014) (Amendments made by this section shall apply to months beginning after December 31, 2013).

148. *See* Valerie Jarrett, *We're Listening to Businesses About the Health Care Law*, WHITE HOUSE BLOG (July 2, 2013), <http://www.whitehouse.gov/blog/2013/07/02/we-re-listening-businesses-about-health-care-law> ("[P]ayments won't be collected for 2014."); *See also* Mark Mazur, *Continuing to Implement the ACA in a Careful, Thoughtful Manner*, U.S. DEPT. OF TREASURY (July 2, 2013), <http://www.treasury.gov/connect/blog/Pages/Continuing-to-Implement-the-ACA-in-a-Careful-Thoughtful-Manner.aspx> ("Any employer shared responsibility payments will not apply until 2015."); *see also* I.R.S. Notice 2013-45, 2013-31 I.R.B. 116 (providing transition relief for 2014).

149. *Treasury and IRS Issue Final Regulations Implementing Employer Shared*

requirements were relaxed.¹⁵⁰ The business community's sighs of relief were drowned out by angry shouts of ACA opponents who, instead of applauding the Administration for its reasonableness and flexibility, denounced it for high-handedly violating its duty by not implementing the law as passed.¹⁵¹ These critics claimed the Administration was playing a political game, holding back the unpopular requirements until after the November 2014 mid-term elections.¹⁵² While political considerations may have factored into the postponement, the Administration's decision to slow implementation was likely driven mostly by genuine regard for employers' difficulties.¹⁵³ Whatever the reasons for the delay, the effect is that, once

Responsibility Under the Affordable Care Act for 2015. U.S. DEPT. OF TREASURY (Feb. 2, 2014), <http://www.treasury.gov/press-center/press-releases/Pages/j12290.aspx> [hereinafter *Treasury and IRS Issue Final Regulations*].

150. *See id.*

151. *See* Bruce Japsen, *Why Obamacare Delay? Because Half of Employers Aren't Ready for Rollout*, FORBES (July 3, 2013), <http://www.forbes.com/sites/brucejapsen/2013/07/03/obamacare-delay-until-2015-relief-for-half-of-employers/> ("Employers simply were not ready."); *see also* Jackie Calmes & Robert Pear, *Postponing Health Rules Emboldens Republicans*, N.Y. TIMES, July 4, 2013, at A14, available at <http://www.nytimes.com/2013/07/04/us/politics/postponing-health-rules-emboldens-republicans.html?pagewanted=2> (referring to the delay as a "temporary reprieve" for U.S. companies); Jonathan Adler, *Was Delaying the Employer Mandate Legal? Did the IRS Even Check?* WASH. POST (Mar. 22, 2014) <http://www.washingtonpost.com/news/volokh-conspiracy/wp/2014/03/22/was-delaying-the-employer-mandate-legal-did-the-irs-even-check/> (questioning whether the Obama administration even had legal authority to justify waiving tax liability and stating that the legal justification offered by the Treasury Department "has been exceedingly weak").

152. *See* Adler, *supra* note 151 (asserting that some argued the delay in the employer mandate "conveniently pushed enforcement of the mandate beyond the 2014 election"); *see also* Elise Viebeck, Sam Baker, & Amie Parnes, *Obamacare Employer Mandate Delayed Until After 2014 Midterms*, THE HILL (July 3, 2013), <http://thehill.com/policy/healthcare/309003-obamacares-employer-mandate-delayed> (recognizing the delay will be implemented after the 2014 midterm elections); Calmes & Pear, *supra* note 151 ("Some Republicans said the White House was trying to help Democrats by postponing the changes until after the midterm elections, but others saw no gain for Democrats either way.").

153. Surely the uproar over the botched roll-out of the *Healthcare.gov* website in October of 2013 and other glitches in the ACA's implementation made the Administration wary of opening another Pandora's box. *See, e.g.*, David S. Joachim, *Last-Day Rush Causes Another Malfunction of Healthcare.gov*, N.Y. TIMES (Mar. 31, 2014), <http://www.nytimes.com/2014/04/01/us/healthcaregov-malfunctions-on-last-enrollment-day.html> (noting that the website unexpectedly ceased taking applications on the last open enrollment day of the year); *See also* Joe Nocera, *Obama's Bay of Pigs*, N.Y. TIMES, Nov. 23, 2013, at A23, available at http://www.nytimes.com/2013/11/23/opinion/nocera-obamas-bay-of-pigs.html?_r=0 (equating the roll out of Healthcare.gov to the Bay of Pigs invasion and a "train wreck"); *see also* Jennifer Haberkorn & Brett Norman, *Probe Exposes Flaws Behind Healthcare.gov Rollout*, POLITICO (July 30, 2014), <http://www.politico.com/story/2014/07/healthcaregov-probe-rollout-flaws-109546.html> (calling the rollout "disastrously flawed" and undertaken "without effective planning or oversight practices").

again, the ACA has generated controversy, hardened positions and made it more difficult to project what will happen going forward.¹⁵⁴ It would be hard enough to predict how employers will deal with the ACA if their decisions were driven only by rational calculations about how best to balance their legal obligations with their self-interest; but when pique and politics enter the picture, prognostication becomes substantially more difficult.¹⁵⁵

The future of the employer mandate is by no means clear. The Administration has shown no eagerness to implement it and, as noted earlier, might be just as happy to consign employment-based health insurance to history.¹⁵⁶ As noted, opponents of the ACA decry the mandate while at the same time also decrying the Administration's failure to implement it more rapidly.¹⁵⁷ Many are still calling for the total repeal of Obamacare,¹⁵⁸ and while the increased Republican composition of the 114th Congress might seem to tilt the scales in favor of that, it is highly unlikely that a repeal bill would ever make it to the President's desk,¹⁵⁹ where it would most surely be met with a veto. That said, there are many on both sides of the aisle who believe the ACA could use some revision.¹⁶⁰ The

154. See Linda Feldmann, *Has Obama Abused Executive Power? His 5 Most Controversial Uses*, The Christian Science Monitor (Aug. 1, 2014), <http://www.csmonitor.com/USA/Politics/DC-Decoder/2014/0801/Has-Obama-abused-executive-power-His-5-most-controversial-uses/The-Affordable-Care-Act-Employer-Mandate-Delay> (where the employer mandate delay is listed number-one on the list); see also Complaint, U.S. House of Representatives v. Burwell et al., No. 14-cv-01967 (D.D.C. Nov. 21, 2014), Allegations 42-50, available at <http://online.wsj.com/public/resources/documents/HouseACAcomplaint112014.pdf>.

155. See Mary Mosquera, *Delay in ACA Employer Mandate Adds Uncertainty*, HEALTHCARE PAYER NEWS (Feb. 11, 2014), <http://www.healthcarepayernews.com/content/delay-aca-employer-mandate-adds-uncertainty>.

156. See Holan, *supra* note 104.

157. See Walsh, *supra* note 146; see also Complaint, *supra* note 154. Republican representatives have, in fact, sued the Administration over the delay of the employer mandate.

158. WASH. POST, *TRANSCRIPT: Sen. Ted Cruz's marathon speech against Obamacare on Sept. 24* (Sept. 24, 2013), <http://www.washingtonpost.com/st/national/2013/09/25/transcript-sen-ted-cruzs-filibuster-against-obamacare/>.

159. See Jennifer Haberkorn, *A GOP Senate Could Take on Obamacare - But Not Repeal It*, POLITICO (Sept. 15, 2014), <http://www.politico.com/story/2014/09/2014-elections-gop-senate-obamacare-110936.html> ("A Republican-controlled Senate cannot repeal Obamacare, no matter how fervently GOP candidates pledge to do so on the campaign trail this fall. But if they do win the majority, Senate Republicans can inflict deep and lasting damage to the president's signature law.").

160. See Paige Winfield Cunningham & Kyle Cheney, *Why Liberals Are Abandoning the Obamacare Employer Mandate*, POLITICO (July 6, 2014), <http://www.politico.com/story/2014/07/obamacare-employer-mandate-108578.html> ("[The employer mandate] cries out for repair," and evaluating Republican and Democratic voices calling for revision of the mandate.).

House now has before it a proposal to change the definition of full-time employment from thirty hours per week to forty hours to scale back the reach of the mandate.¹⁶¹ It is possible that sufficient bipartisan support could emerge for dropping the employer mandate entirely.

As this article goes to press, the Supreme Court has just eliminated a major threat to implementation of the ACA with its decision in *King v. Burwell*.¹⁶² In a 6-3 vote, the Court upheld the Obama Administration's position that the ACA supports providing federal subsidies, in the form of tax credits, to help qualified, lower-income individuals purchase insurance on an ACA exchange whether the exchange is run by a state or the federal government.¹⁶³ The Administration's position runs counter to language in the Act which, if read literally and without due regard for the apparent legislative intent to give federal assistance to all qualified citizens, could be construed to restrict subsidies to only those who purchase on an exchange "established by (a) state."¹⁶⁴ If the Supreme Court had accepted the plaintiffs' position and denied subsidies to persons who purchased on federal exchanges in the thirty-four states that had chosen not to set up their own exchanges, a large percentage of the 6.4 million people who received federal subsidies in connection with their purchases since January of 2014 may have been forced to drop out of the insured pool, possibly sending it into a so-called "death spiral."¹⁶⁵ Although further legal and political challenges are still possible, it is widely believed that the High Court's latest "rescue" of the ACA effectively assures that it is here to stay. If the insurance exchanges, be they state or federal, continue to function well—as, thankfully, they seem to be now—it might be acceptable to drop the employer mandate and let the natural process of attrition nibble away at EBHI. How long that attrition might take is an important question addressed in Section IV *infra*.

A May 2014 policy brief by the Robert Wood Johnson Foundation and the Urban Institute ("RWJF-Urban") questions whether the mandate is needed, opining that eliminating the mandate will not decrease insurance coverage significantly.¹⁶⁶ That prediction reflects the belief that many

161. Save American Workers Act of 2015, H.R. 30, 114th Cong. (2015).

162. *King v. Burwell*, 759 F.3d 358, 365 (4th Cir. 2014), *cert. granted*, 576 U.S. ____ (Decided June 25, 2015) (No. 14-114).

163. *Id.*

164. *Id.* (Challengers of the law argue the text of the ACA only allows for state-run exchanges, not federally-run exchanges "enrolled in through an Exchange established by the State under 1311.").

165. See notes 111-112 *supra* and accompanying text.

166. Linda J. Blumberg, John Holahan and Matthew Buettgens, *Why Not Just Eliminate the Employer Mandate?*, ROBERT WOOD JOHNSON FOUND. & URBAN INST. (May 2014), available at <http://www.urban.org/UploadedPDF/413117-Why-Not-Just-Eliminate-the->

employers will continue to provide insurance even without the mandate, and people who do lose employer-provided coverage will either be covered by the Medicaid expansion or will purchase coverage on the insurance exchanges assisted by federal subsidies.¹⁶⁷

A key problem, though, is that expansion of Medicaid and the federal subsidies for individually purchased insurance will inevitably increase the portion of the nation's healthcare bill that is carried on the federal budget. Employer provision of insurance keeps much of that cost "off-budget."¹⁶⁸ The RWJF-Urban report projects that eliminating the mandate could add some \$46 billion to the federal cost between 2014 and 2023.¹⁶⁹ The Congressional Budget Office estimates the same figure at \$130 billion, almost three times as much.¹⁷⁰ While some in Congress—mostly Republicans—might like the employer mandate to go away, they surely would not be pleased to see the cost burden transferred to the federal budget. Given that, the success of an amendment to do away with the employer mandate while keeping the rest of the ACA intact is highly questionable.

IV. WHAT WILL EMPLOYERS DO?

The principal objective of this paper's evolutionary analysis is to try to project what role employment-based health insurance will play in the future of our nation's healthcare system. Some believe that role will be quite limited. A very vocal and visible commentator on the point is Dr. Ezekiel Emanuel, one of the architects of the ACA, who has predicted that 80 percent of U.S. employers will stop providing health insurance by 2025.¹⁷¹

Employer-Mandate.pdf.

167. *Id.* at 3.

168. The calculation is complex because the tax shelter that employees currently get for the value of employer-provided insurance is, in effect, a federal subsidy. Thus if employees move from employer-provided insurance to exchange-purchased insurance they are trading one federal subsidy for another. Only some who purchase insurance on an exchange will qualify for federal subsidies. By contrast, all who get their coverage through their employers enjoy a federal subsidy in the form of the tax shelter, but that subsidy is very slight in the case of low-income (and thus low-tax-bracket) employees. See Blumberg, *supra* note 166, at 4. The Congressional Budget Office and the Joint Committee on Taxation have attempted to model the net effect of these competing forces. See, e.g. *CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance*, CONG. BUDGET OFFICE 3 (Mar. 2012), http://www.cbo.gov/sites/default/files/03-15-ACA_and_Insurance_2.pdf.

169. Blumberg et al., *supra* note 166, at 4.

170. *Id.*

171. EZEKIEL J. EMANUEL, REINVENTING AMERICAN HEALTH CARE: HOW THE AFFORDABLE CARE ACT WILL IMPROVE OUR TERRIBLY COMPLEX, BLATANTLY UNJUST, OUTRAGEOUSLY EXPENSIVE, GROSSLY INEFFICIENT, ERROR PRONE SYSTEM 319 (2014); See Sandy Fitzgerald, *Obamacare Architect Emanuel: Most Employers Will Drop Health*

Others, such as David Hyman and Mark Hall, previously mentioned, have a more positive view of EBHI and could see it continuing to play a substantial role.¹⁷² While it is tempting—albeit risky—to predict the future, as disclaimed in the introduction this paper’s undertaking is more limited, i.e., to set out the factors the authors believe will guide and determine that future. We will, however, use Dr. Emanuel’s event horizon of 2025, just 10 years from now. A decade seems a short time; but, in these rapidly changing times, even that period exposes predictions to a myriad of factors that could have profound effects on our society, its economy, and the political landscape. While we cannot begin to control for all of the variables,¹⁷³ we will sidestep two linchpin unknowns by assuming that the ACA and the employer mandate both stay in place.¹⁷⁴

A. Employers’ Options

Employers have essentially three options for dealing with their situation under the ACA as it currently stands. First, they can simply comply with the law and provide their FTE employees (and their employees’ dependents under age twenty-six, not including spouses) with insurance that meets the ACA’s minimum requirements. For employers not currently providing insurance, this will be a significant change. For those already providing coverage, compliance may entail increases in premiums since new policies meeting the ACA’s minimum standards may have richer, more durable benefits and, thus, may be more expensive than the lesser coverage many

Coverage, NEWSMAX (Mar. 21, 2014), <http://www.Newsmax.com/Newsfront/Emanuel-employers-drop-health/2014/03/21/id/560906/#ixzz3J34ktkdb>; see also Jim Angle: *If Obamacare Stays, Employer Based Insurance Will Go*, REAL CLEAR POLITICS (Sept. 1, 2014), http://www.realclearpolitics.com/video/2014/09/01/angle_if_obamacare_stays_employer_based_insurance_will_go.html (reacting to Dr. Emanuel’s prediction). (Dr. Emanuel, a University Professor at the University of Pennsylvania, is a colleague of Professor Rosoff in The Wharton School’s Health Care Management Department, and is also Chair of Penn’s Department of Medical Ethics and Health Policy and the University’s Vice Provost for Global Initiatives).

172. See Hyman & Hall, *supra* notes 16 and 94-100 and accompanying text.

173. Donald Rumsfeld might well caution that in addition to the *known unknowns* in this situation we also have to factor in the *unknown unknowns*! David A. Graham, *Rumsfeld’s Knowns and Unknowns: The Intellectual History of a Quip*, THE ATLANTIC (Mar. 27, 2014), <http://www.theatlantic.com/politics/archive/2014/03/rumsfelds-knowns-and-unknowns-the-intellectual-history-of-a-quip/359719/> (“But there are also unknown unknowns—the ones we don’t know we don’t know.”).

174. Although, as discussed *supra* in Section III.C., the Supreme Court’s recent landmark decision for the government in *King v. Burwell* gives strong assurance that the law will remain in force, there are numerous proposals for modifications and improvements, including several that would eliminate or change the employer mandate. See, e.g., note 124 and accompanying text.

companies had before.¹⁷⁵ In both cases, employers will have to decide how much additional cost they will bear themselves and how much they will pass on to their employees, either in the form of higher employee premium contributions or lower wages. This decision, of course, is affected by all of the factors that normally influence employer-employee negotiations concerning wages and other terms and conditions of employment.¹⁷⁶

Second, an employer can choose to not provide coverage, or to provide coverage that does not meet ACA standards and pay the ESR penalty, which, simply put, is \$2,000 per year for each uncovered employee, except for those exempted.¹⁷⁷ A variant of this approach would be to provide ACA-compliant coverage to some FTE employees but not to others. The downside to this approach is that an employer must pay a \$3,000 ESR fee annually for each employee who buys coverage on an exchange and qualifies for a federal (tax credit) subsidy.¹⁷⁸ Since only lower-income employees are eligible for a subsidy, this provides a strong deterrent against an employer continuing to provide good coverage for its executives and higher-paid workers while skimping on coverage for its lower-paid workers.¹⁷⁹

175. Changes in the healthcare system brought about by the ACA may reduce the costs of care and thus insurance premiums—hence the aspirational and optimistically named *Patient Protection and Affordable Care Act*. Early indications, which may be misleading because of the other possible causative factors, are that the ACA has slowed the rise in costs. David Cutler, *The Health-Care Law's Success Story: Slowing Down Medical Costs*, WASH. POST (Nov. 8, 2013), http://www.washingtonpost.com/opinions/the-health-care-laws-success-story-slowing-down-medical-costs/2013/11/08/e08cc52a-47c1-11e3-b6f8-3782ff6cb769_story.html. It will likely take some time, however, before the cost-saving benefits of the Act, including price competition enabled by the exchanges, are realized. In the meantime, premiums may rise.

176. See generally *Questions and Answers*, *supra* note 126. Moreover, the choice is not entirely up to the employer, since the ACA's Employer Shared Responsibility ("ESR") fee provisions put *affordability* requirements on the insurance coverage. If the employee's cost is too high relative to his or her income, or the employer doesn't contribute a sufficient percentage to the premium cost, the employer must pay the ESR penalty.

177. The applicable exemptions are discussed in note 135, *supra* and the accompanying text.

178. Vladimir Shuliga, *Employer Shared Responsibility*, OTTOSEN-BRITZ (Oct. 3, 2013), <http://www.obkcg.com/article.asp?a=721>. Note that the employer is responsible only for the lesser of (a) the \$2,000 penalty for not providing health insurance or (b) the \$3,000 penalty for providing insurance that fails in some way to meet the federal standards for minimal essential coverage and for affordability.

179. As long as the employer meets the minimum standards set by the ACA for its lower-paid workers it can provide richer benefits to its higher-paid workers. Starting in 2018, though, employers who provide benefits higher than the maximum level set by the ACA will be subject to the so-called "Cadillac tax." See 26 U.S.C. § 4980I (West, Westlaw through P.L. 113-296 (excluding P.L. 113-235, 113-287, and 113-291) approved Dec. 19, 2014) (describing the "Cadillac tax"); *Cadillac Tax Fact Sheet*, CIGNA 1 (Jan. 2015), <http://www.cigna.com/assets/docs/about-cigna/informed-on-reform/cadillac-tax-fact-sheet.pdf>

Third, an employer could opt to set up a “private exchange” and arrange for its employees to get coverage through this mechanism. In many respects, this is a half-step between the first two options, one that employers are starting to explore, in large part because insurance brokers and HR consultants are starting to market and aggressively promote private exchange packages.¹⁸⁰ Private exchanges offer some significant advantages. Most importantly, employees receiving their coverage through a private exchange can, if their purchase options are set up properly, continue to get the tax shelter for the premium contribution by the employer and also for any contribution the employee makes through a payroll deduction arrangement.¹⁸¹ On the other hand, employees getting coverage on a private exchange cannot receive federal tax subsidies as they can on public exchanges.¹⁸² Since a tax shelter benefits higher-paid employees more than lower-paid employees, and the tax-credit subsidy on the public exchange is available only to lower-income employees,¹⁸³ it is easy to see why higher-paid employees might favor the private exchange approach more than lower-paid employees. Thus the composition of the employer’s workforce and the “voice” (i.e., influence) that each segment of that workforce has within the company can substantially affect the employer’s decision to use a private exchange. Another important factor in that decision is the cost to maintain a private exchange, which is mostly the fee paid to the entity chosen to administer the exchange.¹⁸⁴ Obviously, the calculations necessary

(explaining basic facts about the Cadillac tax).

180. See Akshay Kapur *et al.*, *The Emergence of Private Health Insurance Exchanges: Fueling the “Consumerization” of Employer-Sponsored Health Insurance*, BOOZ & Co.1, 4-5 (2012), <http://www.strategyand.pwc.com/media/file/Strategyand-Emergence-Private-Health-Insurance-Exchanges.pdf>.

181. See Nancy Duta and Christopher Calvert, *Thinking of Joining a Private Health Insurance Exchange? Look Before you Leap*, 21(1) PERSPECTIVES 2 (Sibson Consulting, 2013), available at http://www.sibson.com/publications/perspectives/volume_21_issue_1/pdfs/printall.pdf (last visited 6/2/2015). See also Emanuel, *supra* note 173, at location 5494 of 7285 (Kindle reference).

182. See *Health Care Reform: What is a Health Insurance Exchange*, AETNA, <http://www.aetna.com/health-reform-connection/reform-explained/video-exchanges.html> (last visited June 22, 2015) (“The Affordable Care Act provides tax credits and subsidies . . . when [individuals] shop on a public exchange.”). See also Duta and Calvert, *supra* note 181, at 2 (“***employees purchasing coverage on a private Exchange will *not* receive the premium assistance subsidies for low-income employees. This difference between the private and public Exchanges can be extremely significant for individuals in lower-paid jobs.”)

183. See Duta and Calvert, *supra* note 181, at 2 (discussing how subsidies are available to qualifying individuals who do not have access to affordable insurance). See also discussion at *supra* note 168. In absolute dollars a tax shelter is more valuable to higher-paid employees who are in a higher income tax bracket. However, in relative terms the tax benefit may be less critical to a wealthier employee’s ability to afford health insurance.

184. See *Health Care Reform: Private Exchanges Considered*, GATEWAY FIN. (June

to decide what is best for a particular employer and its employees, class by class, are very complex. An important service HR consultants and promoters of private exchanges provide is helping employers think through these pros and cons and make the decision.¹⁸⁵ One factor that may favor private exchanges in some instances is that an employer may be able to use key HR staff already in its organization to help set up and administer the private exchange. Preserving the in-house HR function and staff positions may have strong appeal to some executives who are well positioned to influence top management's decision on how to handle health benefits. Therefore, private exchanges may play a significant role in the future of the ACA.

B. How Will Employers Decide?

A complex of factors will affect how employers choose among the above three approaches and their variants. Many of these factors predate the passage of the ACA. Employers previously had to decide, for example, whether to provide health insurance to their employees, how generous that insurance should be, how best to provide it,¹⁸⁶ and whether all employees would be treated the same.¹⁸⁷ All of these decisions reflect a broader set of factors, which include, *inter alia*: corporate philosophy,¹⁸⁸ the labor market,¹⁸⁹ and the composition of the employer's workforce.¹⁹⁰ To all of the

2014). http://www.gatewayfinancial.biz/sites/all/files/gatewayfin/Health_Care_Reform-Private_Exchanges_Considered_06-20-14.pdf (explaining how a private exchange can reduce operational costs).

185. *Transforming How Employers Provide, Fund and Manage Health Benefits*, TOWERS WATSON 1-2 (2014), <https://www.towerswatson.com/DownloadMedia.aspx?media=%7B3ECBC33E-F9CD-4906-B9E3-29FBD1BA7AED%7D>.

186. For example, whether to offer a single health plan or a "cafeteria" plan with various options from which employees can choose. See Hyman & Hall, *supra* note 16, at 25-27.

187. Employers commonly treat part-time employees differently from full-time employees in terms of health insurance and other fringe benefits. Beyond this, some employers have different health insurance benefits for certain classes of full-timers, *e.g.*, upper management, as compared with rank-and-file workers. See *Health Coverage if You Work Part-Time*, HEALTHCARE.GOV, <https://www.healthcare.gov/have-job-based-coverage/part-time-workers/>.

188. *E.g.*, how the owners/managers of the firm feel about their obligations to their employees. *Small Employer Health Insurance Survey*, EHEALTH 5 (Mar. 2013), http://news.ehealthinsurance.com/_ir/68/20132/eHealth%20Spring%202013%20Small%20Bus%20Survey.pdf.

189. *E.g.*, how hard the firm has to compete with other companies to recruit and retain employees and what its competitors are doing with regard to health insurance. See *id.*

190. This includes a myriad of factors such as: how many different classes of workers the company employs, the number of people in each class, the wage distribution among the employees, whether the company is unionized, the health-risk characteristics of the various employee classes, which bears on the cost of providing coverage, and the level of healthcare

above factors affecting employers' decisions regarding health insurance are added the following elements introduced, either directly or indirectly, by the ACA. These include:

1. The employer mandate: This is a huge factor that directly impacts the decision whether to provide, or continue to provide, employee health benefits. The ACA-imposed ESR fees, while they may not be large enough in many cases to absolutely dictate what the employer must do, are an enormous consideration, as they were intended to be.

2. The individual mandate: While a firm's employees surely cared before the ACA whether the employer provided health insurance, they will care more now that they are subject to the Act's individual mandate and will have to pay a penalty if they are not covered.

3. Other options for employees to get coverage: The ACA's patient protection provisions and the insurance exchanges now make it possible for people who previously could not get coverage other than through an employer's group insurance—or could not get it at an affordable price—to get it on their own. Moreover, low-income employees purchasing insurance on the exchanges may be eligible for federal subsidies that are more beneficial to them than the tax shelter they would enjoy if they got employer-provided insurance.¹⁹¹ For them, the employer's decision to not provide coverage and to compensate by raising wages could be a plus, provided wages are increased enough to cover the employee's cost of purchasing insurance on an ACA exchange. Further, if an employee's income level is low enough and his or her state has opted to expand its Medicaid eligibility, coverage options may be available that previously were not.

4. The attractiveness of choice: Employees who may previously have been happy enough to have their employer choose coverage for them, often on a "one size fits all" basis, may be attracted to the exchanges, which are

costs in the various geographic area(s) in which the company operates. *See Health Care Reform May Change the Cost and Composition of the Part-Time Workforce*, ADP RESEARCH INST., <http://www.adp.com/tools-and-resources/adp-research-institute/insights/insight-item-detail.aspx?id=C2ECCF4C-C999-45BB-B20E-DA4FE3C4579A> (last visited Mar. 20, 2015).

191. Rick Curtis & Ed Neuschler, *Affordable Access for Modest-Income Workers Eligible for Group Coverage*, HEALTH AFF. (Aug. 18, 2009), <http://m.healthaffairs.org/blog/2009/08/18/affordable-access-for-modest-income-workers-eligible-for-group-coverage/>. To review the tax implications for lower-paid employees, see the discussion at note 183, *supra*, and accompanying text.

essentially retail websites where they can make their own choices. As Hyman and Hall point out,¹⁹² employer provision of insurance helps some employees by choosing for them among a confusing myriad of options. However, some employees, for a variety of reasons, might be better off, or perceive themselves to be, if they were free to choose for themselves in a more open market.

5. Public acceptance of the exchanges: After a rocky start in the fall of 2013, *Healthcare.gov* and the state exchanges are doing well.¹⁹³ Enrollments are exceeding expectations and TV ads, billboards, and consumer-assistance organizations are generally painting a rosy picture of the available choices.¹⁹⁴ This is not just hype; many who have purchased insurance on the exchanges are very pleased with the process and with the coverage they now have.¹⁹⁵ Presumably, the word will spread and

192. Hyman & Hall, *supra* note 16, at 30.

193. Elise Hu, *HealthCare.gov Is Now Working Smoothly, White House Says*, NPR (Dec 1, 2013), <http://www.npr.org/blogs/thetwo-way/2013/12/01/248049882/healthcare-govs-capacity-is-stable-at-its-intended-level>. See Obamacare Facts, *State Health Insurance Exchange: State Run Exchanges*, <http://obamacarefacts.com/state-health-insurance-exchange/> (last visited July 1, 2015). See *State Health Insurance Marketplace Types, 2015*, <http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/> (last visited June 3, 2015). Obviously, the Supreme Court's recent decision in *King v. Burwell* may affect states' decisions about whether to set up their own exchange or, for states that have already done so, to continue to operate the exchange. With federal subsidies now held to be available on federal exchanges, a state's motivation to operate its own exchange is diminished. See, e.g., Margot Sanger-Katz, *Obamacare Ruling May Have Just Killed State-Based Exchanges*, N.Y. TIMES (June 25, 2015), available at http://www.nytimes.com/2015/06/26/upshot/obamacare-ruling-may-have-just-killed-state-based-exchanges.html?_r=0. See also Lena H. Sun and Niraj Chokshi, *Almost Half of Obamacare Exchanges Face Financial Struggles in the future*, WASH. POST (May 1, 2015), available at http://www.washingtonpost.com/national/health-science/almost-half-of-obamacare-exchanges-are-struggling-over-their-future/2015/05/01/f32eaea2-ea03-11e4-aae1-d642717d8afa_story.html.

194. Igor Volsky, *6 Reasons Why Obamacare Enrollment Is Going Better Than You Think*, THINKPROGRESS (Nov. 12, 2013), <http://thinkprogress.org/health/2013/11/12/2923931/obamacare-enrollment-going-better-think/> (describing how enrollment has exceeded expectations). Some commentators have observed, however, that enrollment projections were revised downward by the Obama Administration after the initial epic fail of the Healthcare.gov roll-out. See Chrysler Summer, *Has Obamacare Been A Success Or A Failure?* OPPOSINGVIEWS, Dec. 10, 2014, available at <http://www.opposingviews.com/i/columns/has-obamacare-been-success-or-failure> (downloaded 6/3/2015). See also Bruce Japsen, *Ad Spending on Obamacare May Make Don Draper Blush*, FORBES (May 11, 2013, 8:31 AM), <http://www.forbes.com/sites/brucejapsen/2013/05/11/ad-spending-on-obamacare-may-make-don-draper-blush/> (describing the types of advertising used in the campaign); Sun and Chokshi, *supra* note 193.

195. Joan McCarter, *Obamacare Enrollees Overwhelmingly Approve of Quality and Affordability of their New Insurance*, DAILY KOS (Nov. 14, 2014, 12:01 PM), <http://www.dailykos.com/story/2014/11/14/1344969/-Obamacare-enrollees-overwhelmingly-approve-of-quality-and-affordability-of-their-new-nsbp-insurance> (discussing how

employees who might previously have been discomfited by the possibility that their employers would stop providing coverage may now be much more accepting of, and perhaps even desire, that change.

6. Differential advantage: As with all change, there will be winners and losers; the question in a particular company may not be “which approach is better,” but rather, “which is better for whom?” Moreover, the perception of who gains and who loses may not match the reality, and the angst over the possibility of losing is a factor in itself. An employer who discontinues coverage or sets up a private exchange may benefit one class of its employees while disadvantaging others. Employers who make a choice about whether and how to comply with the ACA without carefully assessing their employees’ likely reaction may be shooting themselves in the foot. And, as noted above, some employees who are impacted, or who perceive themselves to be impacted by the change, may be better positioned than others to make their voices heard and responded to by their employer.¹⁹⁶

7. Compensation equity: Closely related to the preceding point, some employees who lose employer-provided health coverage may be given, or be able to get, higher wages to make them whole, or perhaps even improve their position. This adjustment of compensation may come more or less automatically and immediately or it may come about only after a period of employer-employee tension and negotiation; and, as noted above, it may come about for some parts of an employer’s labor force and not for others

8. Diplomacy: How an employer goes about deciding what to do about health insurance and how it involves its employees in the decision process — i.e. making clear that it is taking their interests and feelings into account — may matter as much as the substance of the decision.

9. What other employers do: In all situations, there are leaders and followers. As Dr. Emanuel points out in his predictions,¹⁹⁷ there will be industry leaders who will take action and point the direction others will follow. It’s impossible to foresee how this factor will play out and how it will affect employers’ actions.

customers are satisfied with their coverage).

196. For example, managerial class employees may be able to “push back” against an employer’s decision to stop providing health insurance while rank-and-file workers in the same company have no recourse but to accept it.

197. See Emanuel, *supra* note 171 at 317-318.

10. How the world turns: From the start, the ACA has been, and continues to be, enormously controversial. Much of the controversy has to do with the substance of the law itself and its implications, but a great deal has also been political football. Republicans, aided in no small measure by Fox News, have worked hard to convince the public that Obamacare is a travesty, an insidious encroachment upon American principles and its citizens' freedoms, and a constitutional violation that was crammed down the public's throat without its understanding or approval.¹⁹⁸ Even some supporters of the law, such as MIT professor Jonathan Gruber, have added to that perception.¹⁹⁹ As a result, some five years after the passage of the ACA, with millions more people covered than before, acceptance of the law is still widely variable, in part because it is only dimly understood.²⁰⁰ Happily, there are signs that the ACA's popularity has continued to grow and its supporters are now in the majority;²⁰¹ but the game is not over. What employers will do and how employees, and the public in general, react will certainly be influenced by the broader political landscape. With the 2016 national elections coming up fast, that landscape will be the scene of some brightly lit struggles. The fate of the Affordable Care Act will undoubtedly be affected by all of this and by how the many components of the ACA prove to work. Will healthcare costs go up, down, or stay the same? Will the availability of health services and the quality of care improve or decline? Such questions abound, but the point is clear: the future is uncertain and many U.S. employers will wait to see how things shake out before deciding whether and how much to change their approach to health care and to EBHI.

The above is not an exhaustive list of factors affecting how employers will handle their health insurance decisions and, more broadly, the implementation and ultimate fate of the ACA; but it highlights the main and

198. Mark NC, *Is Fox News the Most Flaccid Propaganda Tool Ever?*, NEWS CORPSE (Oct. 12, 2013, 3:09 PM), <http://www.newscorpse.com/ncWP/?p=10698>.

199. Kate Pickert, *The Truth About Gruber-Gate*, TIME (Nov. 13, 2014), <http://time.com/3583526/the-truth-about-gruber-gate/> (discussing how Jonathan Gruber called the American people "stupid" and said "a lack of transparency" was crucial to getting the ACA passed); see John Cassidy, *The Real Lessons of "Gruber-Gate"*, THE NEW YORKER (Nov. 18, 2014), <http://www.newyorker.com/news/john-cassidy/real-lessons-gruber-gate> ("Gruber says that the creators of the A.C.A. deliberately misrepresented, or kept vague, some of its contents, seeking to exploit the 'stupidity' of ordinary voters.").

200. See Steve Liesman, *What's in a Name? Lots When It Comes to Obamacare ACA*, CNBC (Sep. 26, 2013), <http://www.cnbc.com/id/101064954> (showing that more Americans say that they favor the "Affordable Care Act" than those who like "Obamacare," even though they're the same exact law).

201. See Caitlin Owens, *Poll: Just as Many Americans Like Obamacare as Dislike It*, NATIONAL JOURNAL (Apr. 21, 2015), <http://www.nationaljournal.com/health-care/poll-more-americans-like-obamacare-than-dislike-it-20150421>.

most obvious ones. Moreover, it shows that the calculations each employer makes and the conclusions it reaches on the subject may be somewhat different. The authors hope this analysis and exposition will make those calculations easier and the conclusions reached more likely to be the right ones.

V. CONCLUSION: WHAT WILL THE FUTURE BRING?

This paper has tracked the evolution of employment-based health insurance in the U.S. from its earliest days to the present and attempts to project its path into the future. This final section draws these evolutionary steps together into a conceptual framework to help readers evaluate and project for themselves what the future will bring.

To properly understand our pluralistic, disjointed healthcare system, one has to recognize that, unlike other major nations that have had UHC for many years, the U.S. system did not grow as a coordinated government-directed program. Rather, it evolved over roughly a century through a countless number of independent choices.²⁰² Our system is in many respects a “non-system,” but just because it’s uncoordinated and disjointed, one cannot assume it’s easy to change. It is held together by an extensive and intricate web of private arrangements, decisions, relationships, and economic interactions. Because these links were independently developed and put in place at different times, they are harder to dismantle and replace with something new – and that’s even without considering the myriad of political barriers that would have to be surmounted to accomplish major systemic change. The *Gordian knot* nature of things has made healthcare reform an exceedingly difficult task, one that has taken such a long time and is still far from being achieved.

The ACA, by strengthening the health insurance marketplace and requiring insurers to make adequate coverage available to all on a more affordable and non-discriminatory basis, has largely undercut the rationale and necessity for EBHI. Nevertheless, the ACA hasn’t simply done away with employment-based coverage, because it couldn’t. Our healthcare system is resistant to change because it has evolved in a way very much in sync with “the American way” of doing things. As a people we value choice; we don’t want anyone telling us what to do—and, for a large

202. Note, though, that government actions - such as the passage of Medicare, Medicaid, the HMO Act, ERISA, the Internal Revenue Code provisions granting favored treatment to employer provision of health benefits and, of course, the ACA - very much created the context and opportunity for many free market developments. For an excellent analysis of this interplay between government actions and private initiatives, see ROBERT I. FIELD, *MOTHER OF INVENTION: HOW THE GOVERNMENT CREATED “FREE-MARKET” HEALTH CARE* (Oxford U. Press, 2014).

segment of our population at least—especially not when it's the government doing the telling. Our healthcare system is full of choice, choice that often adds cost and confusion without providing any meaningful advantage but that the public holds dear anyway.

Tied in with this choice structure, the pluralistic, free enterprise nature of the system is now reinforced by a broad and deep network of providers and payers who have a stake, or believe they do, in preserving the *status quo*. These stakeholders have substantial economic power and political clout; their perspectives, desires and fears must be considered when any change is contemplated. Compounding this point, our national commitment to the *status quo* in health care matters is reinforced by a broader societal suspicion of change. We are loath to let go of what we have unless we know, or at least are fairly sure, that what will replace it will be better. Unfortunately, with so many separate elements, forces and imponderables in our system, no one can assure that the ACA's path to healthcare reform will play out well enough to satisfy all, or nearly all, of the U.S. public. It is painfully obvious that many believe the ACA is a disaster and will destroy, or at least greatly damage, a system that is one of the best in the world.²⁰³

The foundational concept of the ACA, one that makes it uniquely American and consistent with our national history and expectations, is that it is not highly prescriptive. It leaves much room for free choice and operates largely by incentives and disincentives rather than by rigid rules. A key example of this flexibility is that the employer and individual mandates are not full mandates; the penalties for non-compliance are not so severe that compliance is the only option. This latitude for free choice, more than any other aspect, makes it difficult to predict what the future will bring. Under the ACA, the future will be what countless parties decide to make it. Insurers can decide, within limits, what their health plan offerings will include and what they will cost. Employers can decide what they want to do regarding the provision or non-provision of insurance and the adjustment of compensation packages to adapt to their coverage decisions. Employees can accept what their employers offer them or push back in an attempt to affect employer actions. If they push back, they may be more or less successful. The quality and cost of health care may rise, fall, or stay relatively unchanged because of the ACA's innovations and requirements and providers' reactions to them. Moreover, people's perceptions of how the ACA is working will differ depending on their personal situation and may

203. Whether the U.S. healthcare system really is one of the best in the world depends on whom you ask and what criteria are used to evaluate it. Clearly on many well-established measures - e.g., longevity, infant mortality, percent of the population with reliable access to good quality care, etc. - our system does not rate so well. See Orlando (2013), *supra* note 78, at 68-69.

be accurate or misinformed. Finally, the national and global economy, evolving demographics, any further legal challenges, and political developments, most notably the run-up to the 2016 elections, will all bear heavily on how the other factors outlined above play out.

Like Ezekiel Emanuel, we believe that Employment-based Health Insurance is an anachronism and is on its way out. For well over half a century, it has served our nation fairly well and has largely satisfied employers and employees (and their dependents). Its main failing has been the large number of Americans who were unable to get good coverage reliably under that regime. The ACA addresses that in two ways: first, by having the employer “mandate” and, second, by establishing exchanges where people can bypass the EBHI system and still get satisfactory insurance coverage. Now employers can choose, with some pressure but no coercion, to play or not play, and their employees are not in danger of being shut out of coverage if the employer chooses not to play. They have a viable alternative. For these reasons, the path taken in the future will be determined by a complex interplay of employers and employees, each side making its own choice as to what best serves its interest and then trying to get the other to go along with that choice. It will be a complex “negotiation” and it may well play out differently in different sections of the country, in different industry sectors, in different companies within the same industry, in different socioeconomic strata, and so on.

Although we see things going in the direction that Dr. Emanuel predicts, unlike him, we’re not prepared to put a time limit on our projection. The myriad operative factors intertwine and the forces propelling them all can, and most likely will, move at different speeds. Suffice to say we think employment-based health insurance has pretty much run its useful life course. It’s time for a change, and the ACA has laid a good foundation to promote and facilitate that change.