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Unlocking Exchanges

Brendan S. Maher

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If so, one fact about the ACA should not escape the attention of serious reformers: the legislation has already accomplished the difficult task of laying the ground work for a move away from employment-based (EB) insurance, a move scholars have urged for years. That said, not all features of employment-based insurance are undesirable, and certain reforms to the ACA could preserve those desirable features while nonetheless guiding the nation away from a flawed system.

For largely (but not entirely) political reasons, the ACA made it difficult for those receiving or providing EB insurance to migrate to the individual exchanges the Act took great pains to create. Yet if there is political will to modify the employer mandate and adjust the tax treatment of insurance purchases, access to the individual exchanges could be cautiously "unlocked," and millions could migrate from EB insurance to individual, exchange-based insurance. With certain additional reforms, there is reason to believe that migration will lead to stronger, healthier exchanges; to a reduced regulatory burden on employers; to a clearer stakeholder understanding of the relationship between health insurance and wages; and perhaps a diminished need to rely on the controversial individual mandate, with individual States making that final assessment.

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I. INTRODUCTION

The fate of the Affordable Care Act[1] is uncertain. Moreover, the nation is in an unusual state of political turmoil and may have no appetite for anything other than revolutionary changes to the ACA, if not its outright repeal. But press reports suggest even Republican officials formerly committed to its extirpation are now thinking instead about a measured path forward.[2]

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[1] The Affordable Care Act consists of both the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. I refer to them jointly as the "ACA."

N.B.: This article was conceived before Donald Trump was elected, and largely finished in early 2017. To say the period since President Trump's election and inauguration has been turbulent—both in terms of politics and policy—would be an understatement. I have not meaningfully revised this paper since then, having given up trying to predict the future. I thus consider this piece as much a time capsule as an idea.

[2] Virtually every day, reports surface of reform proposals being considered by influential Republicans. *See, e.g.*, Susan Cornwell, *Some U.S. House Republicans Doubtful Ahead of Vote to Begin Obamacare Repeal,* REUTERS (Jan. 12, 2017, 1:42AM), http://www.reuters.com/article/ us-usa-obamacare/some-u-s-house-republicans-doubtful-ahead-of-vote-to-begin-obamacare-repeal-idUSKBN14W0MC; Mike DeBonis, *Anxious lawmakers to GOP Leaders: What's the Plan to Replace Obamacare?*, WASH. POST A1, A1 (Jan. 12, 2017), https://www.washingtonpost.com/ powerpost/anxious-lawmakers-to-gop-leaders-whats-the-plan-to-replace-obamacare/2017/01/12/bdbea6bc-d8e1-11e6-9a361d296534b31e_story.html?utm_term=.cbc6028fee7f; Juliet Eilperin and Amy Goldstein, *A Divided White House Still Offers Little Guidance on Replacing Obamacare*, WASH. POST (Feb. 26, 2017) https://www.washingtonpost.com/national/health-science/a-divided-white-house-still-offers-little-guidance-on-replacing-obamacare/2017/02/26/3981bb8c-fb8c-11e6be051a3817ac21a5_story.html?utm_term=.f20957 8e2157; Caitlin Huey-Burns & James Arkin, *GOP Governors Worried About Obamacare Repeal*, REAL CLEAR POLITICS (Jan. 20, 2017), http:// www.realclearpolitics.com/articles/2017/01/20/gop_governors_worried_about_obamacare_repeal.html; Sarah Kliff, *The Leaked Republican Plan to Replace Obamacare, Explained*, VOX (Feb 24, 2017, 1:20 PM) http://www.vox.com/ policy-and-politics/2017/2/24/14726916/leakedrepublican-obamacare replacement-plan-explained. Admittedly, by the time this Article is

If so, one fact about the ACA should not escape the attention of serious reformers: the legislation has already accomplished the difficult task of laying the groundwork for a move away from employment-based (EB) insurance, a move scholars have urged for years. That said, not all features of EB insurance are undesirable, and certain reforms to the ACA could preserve those desirable features while nonetheless guiding the nation away from a flawed system.

For largely (but not entirely) political reasons, the ACA made it difficult for those receiving or providing EB insurance to migrate to the individual exchanges the Act took great pains to create. Yet, if there is political will to modify the "employer mandate" and adjust the tax treatment of insurance purchases, access to the individual exchanges could be cautiously "unlocked," and millions could migrate from EB insurance to individual, exchange insurance. With certain additional reforms, there is reason to believe that migration will lead to stronger, healthier exchanges; to a reduced regulatory burden on employers; to a clearer stakeholder understanding of the relationship between health insurance and wages; and, perhaps, a diminished need to rely on the controversial individual mandate, with individual States making that final assessment.

In Part II, I give some necessary background about individual and employment-based health insurance. In Part III, I describe how EB systems are best thought of as a form of government intervention to remedy market failures concerning the quantity, quality, or distribution of some socially desirable good, and describe the case for and against EB health insurance. In Part IV.A, I explain how the Affordable Care Act undertook a series of reforms to create insurance exchanges that would make previously deficient individual insurance markets stable, accessible, affordable, and comprehensible. In Part IV.B, I explain how and why Congress took legislative steps to forestall migration from the EB system to the newly-created individual exchanges. In Part V, I consider the preliminary case for taking regulatory steps to *promote* (rather than hinder) migration from EB insurance to exchange insurance, and then consider objections. In Part VI, I sketch two reform suggestions intended to encourage, or at least permit, migration to the exchanges.

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published, the ACA may have already been reformed, or perhaps repealed. But whether such legislative action includes or ignores what is discussed herein, the Article will stand as a defense or criticism of what was done.

II. INSURANCE & EB BASICS

The United States is unique among advanced economies in its approach to health care. It uses a combination of public insurance programs and private insurance to finance, and thus deliver, care.[3] While the elderly and the poor receive health care through public financing models (Medicare and Medicaid), persons outside those groups rely on private insurance to finance care, and they largely rely on a special type of private insurance: EB insurance. I discuss below some necessary basics of both individual and EB insurance.

A. INSURANCE BASICS

Insurance is an ancient means to trade and spread risk.[4] Because the risk-averse insured fears the possibility of a large, unexpected loss, he is willing to pay the insurer a small, fixed amount (the premium) in return for the insurer agreeing to cover the loss if it occurs. The risk deal between the two is set forth in an insurance "policy."

For a policy to be profitable for insurer, the premiums it collects (plus the investment return it earns on those premiums) must exceed the payouts associated with covered loss events. To charge a fair price for a policy, the insurer need engage in "underwriting," i.e., it must determine, the best it can, the likelihood and magnitude the loss events it is agreeing to insure a particular insured for.[5] Underwriting is a difficult task, even for insurance companies, because the true risk an insured poses can be different than the risk one would assign to the insured based on an evaluation of information the insurer has access to through underwriting.[6]

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[3] *See* Brendan S. Maher & Radha A. Pathak, *Enough About the Constitution: How States Can Regulate Health Insurance Under the ACA*, 31 YALE L. & POL'Y REV. 275, 282 (2013) (explaining and noting the prevalence of the "Medi-" and private insurance models).

[4] *See generally* C.F. TRENERRY, THE ORIGIN AND EARLY HISTORY OF INSURANCE (1926) (describing insurance-like arrangements beginning millennia ago).

[5] 43 AM. JUR. 2D INSURANCE § 2 (explaining underwriting and risk transfer).

[6] *See* David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 32 (2001) (explaining underwriting).

The problem is complicated by adverse selection, which is the term for the idea that those seeking to obtain insurance are those most likely to incur losses. Asymmetric information makes adverse selection dangerous. Because an insurer often has less information than a potential insured about the actual risk the insured poses, the insurer may charge an insufficiently high premium and incur losses on the policy. Should the insurer attempt to raise premiums the next time around, the higher premium may drive away potential insureds who lack the hidden risk justifying the higher premium, thus making the pool of insureds the insurer attracts riskier (and more costly to the insurer) overall.[7] Adverse selection can damage or destroy insurance markets.[8]

Health insurance is particularly challenging to underwrite. As opposed to other forms of insurance, where the likelihood and magnitude of loss events is relatively easier to calculate and predict (and thus price), health insurance is difficult to underwrite and issue.[9] Even putting aside

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[7] In a now-classic article, Professor Peter Siegelman explained that adverse selection's threat to insurance markets often may be overemphasized by observers. *See generally* Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223 (2004) (concluding that propitious selection—an alternative method of selection—may be at least as common as adverse selection). That said, the consensus view is that adverse selection is a nontrivial threat to health insurance markets, and Siegelman's article did point to some clear examples of adverse selection in health insurance.

[8] JONATHAN GRUBER, PUBLIC FINANCE AND PUBLIC POLICY 311-13 (2005) (explaining perils of adverse selection). The same is not true of broccoli markets, which is why that particular analogy, although colorful, was of limited appeal to insurance scholars who were following the famous *NFIB v. Sebelius* case involving, *inter alia*, the reach of the Commerce Clause. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U. S. 519, 615 (2012) (Ginsburg, J., concurring in part, concurring in the judgment in part, dissenting in part) (rejecting broccoli analogy).

[9] *Cf.* Jayanta Bhattacharya & William B. Vogt, *Employment and Adverse Selection in Health Insurance 1* (Nat'l Bureau of Econ. Research, Working Paper No. 12430, 2006) (acknowledging a widespread belief by economists that employment "ameliorates the adverse selection problem in health insurance provision").

underwriting challenges, the rising cost of health care also makes health insurance expensive.[10]

As a result, unlike markets in other goods, insurance markets (and particularly health insurance markets) need to be regulated with care. In the wild, health insurance markets are likely to be unstable, and market forces alone will probably not guarantee that insurance will be affordable and available to those whose need it.[11] And health insurance is not an ordinary good. Because of the high cost of health care, insurance is the sole practical means to privately pay for most care, and thus the sole practical means to ensure, without recourse to the public fisc or charity, that people's most basic needs—health and life—are addressed. There is thus a considerable societal interest in ensuring that people have access to some insurance mechanism to finance care.

Interestingly, in the United States, until the passage of the Affordable Care Act, the primary regulatory response to addressing the problems of the individual health insurance market was to sidestep the issue. This was accomplished by relying on insurance provided in connection with one's job—i.e., "employment-based insurance"—to finance care for Americans outside of public programs like Medicare and Medicaid.[12] To the EB world I turn to next.

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[10] As for why health care is expensive, the explanations are many. *See, e.g.*, Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 Wake Forest L. Rev. 537, 547-49 (2006) (tying high cost of care to a variety of causes); Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531, 535-36 (1968) (theorizing that moral hazard in health insurance leads to upward price pressure).

[11] *See, e.g.*, Jonathan Gruber, *Covering the Uninsured in the United States*, 46 J. ECON. LITERATURE 571, 574-77 (2008) (describing individual market as inhospitable and unaffordable); Peter Diamond, *Organizing the Health Insurance Market*, 60 ECONOMETRICA 1233, 1236-37 (1992) (describing inability of high risk persons obtain affordable coverage in individual markets).

[12] Indeed, prior to the Affordable Care Act, many people were saved from being exposed to the vicissitudes of the individual market by COBRA, which was enacted to allow those who had left a job with insurance to continue to buy into the employer policy for a period of time. Thus, the prior Congressional effort to deal with individual insurance market infirmity was not to solve individual market problems, but merely to use EB insurance to more aggressively sidestep the problem.

B. EB BASICS

EB insurance is far more than a fringe work benefit. It is massive in size and regulatory scope, covering over 150 million people and occupying countless pages of the United States Code, including the Internal Revenue Code, the Employee Retirement Income Security Act of 1974 (ERISA), and the Affordable Care Act.

The historical justification for the rise of EB insurance is well known: during World War II, wages were subject to wartime price controls, but benefits were not.[13] Providing benefits (including health insurance) thus allowed employers to compete for workers by increasing their compensation without increasing their wages.[14] The provision of health insurance through the workplace proved popular, and by the time of the passage of the Affordable Care Act in 2010, EB health insurance was a familiar fact of life to most Americans.[15]

The theoretical appeal of EB insurance is a subject that has received uneven treatment. Part of that is attributable to the underlying evolution of both health care and insurance. Health insurance in the form we recognize it today—paying a premium to ensure that one could receive paid-for medical care—began in the late 1920s, less than ninety years ago.[16] Medical care at the time was both far less effective and far less costly than today, and so the need to ensure proper financing for it was less pressing.[17] But as the practice of medicine modernized and became more effective, health care

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[13] *See* Clark C. Havighurst, *American Health Care and the Law*, *in* THE PRIVATIZATION OF HEALTH CARE REFORM: LEGAL AND REGULATORY PERSPECTIVES 3-4 (M. Gregg Bloche ed., 2002) (explaining the relevance of wartime wage controls).

[14] *Id.*

[15] *See* CONG. BUDGET OFFICE, CBO AND JCT'S ESTIMATES OF THE EFFECTS OF THE AFFORDABLE CARE ACT ON THE NUMBER OF PEOPLE OBTAINING EMPLOYMENT-BASED HEALTH INSURANCE tbl.2 (2012), https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/03-15-ACA_and_Insurance_2.pdf (estimating that over 150 million people would receive EB insurance in 2012).

[16] *See* Laura A. Scofea, *The Development and Growth of Employer-Provided Health Insurance*, 117 MONTHLY LAB. REV. 3, 4-5 (1994).

[17] *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 259-60 (1982) (describing the transformation of medical services in the early twentieth century).

costs began to rise. And while the rate of health care cost increases had begun to become worrisome by the early 1970s, the scope of the problem was not broadly appreciated until later. For example, at the time of the enactment of ERISA in 1974, Congress was not convinced that either health care costs or health insurance was in crisis.[18] By the late 1970s, however, health care costs were rising fast enough to earn front-page treatment and warnings of catastrophe.[19]

Like health care, insurance (and thinking about insurance) was also evolving. "Major-medical" policies (policies that covered treatment for most conditions) did not start to become widely offered until the 1950s; previously, health insurance covered only a narrow set of conditions, often those attributable to an injury suffered while working.[20] And, while insurers had been aware of the possibility of adverse selection for decades, only in the 1970s did formal theoretical treatments of the subject appear.[21] These

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[18] Congress believed that "there was no crisis in health plans in 1974." Michael S. Gordon, *Introduction to the Second Edition: ERISA in the 21st Century*, *in* EMPLOYEE BENEFITS LAW lxiii, lxviii (Steven J. Sacher et al. eds., 2d ed. 2000). Yet health costs were already growing at accelerating rates. *See, e.g.*, Walter W. Kolodrubetz, *Two Decades of Employee-Benefit Plans, 1950-70: A Review*, 35 SOC. SEC. BULL. 10, 15 (1972) (reporting that by 1970 "[t]he inflation of medical costs ... left its imprint on the rapidly increasing [EB] expenditures for health care benefits").

[19] *See, e.g.*, HENRY J. KAISER FAMILY FOUND., HEALTH CARE COSTS: A PRIMER 4-5 (2012), http://kaiserfamilyfoundation.files.wordpress.c/2013/01/7670-03.pdf (showing the rise in health care costs between 1960 and 2010); E. Kash Rose, *Bringing Costs Under Control*, 126 WESTERN J. MED. 513 (1977) ("Between 1950 and 1976, the cost of a day in the hospital climbed five times as fast as the general inflation rate, reaching an average of $175 last year, up from $16 a day in 1950.").

[20] *See* Scofea, *supra* note 16 at 3-4; *see also* Louis S. Reed, *Private Health Insurance in the United States: An Overview*, SOC. SEC. BULL., Dec. 1965, at 3-21, 48, https://www.ssa.gov/policy/docs/ssb/v28n12/v28n12p3.pdf.

[21] *See generally* George A. Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488 (1970). While not treated formally, adverse selection had been in the insurance vernacular since at least the mid-19th century. *See, e.g.*, G.E. Currie, THE UNITED STATES INSURANCE GAZETTE AND MAGAZINE OF USEFUL KNOWLEDGE 132 (1869) (discussing adverse selection in life insurance policies). The first model of adverse selection in insurance markets was offered in 1976. Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance*

theoretical tools provided observers with the tools to identify and catalogue the flaws of providing health insurance through private markets—whether individual or through the workplace.

While the story is more complex than described above, for a number of reasons—such as rising health care costs and the development of a more sophisticated understanding of health insurance markets—it was surprisingly late that the comparative worth of EB health insurance was evaluated and scrutinized by disciplined observers. Those evaluations, nonetheless, were largely disapproving.[22] That negative critical consensus motivated many commentators to explain the United States' then (and now) large scale reliance on EB health insurance not as something that made objective sense, but instead as an "accident of history."[23]

Scholarly disapproval of EB insurance, however, was not matched by a political or public desire to abandon it. Indeed, the prevailing view in the run-up to the Affordable Care Act was to the contrary: the public attachment to EB insurance was thought sufficiently strong that legislative

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Markets: An Essay on the Economics of Imperfect Information, 90 Q.J. ECON. 629 (1976).

[22] *See e.g.,* Nancy S. Jecker, *Can an Employer-based Health Insurance System Be Just?*, 18 J. HEALTH POL. POL'Y & L. 657 (1993) (arguing that EB insurance is inherently unjust); Jonathan Gruber & Brigitte C. Madrian, *Health Insurance and Job Mobility: The Effects of Public Policy on Job-Lock*, 48 IND. & LAB. REL. REV. 86, 88 (1994) (EB insurance produces significant "job-lock"); David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights*, 73 S. CAL. L. REV. 221, 227, 233-34 (2000) (EB insurance causes misaligned incentives between employers and employees); *see generally* David S. Caroline, *Employer Health-Care Mandates: The Wrong Answer to the Wrong Question*, 11 U. PA. J. BUS. L. 427 (2009) (discussing EB insurance's poor ability to provide broad coverage); Meir Katz, *Towards a New Moral Paradigm in Health Care Delivery: Accounting for Individuals*, 36 AM. J. L. & MED. 78, 82 (2010) (EB insurance limits employees' options and negotiating power); Allison K. Hoffman, *An Optimist's Take on the Decline of Small-Employer Health Insurance*, 98 IOWA L. REV. BULL. 113, 123 (2013) (EB insurance is not portable and brings personal health matters into the workplace).

[23] David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 NEW ENG. J. MED. 82, 82 (2006) (referring to the "many accounts" that have described the United States' embrace of EB insurance as "an accident of history").

moves to undermine it were seen as politically perilous.[24] This likely (although not entirely) explains the curiously schizophrenic nature of the ACA, namely, the legislation created a regulatory super-structure that—by solving certain problems for those outside the EB health insurance system—*could* easily have served as a platform to transition most of the nation away from EB insurance to a different (but still private) system of insurance. But that did not occur—because Congress took steps to ensure that it would not. To that we will return.

III. THEORIZING EB INSURANCE

As mentioned above, on balance the scholarly consensus has long been that EB insurance is an undesirable way for a society to pay for health care for its members.[25] But a conclusion that EB insurance is suboptimal is insufficient for our purposes here; when considering reform, it is preferable to be specific about what a disfavored approach does wrong, as well as—importantly—to acknowledge what it does right.

In previous work, I developed a framework that helps clarify the positives and negatives of using an employment-based mechanism to provide *any* socially desirable good, compared to using alternative regulatory approaches to do so.[26] With some adjustments suitable for the special characteristics of EB health insurance, I follow that approach here.

A. EB SYSTEMS AS REGULATORY INTERVENTIONS

Markets are imperfect. Sometimes they are imperfect with respect to goods that are especially socially desirable—pensions, health care, home

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[24] *See* Chad Terhune & Laura Meckler, *A Turning Point for Health Care*, WALL ST. J., Sept. 27, 2007, at A1 ("In an interview last week, Sen. Hillary Rodham Clinton said people aren't ready to cross employers out of the equation. . . . 'There's great attachment to the employer-based system, even though it is eroding.'"); Uwe R. Reinhardt, *Is Employer-Based Health Insurance Worth Saving?*, N.Y. TIMES, (May 22, 2009, 6:05 AM), https://economix.blogs.nytimes.com/2009/05/22/is-employer-based-health-insurance-worth-saving/?_r=0.

[25] *See* Blumenthal, *supra* note 23, at 82.

[26] *See generally* Brendan S. Maher, *Regulating Employment-Based Anything*, 100 MINN. L. REV. 1257 (2016).

mortgages, education, etc.[27] We might say that, for a given socially desirable good, a market may fail to (1) offer enough of the good at an accessible price; (2) provide a version of the good that is of sufficient quality; or (3) make that good available in sufficient amount or quality to certain segments of the population.

In response, the government has several options. One option is to do nothing. Another is for the government to provide the good in question itself. A third option is to regulate private markets (or private players in those markets) in the hopes of improving the quantity, quality, or distribution of the good. EB approaches are simply particular species of that third category; instead of regulating "open market" transactions regarding those goods, the government regulates (through both carrots and sticks) the provision of those goods as a component of the labor deal. Examples of EB regulations include tax incentives, deal prohibitions, funding requirements, liability standards, and damage limitations.[28]

Whether the government is *right* to choose to use an EB system—as opposed to some other regulatory intervention—is a complex subject incapable of resolution here. However, methodically thinking about why a government might reasonably *believe* an EB approach is desirable can serve as a useful conceptual accounting of what an EB approach might do well and what it might do poorly. That accounting can, in a reasonably tidy fashion, be compared to a similarly organized review of an alternative regulatory approach.

Below I consider why, compared to not intervening in the market for health insurance at all, an EB approach might seem attractive. I then consider the shortcomings of an EB insurance approach.

B. THE PRELIMINARY CASE FOR EB HEALTH INSURANCE

Compared to an unregulated market, the general case for using an employment-based mechanism to improve the quantity, quality or distribution of any socially desirable good can be summarized as follows. EB mechanisms improve market problems by leveraging the advantages of group purchasing; by relying on employers as sophisticated agents; by using the labor deal as a behavioral fulcrum to focus attention and reduce the

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[27] Socially desirable goods are "those goods for which there is broad agreement that society is better off if most individuals have or are able to obtain them." *Id*. at 1276.

[28] All of these are used under ERISA. *See generally* PETER J. WEIDENBECK, ERISA: PRINCIPLES OF EMPLOYEE BENEFIT LAW (2010).

likelihood of poor decision-making; and by utilizing employers and the labor deal as a convenient regulatory nexus.[29] All of these arguments apply with some force in the health insurance context.

Group purchasing. The central (although not only) advantage of EB health insurance is that it leverages the power of groups to purchase insurance. With respect to any good, bulk purchasing reduces unit cost, but with respect to insurance, group purchasing is particularly valuable.

Using the employee group as the purchasing unit for policies is attractive on multiple grounds. First, it is easier to underwrite and insure a group than an individual; the larger the group, the more the risks of the group approach the risk of the community, for which reliable rating information is available (and for which adverse selection is not an issue).[30] Not only does this make groups less risky to insure, it gives particularly large groups meaningful market power to negotiate. Put slightly differently, underwriting is more difficult (and thus more costly) to do properly the smaller the group.[31] The larger the group, the more the group is a prize customer for the insurer, and thus the better suited the group is to negotiate attractive deal terms—e.g., broad doctor networks—that please group members. Thus, group power, combined with sophisticated employees that a large company may employ to oversee its insurance purchases, can often result in desirable policies whose generous coverage legitimately advantages employees.

Moreover, current law requires an insurer to offer the same rate for the whole group, *i.e.,* to not price discriminate among different risks within the group.[32] As a result, being a part of the group makes health insurance accessible to individuals who otherwise—in an unregulated, open market—

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[29] *See* Maher, *supra* note 26, at 1275-90.

[30] This assumes that the group is assembled for some reason other than to buy insurance; that is obviously the case with employee groups, who are assembled by dint of their decision to work for a given employer. *See, e.g.,* Allison Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 28 (2010) (noting that there is "little concern of adverse selection with respect to large, employer-sponsored group insurance"); *see also* Hyman & Hall, *supra* note 6.

[31] *See* Amy B. Monahan & Daniel Schwarcz, *Saving Small-Employer Health Insurance*, 98 Iowa L. Rev. 1935, 1947-48 (2013) (explaining that small groups are riskier to insure).

[32] *See* Hoffman, *supra* note 30; *See generally* Hyman & Hall, *supra* note 6.

would have had to pay a very high price for insurance (or, who, with certain conditions, would have been unable to buy insurance at all).[33]

Sophisticated agents. Insurance, particularly, health insurance, is not a simple good to evaluate or purchase.[34] An average worker may find researching, comparing, and consummating such a purchase to be difficult or time-consuming, and might make suboptimal choices.[35] In contrast, company management is comparatively more sophisticated and has more resources to devote to understanding the purchase.[36] To the extent EB insurance results in leveraging management's sophistication to legitimately aid the employee in insurance procurement, that is a potential advantage over leaving employees to attempt to secure health insurance on the open market.[37]

Behavioral economic advantages. Human beings are imperfect decision makers who fall victim to systematic errors.[38] The purchase of complicated goods—such as health insurance, which involves pricing contingent events—is a context particularly likely to result in suboptimal outcomes like procrastination, refusal to purchase, or purchase by inefficient heuristic.[39] Tying health insurance to the labor deal increases the likelihood

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[33] *Cf.* Richard A. Posner, *Taxation by Regulation*, 2 BELL J. ECON. & MGMT. SCI. 22, 27-28 (1971) (explaining how regulation is needed to preserve internal subsidization). This cross-subsidy, of course, is a *negative* feature for those who would have paid less on the open market. But that cost might be worthwhile if that person believes, at some point in the future, he will benefit from being in the group.

[34] *See generally* George Loewenstein et al., *Consumers' Misunderstanding of Health Insurance*, 32 J. OF HEALTH ECON. 851 (2013) (consumers do not understand traditional health insurance plans).

[35] Russell B. Korobkin & Thomas S. Ulen, *Law and Behavioral Science: Removing the Rationality Assumption from Law and Economics*, 88 CAL. L. REV. 1051, 1095-100 (2000) (explaining difficulties in choosing health insurance); *cf.* Oren Bar-Gill & Elizabeth Warren, *Making Credit Safer*, 157 U. PA. L. REV. 1, 47 (2008) (noting consumers are vulnerable because of "imperfect information and imperfect rationality").

[36] *See* Hyman & Hall *supra note 6, at* 30 (arguing that with respect to health insurance decisions, employers have superior personnel resources).

[37] *Id. See also* Maher, *supra* note 26, at 1278-80.

[38] *See generally* DANIEL ARIELY, PREDICTABLY IRRATIONAL: THE HIDDEN FORCES THAT SHAPE OUR DECISIONS (2008); DANIEL KAHNEMAN, THINKING, FAST AND SLOW (2011).

[39] *See, e.g.*, George A. Akerlof, *Procrastination and Obedience*, 81 AM.

that it will be purchased, promotes the likelihood that individuals will pay attention to the insurance decision, and increases the chance the investment of attention by the employee will be worth it.[40]

In addition, if we assume that (at least with respect to the insurance purchasing decision) employers are less subject to cognitive biases[41] than individual workers, if the employer presents a default choice, that outcome is likely to be better than an individual would obtain on his own.[42]

ECON. REV. 1, 1-19 (1991) (noting how procrastination affects decision-making); Brian Galle, *Hidden Taxes*, 87 WASH. U. L. REV. 59, 83 (2009) ("[T]here is now extensive evidence that most people are disproportionately sensitive to small, immediate costs; that is one of the reasons we procrastinate even essential tasks."); Piers Steel, *The Nature of Procrastination: A Meta-Analytic and Theoretical Review of Quintessential Self-Regulatory Failure*, 133 PSYCHOL. BULL. 65, 66 (2007) (considering scholarly treatments of procrastination).

[40] To elaborate, one is more likely to purchase an item if that item comes with something else than if one had to buy that item on its own. Second, people think more about decisions put in front of them; connecting insurance to the job essentially forces people to think about insurance when they take the job (and perhaps each time they see the paycheck deduction). Third, EB insurance is a constrained choice: if one wants insurance, one chooses among the options (if any) the employer has provided. That is much more likely to result in a decision—and to reward the investment of attention— than is an effort to buy health insurance in the open market, which can paralyze consumers with too many choices.

[41] *See* Donald C. Langevoort, *Behavioral Theories of Judgment and Decision Making in Legal Scholarship: A Literature Review*, 51 VAND. L. REV. 1499, 1515 (1998) ("Because corporations and other business associations are so subject to market constraints, there have been long-standing doubts as to whether psychological biases, even if robust at the individual level, are likely to have much impact on organized economic behavior."); *See also* Chip Heath et al., *Cognitive Repairs: How Organizational Practices Can Compensate for Individual Shortcomings*, 20 RES. ORGANIZATIONAL BEHAV. 1 (1998).

[42] *See* Cass R. Sunstein & Richard H. Thaler, *Libertarian Paternalism Is Not an Oxymoron*, 70 U. CHI. L. REV. 1159, 1196 (2003) ("[T]he more complex the decision, the less attractive it will be to force people to choose for themselves, as opposed to having the option of . . . receiving a default option that has been selected with some care.").

EB settings can also influence decisions by constraining compensation; an employer may offer health insurance but refuse to increase wages by an equivalent amount if the employee declines the insurance. One way to view constrained compensation is as a commitment device that promotes good decisions. If one realizes that spending money on health insurance is the right decision, but worries that the freedom to spend wages as one likes will result in consumer electronics instead of health insurance,[43] labor deals that come with constrained compensation are welfare-enhancing.

Regulatory amenability. All regulatory interventions must regulate some act, and impose upon some party a burden to comply. Providing health insurance through an EB system makes the labor deal the act that is regulated and the employer the primary compliance agent. Because labor deals are necessary elements of a market economy, they are unlikely to be abandoned if regulated, thereby reducing the chance that a significant segment of the population will dodge EB regulation by not working.[44] In addition, employers have experience as compliance actors; drafting them could be more attractive than creating a new compliance structure from scratch (such as creating a federal agency to administer a national health service.)[45] In other words, delivering and regulating health insurance through the work place utilizes a pre-existing structure (and familiar actors) as the attachment points for the government's regulatory will.

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[43] *See generally* Ted O'Donoghue & Matthew Rabin, *Doing It Now or Later*, 89 AM. ECON. REV. 103 (1999) (discussing commitment devices). For the record, Maher prefers craft beer to consumer electronics, and does not believe it is a close call.

[44] Maher, *supra* note 26, at 1288 ("Other bargains (or mere acts), in contrast, if burdened with interventionist regulation, might be more readily abandoned."). There could, of course, be some employment effects.

[45] Employers have functioned as compliance actors in the context of both taxes and immigration status. *See, e.g.*, Raquel Aldana, *Of Katz and "Aliens": Privacy Expectations and the Immigration Raids*, 41 U.C. DAVIS L. REV. 1081, 1096-97 (2008) (discussing employer obligations regarding employee status); Edward K. Cheng, *Structural Laws and the Puzzle of Regulating Behavior*, 100 NW. U. L. REV. 655, 677-78 (2006) (praising the federal approach to tax collecting, which heavily involves employers, as an "unqualified success").

C. THE PRELIMINARY CASE AGAINST EB INSURANCE

Having laid out the potential advantages of EB insurance, in this Part III.C. I consider the downsides.

Self-evident limitations. The first limitation is the most obvious: EB health insurance only reaches the employed and their dependents. Those outside the employed population must be reached in some other way. The second limitation relates to the labor deal itself: if wages are to be reduced to pay for the benefit of health insurance, that tradeoff has limits, based the cost of health insurance, the size of the wage, minimum wage laws barring wages from dropping below a certain level, and the preference of workers.[46] Thus EB health insurance is not only not going to reach non-employees, it is also highly unlikely to reach all the employed. (Mandates[47] are not cure-alls, as they generally do not reach part-time or "gig" workers.) Third, while the use of group purchasing benefits those who would otherwise be unable to purchase insurance on the individual market, it forces those who would have been able to do so to pay a higher price as a part of the group.

Myopic actors. Management may be more sophisticated than labor. But at least two concerns undermine one's confidence that that comparative sophistication will be deployed to make employees better off. First, employers are not particularly sophisticated regarding health insurance, and often rely on third party providers—who *are* experts with respect to health insurance—to strike deals.[48] Absent significant regulation, an employer could be exploited by a third-party provider, with the result being suboptimal insurance for workers. Put differently, even if employers hope to be good agents regarding procuring insurance for their employees, they may be victimized at the bargaining table by expert insurers.

Second, the reality is that insurance is compensation, and on the matter of compensation, employers and employees have an adversarial

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[46] *See* Maher, *supra* note 26, at 1292-93.

[47] Mandated benefits have their own strengths, weaknesses, and employment effects. *See* Lawrence H. Summers, *What can Economics Contribute to Social Policy? Some Simple Economics of Mandated Benefits*, 79 AM. ECON. REV. 177 (1989).

[48] *Cf.* Russ Banham, *The Great Pension Derisking*, CFO MAG., Apr. 2013, at 40, 42, http://ww2.cfo.com/retirement-plans/2013/04/the-great-pension-derisking/view-all (quoting company executives at General Motors explaining that car-making, not benefits, is the company's core competency).

relationship.[49] Employers might be inclined to use their extra sophistication to offer health insurance with terms that an employee is unlikely to realize is undesirable. And even to the extent employees do realize that, in non-union settings, their power to *alter* the deal is likely modest.[50]

Acknowledging employer power is not to impugn the character of employers. But the reality is that employers have objectives, and if the point of using an EB system is to deliver health insurance that approaches a version of health insurance that society believes is optimal, it is unlikely employers will, absent regulation, be inclined to offer health insurance that has those characteristics. And it is unlikely non-unionized employees will have the expertise or power to push back.

Consider the Hobby Lobby case.[51] For present purposes, the issue can be stated fairly simply. Society—its preferences embodied in the Affordable Care Act's requirements—determined that health insurance should cover contraception.[52] The owners of Hobby Lobby, for religious reasons, did not wish to offer to their employees insurance that did so.[53] While the resulting dispute over that particular insurance term attracted a lot of attention, there are many potential terms in insurance policies that employers—even those who generally prefer offering insurance as a benefit to their employees—might refuse to accept on economic or social grounds.[54] Thus, absent regulation that limits what employers can offer employees as health insurance, the likelihood that employers will use their additional sophistication and superior bargaining power to offer health insurance *worse* than what society believes is optimal is significant.

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[49] In addition, the current regulatory set-up assigns liability to the employer for health insurance disputes. More generous policies correspondingly increase an employer's liability risk. *See* Brendan S. Maher & Peter K. Stris, *ERISA & Uncertainty*, 88 WASH. U. L. REV. 433, 460-74 (2010).

[50] Most employees are not unionized. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, NEWS RELEASE: UNION MEMBERS – 2016 (Jan. 27, 2017), https://www.bls.gov/news.release/pdf/union2.pdf (reporting that 10.7 percent of workers are in unions).

[51] Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751 (2014).

[52] 42 U.S.C § 300gg-13(a)(4) (2012).

[53] *Hobby Lobby*, 134 S. Ct. at 2759.

[54] Examples might include coverage relating to assisted suicide, stem cell treatments, pre-natal genetic testing, or surrogate motherhood.

Regulatory fragility. While the labor deal might be a resilient regulatory target and employers experienced compliance agents, regulating employers comes with a cost.

Employers are not in the business of providing health insurance; they are in the business of paying wages to workers to produce widgets or services for sale. To the extent the regulatory burden connected with providing health insurance becomes high, employers may choose to not offer it—or, in the case of a mandate, structure their affairs such that the mandate's impact is minimized.

The practical consequence is regulations that make offering health insurance more onerous—which includes virtually any rule that favors employees and beneficiaries—can be met with a credible threat to stop offering health insurance. And because health insurance is very hard to come by in the open market—i.e., outside of an EB system, or absent some other government intervention—this threat is particularly powerful in the health insurance context.[55] Employers thus hold tremendous leverage with regulators (and implicitly with the judges charged with interpreting the rules), and the result is that EB health insurance systems come with an inherent bias against regulators (and employees) in favor of employers.[56]

Opacity. EB health insurance obscures the reality of health insurance in multiple ways. First, because health insurance is an employment benefit, the cost of the health insurance is generally obscured to the worker—at least as compared to how clear the cost would be if the worker acquired health insurance on the open market.[57] There is no finer mechanism for making clear the cost of something than to ask the person purchasing it to write a check equal to its cost.

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[55] And those threats will have even more force in difficult economic times—precisely when health insurance is most needed—because that is when employers will be looking to trim costs, including by shedding the explicit and implicit costs of regulatory compliance.

[56] Several scholars have suggested this is the reason the courts have trimmed ERISA's remedies at every turn. *See, e.g.*, Brendan S. Maher, *The Affordable Care Act, Remedy, and Litigation Reform*, 63 AM. U. L. REV. 649, 665-67 (2014); Paul M. Secunda, *Sorry, No Remedy: Intersectionality and the Grand Irony of ERISA*, 61 HASTINGS L.J. 131, 133-36 (2009).

[57] Unlike in the past, now the "employer contribution must be shown on an employee's W-2." John Aloysius Cogan Jr., *Health Insurance Rate Review*, 88 TEMP. L. REV. 411, 424 (2016) (citing 26 U.S.C. § 6051(a) (2012)). As Professor Cogan points out, however, "it is not entirely clear that all employees fully understand or even notice this information." *Id.*

Second, this confusion goes beyond the micro-level. It is clear that many voters do not appreciate that health insurance is paid, *not* by the employer, but by the foregone wages of the employees.[58] This means EB insurance has support based on a false premise.[59] Believing EB insurance is paid for by the employer is equivalent to viewing the current system as providing workers with a gift. When one laboring under this misapprehension learns alternative health insurance approaches will no longer rely on employers, one will conclude that one is "losing" an employer gift, and resist any such change, leaving public support of EB insurance higher than it should be.

Third, EB insurance systems are likely to perpetuate mistaken beliefs about who *deserves* health insurance (and thus health care). Providing health insurance through the workplace was not done *because* only those employed deserved health insurance and health care; it was done because it was held to be an effective way to provide a significant population—the employed and their dependents—health care. But the dominance of an EB health insurance approach has led people to confuse cause and effect by concluding that health insurance and care are somehow morally linked to having a job, even though, upon inspection, that is not the case. No credible moral theory conditions the availability of health insurance and care upon having a job with health insurance benefits; that would exclude, just to name a few examples that come to mind, the young, the old, freelancers, entrepreneurs, the disabled, homemakers, and the unemployed.[60]

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[58] *See* Maher, *supra* note 26, at 1307 (arguing that the public largely misunderstands who pays for benefits). *Cf.* Uwe Reinhardt, *The Illogic of Employer-Sponsored Health Insurance*, N.Y. TIMES (July 1, 2014), http://www.nytimes.com/2014/07/03/upshot/the-illogic-of-employer-sponsored-health-insurance.html (Professor Reinhardt argued that the Supreme Court itself failed to understand that employees, not employers, pay for benefits.).

[59] *Cf.* Lauren R. Roth, *Overvaluing Employer-Sponsored Health Insurance*, 63 U. KAN. L. REV. 633, 647 (2015) (arguing that as a result of misunderstandings about EB insurance, "[f]ew doubt that attachment to [EB insurance] is a significant impediment to a dramatic overhaul of our healthcare system"). Roth also argues that cognitive biases account for the nation's attachment to EB insurance. *Id.* at 647-48 (arguing that prospect theory and the endowment effect illustrate why people are more attached to EB insurance than is objectively rational).

[60] *See* Maher, *supra* note 26, at 1295. *Cf.* Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C. L. REV. 1, 8 (2016) (identifying and criticizing the "perceived divide between good

IV. THE AFFORDABLE CARE ACT

Although the ACA changed much about health care in the United States, for our purposes, the relevant question is what action it took (and did not take) with respect to the regulation of private insurance.[61] As explained below, the Affordable Care Act took various steps with respect to both employment-based health insurance and individual health insurance. The technical particulars are quite complex, and federal agencies enjoy considerable power to promulgate implementing regulations.

For this Article, however, a detailed dive is not necessary. The relevant takeaways can be set forth with only modest reference to the underlying statutory and regulatory specifics. The first takeaway is that the Act implemented a series of reforms to fix the problems that have long bedeviled and rendered inaccessible individual insurance markets. The second is that Congress took steps to ensure that fixing the individual markets would not undermine the existing EB system.

A. FIXING INDIVIDUAL MARKETS

A central reason for the ACA's enactment was to achieve near-universal coverage for Americans. Health care is so costly that it is not meaningfully available without some source of financing. Thus, prior to the Affordable Care Act, health care was reliably available only to those that had access to private or public insurance, namely the elderly (through Medicare), the poor (through Medicaid), or the employed (through EB coverage). Those outside those categories could only obtain insurance through the individual market, which was not accessible to most people. As noted in Part II.A. above, individual markets are plagued with administrative and adverse selection problems. The insurance industry response was to refuse to offer insurance at all to those with preexisting conditions, and otherwise only offer affordable policies to a small set of people.[62]

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citizens with private insurance and socially undesirable dependents with public benefits.").

[61] Thus, the Act's expansion of Medicaid, for example, is not of immediate concern here.

[62] *See* Gruber, *supra* note 11 at 574-77; Diamond, *supra* note 11 at 1236-37 (discussing undesirable pre-ACA state of individual markets). *See also*

The Act addressed the problems of the individual market through several interrelated mechanisms. First, the ACA barred insurance companies from underwriting; any person seeking a policy would be charged the community rate, with premiums adjusted only for geographic area, family size, age, and tobacco use.[63]

Second, all individuals were obligated to obtain insurance coverage or pay a penalty.[64] This "individual mandate" was and is designed to combat adverse selection that could destroy insurers writing community rated policies. If insurers are required to issue policies to all applicants at community rates, many healthy consumers might choose to not buy a policy until they were sick or likely to become sick. In that case, the insurer would be writing policies at community rates but only collecting premiums from the sicker part of the community, which is not sustainable. An individual mandate, by requiring all people (including healthy ones) to buy policies, allows the insurer to offer community rated policies without facing financial ruin.

Third, all policies offered must cover roughly the same "essential health benefits" that corresponded to ten categories of coverage.[65] Those categories reflected Congress's judgment about what a socially valuable health insurance policy must cover. Absent such a requirement, the Act risked creating no more than a market for empty policies that were useful health insurance in name only. The law allowed, however, for policies to vary in the level of coverage a policy provided. Policies were assigned colors (bronze, silver, gold, and platinum) based on the actuarial percentage of costs

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Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 134 (2011) (observing that "because the risks of some individuals can be difficult to predict or are predictably exorbitant" insurers may "refus[e] to insure certain individuals or insur[e] them only with respect to specific types of costs or conditions.").

[63] 42 U.S.C. § 300gg(a)(1)(A) (2012) (listing the permitted rating factors); *id.* at §300gg-4 (prohibiting discrimination based on pre-existing conditions). Community rates are set by state regulation, and are intended to reflect a fair price to insure an average member of the community.

[64] *See* I.R.C. § 5000A (2012) (individual mandate).

[65] 42 U.S.C. § 300gg-6(a) (2012) (providing that individual and small group plans must provide "essential health benefits"). The ACA also requires other consumer protections, such as no lifetime limits.

they would cover for an average patient.[66] This kind of standardization often does not occur in markets operating on their own; thus, this reform can be thought of not only as one regulating quality but also as one that makes consumer choice easier.

Fourth, Congress did not create an unfunded individual mandate. Given the high cost of health care, for many even a community-rated policy is unaffordable. As a result, sliding subsidies were offered to enable low income persons, i.e., those whose income is 400% or less of the poverty line, to purchase insurance.[67]

Fifth, the ACA created insurance "exchanges" where customers could choose between policies, and where the relevant information regarding policy specifics was to be provided in an accessible, consistent way.[68] The exchanges were to be run either by the State or the federal government, if the State declined to do so.

The foregoing changes were intended to fix the individual insurance markets by making them stable, accessible, affordable, and comprehensible.

B. LOCKING INDIVIDUAL EXCHANGES

Market economies are dynamic and change in response to legislation. As a result, some feared the ACA's reforms would result in some employers no longer offering health insurance as a benefit to their workers.

Offering health insurance imposes significant administrative, regulatory, and liability costs upon employers.[69] Prior to the ACA's reforms

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[66] 42 U.S.C. § 18022(d) (2012). The ACA also included reinsurance mechanisms to protect insurers who entered the markets as they equilibrated. *See generally* Mark A. Hall, *The Three Types of Reinsurance Created by Federal Health Reform*, 29 HEALTH AFF. 1168 (2010) (explaining the ACA's reinsurance provisions).

[67] Amy B. Monahan & Daniel Schwarcz, *Saving Small-Employer Health Insurance*, 98 IOWA L. REV. 1935, 1947-48 (2013) (explaining ACA purchase subsidies). The subsidies are only available to if one is unemployed or if one's employer does not provide "minimum essential coverage." I.R.C. § 36B(2)(C) (2012). That requirement pertains to affordability and value, not the benefit package.

[68] Brendan S. Maher, *Some Thoughts on Health Care Exchanges: Choice, Defaults, and the Unconnected*, 44 CONN. L. REV. 1099, 1107 (2012) (explaining how the exchanges simplified insurance purchasing).

[69] *See generally* Maher & Stris *supra* note 49 (describing costs and uncertainties associated with offering benefits).

of the individual markets, however, the inability of many employees (including management personnel) to obtain insurance *outside* the workplace was a strong incentive for employers to offer insurance as way to attract workers. Yet if workers could obtain insurance easily on the ACA individual exchanges, employers might feel less pressure to offer health insurance. Whether an employer deciding to drop EB insurance is actually undesirable is a separate matter (see below), but the structure of the Act (as well as one unmade change) functioned to forestall any migration to individual markets.

The employer mandate. The Act requires large employers to offer health insurance to its workers or pay a penalty.[70] Importantly, the point of this mandate is very different than the individual mandate. The individual mandate was designed to ensure that the individual insurance market did not suffer collapse or severe impairment. See IV.A. above.

The employer mandate (as written) serves an entirely different end. Large employers—who use a group of employees as the insurance purchasing unit—do not face problems procuring insurance, because insurers do not face significant problems underwriting and pricing such policies.[71] Thus, unlike the individual mandate, an employer mandate is not needed to improve the pool and stabilize the market. Instead, the employer mandate was apparently intended to perpetuate the pre-ACA system of EB health insurance. Given the ACA's anticipated creation of a functioning individual market, legislators wanted to discourage employers from abandoning EB insurance, and the employer mandate was one way of doing so.[72]

EB tax-bias preserved. EB health insurance is tax-advantaged; while employers may deduct the cost of the insurance from their income, employees do not pay tax on the value of the insurance.[73] In contrast,

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[70] *See* I.R.C. §4980H(a)(1) (2012) (penalty for large employers not offering health insurance). A large employer employs 51 or more persons.

[71] Large group rating either resembles community rating or is otherwise achievable through standard underwriting methods.

[72] In addition, the Act contained an unusual feature: its much-touted requirement that insurance policies cover "essential health benefits" did *not* apply to large group plans. 42 U.S.C. § 300gg-6(a) (2012) ("essential health benefits" obligation does not reach large employers). Sparing large employers the obligation to offer policies with essential health benefits effectively permits them to whittle down the cost of the mandate by offering narrower policies than what exchange insurers must offer.

[73] *See* Stephen Utz, *The Affordable Care Act and Tax Policy*, 44 CONN. L. REV. 1213, 1233-34 (2012) (explaining disparate tax treatment of EB and

purchasing health insurance on the individual market is generally done with after-tax dollars—even if an employer wished to give an employee money for that express purpose.[74] All things equal, an employee who pays any income tax would prefer to receive insurance through her employer.

Although it changed many things, the ACA did not abolish the tax-bias in favor of EB insurance.[75] While it does award a sliding subsidy to

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individual insurance). Scheduled to go in effect in 2020, however, is a so-called "Cadillac" tax—a 40% excise tax—on high-cost EB insurance. 26 U.S.C. § 4980I (2012).

[74] Utz, *supra* note 73, at 1233-34. The federal government has routinely rejected efforts to use any version of defined contribution health accounts to funnel an employee pre-tax money to spend on premiums outside of group coverage. *See, e.g.*, *Application of Mkt. Reform & Other Provisions of the Affordable Care Act to HRAs, Health FSAs*, *& Certain Other Employer Healthcare Arrangements*, 2013-40 I.R.B. 288 (2013) ("In the HRA FAQs, the Departments state that an HRA is not integrated with primary health coverage offered by an employer unless, under the terms of the HRA, the HRA is available only to employees who are covered by primary group health plan coverage that is provided by the employer and that meets the annual dollar limit prohibition."). *See also generally* Amy Monahan, *The Use of Section 125 Plans for Individual Insurance Following the Enactment of Federal Health Reform*, SHARE FOUNDATION (Oct. 2014), https://www.phs.wakehealth.edu/public/pub_insurance/125/125_plans_and_PPACA_formatv3%20revised.pdf (describing limits of using cafeteria plans to purchase individual exchange polices with pre-tax dollars). That said, in late 2016 Congress provided small employers with a limited ability to enable workers to purchase individual policies with pre-tax dollars. *See* Stephen Miller, *New Law Lets Small Employers Use Stand-Alone Health Reimbursement Arrangements,* https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/21st-century-cures-act-stand-alone-hras.aspx (last updated Feb. 2, 2017) (describing new QSEHRA option).

[75] Observers have long complained that the tax code does not treat insurance purchases equally. Some have argued all health insurance purchases should be with after tax dollars, while others have argued that all health insurance purchase should be with pre-tax dollars. *See* Bradley W. Joondeph, *Tax Policy and Health Care Reform: Rethinking the Tax Treatment of Employer-Sponsored Health Insurance*, 1995 B.Y.U. L. REV. 1229, 1255 (1995) (arguing that the health insurance market will only be efficient if all purchases are made with after tax dollars); REPORT OF THE PRESIDENT'S ADVISORY PANEL ON FED. TAX REFORM, SIMPLE, FAIR, AND

exchange purchasers at or near the federal poverty level, for most employees, losing EB health insurance would result in losing a significant tax break. That, in turn, meant labor pressure on employers to preserve EB insurance would remain significant. In contrast, had Congress, in enacting health reform, simply treated all health insurance purchases equally—whether eliminating the tax break or applying it to *all* insurance purchases—the market pressure on employers to offer EB health insurance would have decreased considerably, and increased the influx of people onto the individual exchanges.

The result of the foregoing is that the ACA was both a revolutionary and conservative statute at once. It was revolutionary in its efforts to fix individual insurance markets around the country. It was conservative in its efforts to preserve the basic system of EB insurance that preceded the ACA, and took steps to ensure that neither employers nor employees could easily migrate from EB health insurance to the exchanges. I next consider if and whether the ACA's pro-EB measures should be modified.

V. UNLOCKING EXCHANGE INSURANCE

In this Part V I make two claims. First, I argue that, on balance, individual exchanges like those created by the ACA are superior to EB health insurance. That said, EB health insurance has some features with positive social value. Second, I argue that, a sensible choice for Congress is to "unlock" the ACA's individual exchanges, i.e., to eliminate or modify the employer mandate and the EB tax-bias so as to promote the migration of employed persons to the individual exchanges.

A. THE PRELIMINARY CASE FOR UNLOCKING

The case for EB health insurance is a comparative one. One must ask not only how EB health insurance does against leaving people to fend for themselves in individual markets (against which it obviously compares well), but also against some other type of government intervention in the health insurance market—whether a single-payer system or insurance through regulated exchanges. Of course, the ACA chose to implement an exchange-based intervention while attempting to prevent migration into it

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PRO-GROWTH: PROPOSALS TO FIX AMERICA'S TAX SYSTEM 81 (2005), *available at* https://www.treasury.gov/resource-center/tax-policy/Documents/Report-Fix-Tax-System-2005.pdf (recommending that individuals be allowed to purchase health insurance with pre-tax dollars up to a specified amount).

from an EB system. The most obvious comparison to make is between the current segregated EB system and one in which migration from EB to the exchanges is not constrained.

Group advantage. Compared to an unregulated market, the chief advantage of an EB system is that it gives employed individuals access to insurance (and thus health care) unobtainable on the individual market. The creation of community-rated, subsidized exchanges solves that problem.[76]

Sophisticated actors. A second advantage of EB health insurance was that employees could benefit from having management act as a bargaining agent; management is more sophisticated than individual employees, and management purchases insurance for a large group, which means insurance companies could be more willing to offer terms that are, objectively speaking, better than what an individual could secure through the exchange. This advantage is one that critics of EB health insurance would be wise to not dismiss. Large employers—both as a result of controlling a large group of insureds and heightened sophistication—may very well strike insurance deals that employees would be hard pressed to obtain on their own. Reasonable evidence suggests that average EB health policies are more generous (in terms of percentage of actuarial value) than most exchange policies.[77] And there is also evidence that EB policies offer more desirable doctor networks.[78] That said, there are several countervailing considerations.

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[76] And, of course, from society's perspective, it solves the problem of coverage for those *not* employed. But that happens even when there is a wall between the EB and individual exchange world.

[77] The average EB policy, in terms of actuarial value, likely falls between gold and platinum exchange policies. *See generally* Thomas G. Moehrle, *Measuring the Generosity of Employer-Sponsored Health Plans: An Actuarial-Value Approach*, MONTHLY LAB. REV. (June 2015), *available at* https://www.bls.gov/opub/mlr/2015/article/measuring-the-generosity-of-employer-sponsored-health-plans.pdf. Most exchange policies, in contrast, are silver or bronze. *March 31, 2016 Effectuated Enrollment Snapshot*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 31, 2016), https://www.cms.gov/Newsroom/MediaReleaseDatabase /Fact-sheets/2016-Fact-sheets-items/2016-06-30.html (reporting that enrollment in bronze and silver policies was, respectively, 22% and 70%).

[78] Mark A. Hall & Paul Fronstin, *Narrow Provider Networks for Employer Plans*, 428 EMP. BENEFIT RES. INST. 3-4 (Dec. 14, 2016) (reporting that exchange policies had narrower doctor networks than EB policies), https://www.ebri.org/pdf/briefspdf/EBRI_IB_428.Pvdr-Nets.13Dec16.pdf.

First, the most likely explanation for why EB insurance is more generous than exchange insurance is because EB dollars go farther. If one wants to get the best possible insurance for some set cost, then one will be able to get better insurance spending pre-tax rather than post-tax dollars.

Second, two salient characteristics about EB policies are worth considering, given the potential disadvantage they could work to employee interests. As discussed in Part III.C above, employers have some measure of religious freedom to refuse to provide policies with certain terms. Contraception was the first flash point, but there could easily be others relating to any number of controversial conditions or treatments.[79]

In addition, virtually all EB policies are governed by ERISA, whereas state law governs individual policies.[80] Although ERISA was intended to protect beneficiaries, it has long been interpreted by the federal judiciary to do anything but.[81] ERISA permits benefit determinations to be heard by conflicted decision-makers; requires exhaustion of internal appeals before suit; allows plans to shorten statutes of limitation; requires judicial deference to plan administrators—even when those administrators are conflicted or have already erred; and does not permit the recovery of consequential or punitive damages on benefit claims.[82] Although that is a feature of federal law, not employer negotiating behavior, it closely resembles the very things an employer and insurance company (both of whom are defendants in benefit claims) would include as terms in a policy. State law is, generally speaking, far more favorable to claimants.

Third, perhaps the lesser quality of the policies on the exchanges may be the consequence of something other than the absence of employer involvement. Specifically, exchange policies may be less generous because the pool of individuals participating in the exchanges is smaller and sicker than originally predicted. That would lead to fewer insurers participating, and for participating insurers being stingier in the terms they were willing to offer. The worse-than-expected pool quality has at least two causes: first, the penalty for violating the individual mandate was not high enough.[83]

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[79] *See supra* note 54.

[80] *See* Maher, *supra* note 56, at 662 (explaining that state law is generally more beneficiary friendly than ERISA).

[81] *Id.* (describing ERISA) ("[O]ne of the most effective pieces of federal litigation reform legislation ever passed.").

[82] *Id.* at 661 (explaining limits on ERISA's remedies).

[83] *See* Bre Payton, *Watch Obamacare's Architect Reveal His Master Plan To Fix The Law: Bigger Penalties*, THE FEDERALIST (Oct. 28, 2016), http://thefederalist.com/2016/10/26/obamacare-architect-reveals-plan-to-

Second, the employer mandate and the tax-bias artificially prevented millions of healthy people from migrating to the exchanges.

Imagine if, tomorrow, employment-based health insurance was forbidden, and all those insureds had to purchase policies on the exchanges or face a meaningful penalty. The individual market pools would collectively swell by 150 million people—leading, no doubt, to more insurers offering policies. Policies with desirable terms would attract large numbers of insureds, which means the exchange would see offerings closer to what large employers might have offered. Barring EB health insurance, of course, will never happen. But while, say, eliminating the employer mandate and the tax-bias would not necessarily result in a total migration to the exchanges, one imagines the migration would be significant enough to make the exchange offerings meaningfully better than they are today.

Behavioral economics. Another advantage of EB health insurance was that connecting health insurance to employment was desirable for behavioral reasons; it prevented employees from making cognitive errors they would make if left on their own. Yet the mandate and the exchanges address a significant number of these concerns. Some of the central behavioral difficulties afflicting insurance purchasing are that it addresses a future contingent need; it is a difficult good to value; and the many choices available to an unguided consumer might be so overwhelming as to paralyze the consumer into doing nothing or relying on an inefficient heuristic. *See* Part III.B above.

The mandate requires insurance be bought, and the exchange makes the purchasing process close-ended and constrained: one need check one website to see all the options, and the options are described in uniform, reasonably accessible terms.[84] Purchasing assistance is also available.[85] Admittedly, compared to a company purchaser, an exchange consumer still may use an inefficient heuristic, but that problem could be addressed in two ways. First, a default option could, by inertia, limit any decision-making (and thus limit bad decision-making). Second, plain English "FAQs" prepared by the exchange could steer those consumers who opt to move away from the default away from making decisional errors. Third, there is also no

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fix-the-law-bigger-penalties/ (economist Jonathan Gruber arguing in favor of higher penalty as a means to draw more healthy people into the exchange pool).

[84] *See* Maher, *supra* note 68, at 1108 (discussing how the exchanges were designed to promote simple and transparent choices).

[85] *Id.* (noting availability of a toll-free hotline and knowledgeable intermediaries the Act calls "Navigators").

reason an employer might not offer an *advice* benefit; i.e., instead of choosing, procuring, and providing health insurance; the employer's experts would simply analyze the yearly exchange options and make recommendations for which plan it would have provided, were it doing the buying.

One EB advantage that is not readily apparent on the exchanges, however, is constrained compensation. Most EB health insurance includes some compensation that is only available to the worker if he elects to be on the company policy; otherwise, that money (or some of it) stays with the company. As explained above, that operates like a commitment device; a worker accepting a position with a company knows that some portion of his compensation must go toward health insurance or be forfeited. The exchanges lack such a feature. Any dollar not spent on the exchange for insurance can be used for something else.

Regulatory amenability. A regulatory advantage of the EB system is that it draped itself onto a pre-existing web of players to achieve its effects. And while the ACA illustrates the enormous effort and difficulty in creating a *new* structure—i.e., comprehensible, subsidized, community-rated exchanges—once that structure has been created, there is little regulatory advantage in *preventing* EB participants from flowing into it. The regulatory cost of additional participants is small.[86] Moreover, because the exchanges cut out the employer as middleman, the relationship will not only be easier to regulate, but the regulations will be targeted at providers of health insurance, who, relative to employers, can make a less credible threat about refusing to offer health insurance in response to consumer protective legislation.[87]

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[86] It may even be negative. If healthier people flood the exchanges, the average cost of a policy should decrease, which could reduce the subsidy the government extends to low-income exchange purchasers.

[87] *See* Sam Solomon, *Health Exchange Federalism: Striking the Balance Between State Flexibility and Consumer Protection in ACA Implementation*, 34 CARDOZO L. REV. 2073, 2083-89 (2013) (examining the success of several insurance exchanges). Current insurer refusals to participate in some exchanges markets are likely attributable to the small, sick pools in those exchanges. *See* Mark A. Hall, *Evaluating the Affordable Care Act: The Eye of the Beholder*, 51 HOUS. L. REV. 1029, 1039 (2014) (explaining reasons why insurers would leave the exchanges); Tom Murphy, *Insurers Continue to Abandon ACA Exchanges, Limiting Choices*, U.S. NEWS & WORD REP. (Aug. 16, 2016, 3:42 PM), http://www.usnews.com/news/business/articles/2016-08-16/insurer-aetna-slashes-aca-exchange-participation-to-4-

Opacity. Finally, relaxing the pro-EB restrictions would do much to combat the confused view workers and stakeholders have regarding who pays for health insurance and the implicit connection some might believe exists between having a job with benefits and whether society should make insurance available.

That health insurance has a cost, and that in an EB system workers pay for it with foregone wages, is an economic reality that it is essential to convey. Stakeholder failure to internalize that reality means all reform that moves the nation away from EB health insurance will be perceived as a move away from a system that grants employees a gift. If opening up the exchanges has the effect of employers dropping insurance, wage theory predicts that the wages of workers at those companies would rise (although those workers would then have to buy insurance on the exchange). For employers that continued to offer health insurance, wages would be comparatively less, and it would be difficult for the public to avoid seeing, by experience, the connection between wages and health insurance, and that EB health insurance (whatever its other merits) is not free for employees.[88]

B. OBJECTIONS TO UNLOCKING

Stability concerns. One reason to keep EB insurance is because the ACA reforms of the individual market might take some time to result in stable markets. Whatever the flaws of EB health insurance, it was reasonably stable. Ensuring its preservation by restricting the ability of EB players to effect a migration into the exchange markets until after they were stabilized and/or flaws were rectified makes caution the better part of valor.

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states (insurers abandon exchanges due to inability to sign up enough healthy insureds).

In fact, they continue to sell policies to employers. Interestingly, a federal judge recently held that Aetna's withdrawal from the individual exchanges was motivated by a desire to obtain leverage over the government in connection with obtaining approval of a pending merger, as opposed to an inability to make money on the exchanges. Michael Hiltzik, *U.S. Judge Finds that Aetna Deceived the Public About Its Reasons for Quitting Obamacare*, L.A. TIMES (Jan. 23, 2017, 12:00 PM) http://www.latimes.com/business/hiltzik/la-fi-hiltzik-aetna-obamacare-20170123-story.html.

[88] The point is not that this move would be free of political cost; the point is that the political cost would come with the benefit of educating stakeholders about economic reality. I realize that current times may favor neither education nor reality.

Ultimately, this objection is sensible, although it depends on empirical judgments, and comes with a time limit.

That said, the reported problems with the exchange markets largely revolve around them having too few and too sick people.[89] Undertaking reforms that make it more likely that some of the comparatively healthy employed people would participate in the exchanges is likely to *stabilize* the exchange markets, not topple them. Indeed, even if reformers are committed to eliminating the individual mandate, finding other mechanisms to use in the exchange markets to ensure they remained stable and accessible would be easier if the exchange markets had more, and healthier, employees; it might take time to see which combination of mechanisms could work.[90]

Compensation concerns. Another reason to preserve EB health insurance might be that companies dropping EB coverage will not raise wages an equivalent amount, or will not do so with respect to more vulnerable segments of the working population. While that fear may prove unlikely in the long run, in the short term, many workers could be worse off.[91]

One way to address this concern is to alter the mandate by permitting employers to satisfy it not only by offering insurance, but also by offering a stipend sufficient to buy a policy of some specified value (e.g., the median

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[89] *See* sources cited *supra* note 87.

[90] Some may object that I am failing to sufficiently appreciate the chaos of a large migration from EB to the individual exchanges. Perhaps; but it seems unlikely there is not some way to affect that migration—and benefit the exchanges with healthier people—in a way that would be less disruptive and worth the candle of largely removing employers from a system they have served in long enough.

[91] Workers being worse off would be counterbalanced (in welfare but not distributional terms) by the employer being better off, as money saved via compensation reduction would stay with the company. With respect to the relationship between wages and benefits, and the reaction of the former to the elimination of the latter, I do not intend to imply the real-world economics of that are simple. But it would be surprising if compensation-equilibrium theory were utterly mistaken. Sherwin Rosen, *The Theory of Equalizing Differences*, *in* 1 HANDBOOK OF LABOR ECONOMICS 641 (Orley Ashenfelter & Richard Layard eds., 1986) (identifying tradeoff between benefits and wages).

gold policy) on the exchange.[92] I consider the effects of using such a compensation protection mechanism in Part VI.A. below.

Underinsurance concerns. The role of individual choice in health insurance is controversial. One side ("choice advocates") offers classic arguments in favor of choice: choice is a good in and of itself; individual choice is most likely to lead to optimal outcomes because individuals best know their own preferences; and even individual choice that leads to bad outcomes is desirable because it serves as a necessary feedback mechanism for creating within citizens a sense of personal responsibility. The other side ("choice reformers") offers behavioral arguments that unconstrained choice often does not, on balance, maximize welfare, and that therefore considerable care must go into limiting or guiding individual choice such that choice is preserved, but the likelihood of bad choices is meaningfully reduced.

Choice advocates will likely see exchanges as preferable to EB insurance. Although many employers offer some choice regarding insurance, those choices are fewer than what would be available on healthy exchanges.

Choice reformers might be more cautious, and particularly with respect to the possibility of underinsurance bias. Because employers likely have a superior understanding of risk and discounting, it seems they would be more likely to properly value (and thus buy more of) insurance than would an individual on his own, even if she faces the comprehensible and constrained choices an exchange offers. Put differently, while the exchanges significantly improve the ability of an individual to make an insurance purchasing decision, they might not sufficiently counter the inclination of the individual to purchase less insurance than is optimal.

Even granting the employer is not an ideal agent, its involvement might end up leaving most employees with *more* insurance than they would have if they were choosing to spend the money on their own, where, assuming average risk preferences, the optimal choice for an employee would be more, not less, insurance. In that case, even though the employer is otherwise imperfect, it will generally avoid purchasing the cheapest, least protective insurance, because it realizes that is not the best trade-off between price and risk; in contrast, an unguided exchange purchaser might overly prioritize low cost to the detriment to future risk.

Choice advocates might either deny this outcome—by insisting that the employee is a better determiner of his own preferences—or tolerate it as

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[92] How that minimum stipend would be calculated is no simple matter, but the details of doing so are not insurmountable.

a necessary consequence of the virtue of choice. But choice reformers might worry that moving away from the EB system might eliminate a meaningful paternalistic result. If individuals are inclined to severely underinsure, and EB insurance reduces or eliminates that problem, then the other negatives of EB health insurance might be worth the price, and barriers to prevent migration away from EB health insurance make objective sense. I consider potential ways to deal with this concern below.

VI. TWO REFORM POSSIBILITIES

In this Part VI, I consider two reform possibilities that center on relaxing the anti-migration features of present law. Both suggestions rest upon the idea that permitting a meaningful portion of the employed to participate in the exchanges would have salutary effects, particularly if measures were taken to preserve certain desirable features of traditional EB approaches. In both cases, while I sketch out the contours of the suggested reforms and consider their merits, I by design leave important implementation details for resolution in later work.

A. A DIFFERENT KIND OF EMPLOYER MANDATE

The reform proposed below is based on the intuition that while unlocking the individual exchanges is on balance attractive, we may wish to do so in a way that replicates some of the advantages an EB approach confers. Before discussing the proposal, I briefly note those advantages.

First, I suspect that providing employers with an incentive to offer health insurance makes it considerably more likely that employees will have health insurance than a pure exchange-based system, even one with stronger penalties than today. Management personnel benefits (and know they benefit) from having health insurance, so having in place legal rules that encourage them to do so—while requiring that their doing equally benefits their workers—is a more effective tool to increase the number of insureds than people commonly realize. An employer benefit is a powerful default—even when (and this is never the case) the benefit could be turned down in return for the total cash value of the benefit. It takes a lot of the work out of an otherwise complicated choice; it brings the issue directly to mind; and it operates as a ready default (rather than the exchanges, which depend on a penalty to stir affirmative action). In addition, it seems likely that employers are less likely to underinsure than employees, see above. There is a way, however, to (somewhat) leverage these EB advantages without requiring

employers to offer insurance. (The way I suggest below also addresses concerns that migration to the exchanges will result in workers' compensation dropping.)

The animating idea is to convert the mandate into a funding mandate, that is, give employers the option of funding, for all fulltime employees, an exchange purchase account with an annual stipend equal to an amount set by the employer, but at no less than some minimum tied to buying a median value policy on the exchange. If no policy is purchased, the money returns to the company. If a less expensive policy is purchased, treat the difference between the policy price and stipend as taxable income to the employee. If a more expensive policy is purchased, require the additional price be paid with after-tax dollars.

The benefit of this approach is manifold. First, although it obligates employers to continue to "pay" for EB insurance, it frees them from any meaningful administrative or legal obligations—which, under both ERISA and the ACA, are significant. It would also prevent compensation declines, because, for companies that already are offering EB insurance, it amounts to little more than funding employee accounts with money that would have otherwise been paid to an insurance company.[93] And not only would it make salient to employees the cost of health insurance, it would ensure that the collective foregone wages of the employees used to buy health insurance would—just as if the company obtained a group policy—redound to the benefit of all employees equally.[94] Finally, if the employer mandate was ever lifted, companies that declined to offer exchange purchasing accounts (or health insurance) but did not raise wages would face immediate competitive pressure. It is easy for employees to realize their compensation has been cut when their exchange purchasing accounts go from having thousands of dollars in them to zero.

Second, it ties the insurance fortunes of labor to those of management while discouraging management to be stingy. A lower stipend denies all employees a tax-advantage when purchasing a more generous policy, and that tax-advantage is most valuable to highly compensated

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[93] It will, of course, lead to wage reductions for those companies that had not previously offered health insurance. But that is true of the current employer mandate.

[94] One problem with relying on wages to rise if benefits are reduced is that the collective rise in wages might not be evenly distributed among employees. While that might not be a bad thing in terms of market efficiency, it might constitute an undesirable outcome for some on distributional grounds.

employees—such as management—which would incline them to set the size of the purchase account stipend with care.

Third, it is constrained compensation: the forfeiture and tax consequences of an employee purchasing a less generous policy combat an inclination to underinsure. At the same time, it would still allow for worker choice, but in a constrained, intelligible setting: through the exchanges.

Fourth, it imposes a tax on purchasers who want to buy a policy more generous than the company funds. The size of this tax would of course depend on the degree to which individuals purchased policies more generous than could be purchased with the company stipend.

This would undoubtedly swell the ranks of the exchanges and attract insurer participation that would lead to more and better policy offerings. Few employers would continue to provide, rather than fund, EB health insurance, as they would have little incentive to endure the hassle of doing so. Indeed, the likely enormous influx of the employed into the individual exchanges, combined with defaulting all non-employed into exchange policies and strictly limiting sign up periods,[95] might very well make the exchange pools healthy and deep enough such that the individual mandate would be unnecessary to ensure stable markets.[96] And the above could be combined with a federalism twist: states could be given the freedom to abolish the individual mandate.[97]

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[95] *See* Allison Bell, *6 ACA Individual Mandate Replacement Ideas*, LIFEHEALTHPRO (Jan. 24, 2017), http://www.lifehealthpro.com/2017/01/24/6-aca-individual-mandate-replacement-ideas?page=2&slreturn=1485733601. The idea is that defaulting those without EB insurance into exchange policies will improve the exchange pool because most individuals will be insufficiently motivated to decline a policy they are defaulted into. After all, they are not paying for nothing; they actually get insurance. The more costly the value of the policy people are defaulted into, of course, the more likely they are to modify the default. Proposals that would default people into non-exchange policies will not be useful to improving the exchange pool, obviously. *See generally* Joseph Antos et al., *Improving Health and Health Care: An Agenda for Reform,* AM. ENTER. INST., (2015), http://www.aei.org/wp-content/uploads/2015/12/Improving-Health-and-Health-Care-online.pdf.

[96] I am meaningfully skeptical that this is the case; keeping the mandate would be better. But I do not share the profound distaste for the mandate those currently in power do.

[97] Senators Collins and Cassidy suggested a reform proposal that gave States freedom to pursue various reform options, including keeping or rejecting the individual mandate. Press Release, Sen. Susan Collins, Cassidy

B. NO MANDATES AT ALL (MAYBE)

A second possibility would be to eliminate the employer mandate, but use the tax-differential and management's self-interest as a way to motivate employers to fund exchange purchasing accounts for employees. Under this approach, no employer would be *obligated* to provide insurance or an exchange purchasing account; however, only insurance received through the workplace or acquired with an exchange purchasing account would be treated tax-preferentially, i.e., paid-for with pre-tax dollars.

While this would perpetuate the uneven treatment between EB and non-EB insurance purchases, it would drive some number of employees onto the exchanges, because many employers—not only to curry employee favor, but also to secure for management a tax break on *its* health insurance—would wish to fund exchange purchasing accounts in lieu of offering traditional health insurance. Although less employees would end up in the exchanges than under the proposal above, it might add to the exchanges a sufficient number of healthy workers that, combined with default enrollment of non-EB insureds and other measures, the need for an individual mandate might be avoided, or, as above, left to the decision of state officials.

This approach might raise two concerns. First, it does nothing to protect labor from losing some or all of a preexisting health insurance benefit; a company would be free to neither offer health insurance nor an exchange purchasing account, and workers losing health insurance would have to rely on market forces to replace their lost benefit with higher wages. Second, no employer mandate means no floor on the purchasing account amount an employer could establish; to the extent that some employers funded accounts insufficient to buy a level of policy society deems to reflect the proper amount of insurance, individual inclinations to underinsure would be free to operate. While an inclination to underinsure might be insufficiently strong to motivate a worker to move from a generous employer default to a bare bones policy, that inclination would certainly prevent a

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Introduce Comprehensive Obamacare Replacement Plan (Jan. 23, 2017), *available at* https://www.collins.senate.gov/newsroom/cassidy-collins-introduce-comprehensive-obamacare-replacement-plan. For a terrific and lucid discussion the appeal and limits of appeal of federalism in the health care context, *see* Nicholas J. Bagley, *Federalism and the End of ObamaCare*, Yale Law Review Forum, http://www.yalelawjournal.org/forum/federalism-and-the-end-ofobama care.

converse move. On the other hand, if less generous insurance was in general purchased, that would save the public treasury money, because the tax expenditure would be smaller. In addition, if one believes, as many economists do, that the tax break leads people to buy more insurance than is necessary,[98] the foregoing is a boon, not a flaw.

VI. CONCLUSION

The Affordable Care Act was so polarizing that sober discussions of its technical merits were rare and incomplete; too often it was simply cast as divine or diabolical and praised or cursed accordingly. Such dramatic appraisals make for good politics and entertaining television; and the election of Donald J. Trump suggests the latter and the former are one and the same.

But the world is more than politics, and the fact that—depending on the whims of President Trump—the ACA may be wiped off the books does not mean scholarly attention should be permanently directed elsewhere. In fact, there is reason to believe that, behind closed doors, a variety of reforms are being seriously entertained.[99] And even if the subjects and possibilities considered in this Article have truly been sidelined by politics, that should be no bar to serious scholarly debate about what should be. Times change, and often faster than we expect.

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[98] *See, e.g.*, Joseph R. Antos, *Is There a Right Way to Promote Health Insurance Through the Tax System?*, 59 NAT'L TAX J. 477, 478 (2006) (suggesting tax break leads to excessive purchase of insurance).

[99] *See supra* note 2.