

Social Solidarity in Health Care, American-Style

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The Affordable Care Act (ACA) reflected a significant philosophical shift in the United States from distributing costs associated with sickness based on the principle of actuarial fairness toward a social solidarity principle premised on the “goals of mutual aid and support.”¹ Yet four fixtures of American health care law complicate the translation of the solidarity ethic into real-world outcomes: (1) federalism, (2) fiscal pluralism, (3) reliance on private ordering and private markets for health coverage, and (4) an emphasis on individual rights and personal responsibility. The ACA’s approach to operationalizing solidarity insufficiently accounted for these fixtures. This ultimately limited its success and continues to threaten its durability, in ways laid bare by the 2020 coronavirus pandemic.

After tracing the philosophical evolution of health care law in the United States toward the ethic of social solidarity, this article identifies four legal fixtures of the American health care system in tension with it. Assessing the degrees to which the ACA, Medicare-for-All, and public-option proposals confront these fixtures reveals trade-offs in policy design with which reformers hoping to enhance solidarity must grapple. Health reform must navigate through the fixtures to effectuate an American version of social solidarity in health care. Successfully charting this course may demand that reformers set their sights beyond the modest aim of universal coverage and embrace a broader health justice goal.² Social solidarity in health care requires more than just getting everyone covered in fragmented health insurance pools — it requires a commitment to mutual support and a sense that the benefits and burdens of illness and our system for treating and preventing it should be shared by all in a way that is fair and just. Though the four fixtures make the path toward social solidarity in health care more challenging in the U.S., taking seriously the need to accommodate, leverage, or overcome the fixtures can help to build a mutually-funded health care system that is both durable and distinctively American.

This article’s exposition of the fixtures of American health care law and the trade-offs they force in pursuit of social solidarity offers a framework for discussion among lawmakers, policy advisers, scholars, research-

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ers, and voters as they take the next steps in health reform.

I. Social Solidarity in American Health Care Law

Social solidarity manifests as a driving ethic, a means of pursuing that ethic, and as an outcome.³ This article focuses on achievement of social solidarity in the *outcomes* of health reform. The ACA represented an important change in U.S. health reform policy because it internalized and normalized a social solidarity *ethic*. Yet the ACA's *pursuit* of a modest and compromised "universal coverage" goal and its concessions to competing interests in that pursuit limited the achievement of social solidarity in health care. Recently, the 2020 coronavirus pandemic has underscored these limitations in the ACA's approach to and achievement of social solidarity outcomes, while giving social solidarity added prominence in the national conversation.⁴

A. The Evolution toward a Social Solidarity Ethic in American Health Care Law

Other countries have developed collective financing and administration schemes built on a principle of mutual aid.⁵ In the U.S., however, a decentralized, free-market approach highly deferential to individual choice and personal responsibility has prevailed.⁶ In the early twentieth century, health care providers organized themselves into prepaid insurance plans and employers began to offer health coverage as a benefit to workers.⁷ In 1965, the federal government created Medicare and Medicaid to cover three overlapping groups who were left out of our market-driven private insurance system: people of retirement age, people with qualifying disabilities, and children and some adults living in low-income households who were deemed deserving of public support.⁸ Government administrators took a relatively hands-off approach to prices and utilization, eschewing the negotiating power that publicly-administered programs elsewhere in the world exert to check rent-seeking by providers, and thereby allowing private insurers to reap substantial profits.⁹

As Deborah Stone has argued, the private health insurance on which most Americans rely fosters in people "a sense of their difference, rather than their commonalities, and their responsibility for themselves only, rather than their interdependence,"¹⁰ leading to the fragmentation of "communities into ever-smaller, more homogeneous groups."¹¹ Although private health insurance is subsidized through laws that exempt health care benefits from payroll and income taxes,¹² the relatively well-off households who disproportion-

ately benefit from these indirect subsidies are protected from the stigma that attaches to dependence on public benefits.¹³ Moreover, reliance on private markets to dictate the distribution of health care goods and services has allowed Americans to avoid difficult public deliberations over which people and which conditions should trigger collective responsibility for health and well-being.¹⁴

In some ways, the ACA was a fairly modest extension of what came before. Its primary goal was to achieve "universal coverage" — a source of third-party funding for health care costs — rather than fully securing universal access to care. The ACA's core compromise on coverage preserved the existing fragmentary mix of public and private sources, rather than replacing it with a truly universal and unified system.¹⁵ It excluded undocumented immigrants and (after the Supreme Court's decision in *NFIB v. Sebelius*¹⁶) many people living in states that have rejected federal financing to expand Medicaid eligibility remain uninsured. The ACA subsidized private insurance rather than dismantling it.

In other ways, the ACA was a watershed moment that reflected and reinforced a general trend away from actuarial fairness in American health care. It expanded Medicaid eligibility beyond the groups who have traditionally been understood as the "deserving poor" (children, pregnant women, and people with disabilities). It offered direct subsidies to make private insurance more affordable for additional low- and middle-income households. It fundamentally altered the free-market business model of health insurance — in which each paid according to her likely needs — by sharply limiting underwriting-based factors related to health status in the individual and small group markets. These developments simultaneously signal the emergence of a new approach emphasizing a social solidarity ethic and pave the way for its fuller realization in social solidarity outcomes.¹⁷

B. Reforms' Goals and Objectives

This philosophical evolution brings us to the current moment in health reform: one decade into the Affordable Care Act's implementation, experience with the limitations of the ACA's approach has focused national debate on how to transcend those limits. Most Americans wish to preserve the ACA's progress.¹⁸ The populace also recognizes a need for further reform, but diverges on the best approach and the role that government should play.¹⁹

A slight majority of Americans now for the first time support the basic idea of a single national health plan, though that majority also belies a deep divide along partisan lines and varies with the terminology

used to describe a national plan.²⁰ Public support for expanded national health care finance has prompted progressive lawmakers to introduce proposals for implementing single-payer systems at the national and state levels.²¹ Every Democratic candidate in the 2020 presidential race supported expanding public finance of health care either through a single-payer model (e.g., Medicare for All) or expanding access to existing public programs by creating a buy-in option (e.g., Medicaid or Medicare public option).²²

The stated goals of these single-payer and public-option proposals reflect some consensus among supporters about what needs fixing in the current system, and how they believe expanding access to publicly financed health care will help. Health reform momen-

tives of single-payer and public-option reforms push beyond universal coverage toward solidarity, often expressed in terms of a universal *right* to health *care*,²⁸ not merely universal *access* to health *insurance*.

Proponents of expanded national health care highlight cost-control as a primary goal of reform. Controlling health care “costs” requires effort on two fronts: national and household.²⁹ On a broad scale, health reforms aim to reduce the drain of health care spending on the national economy by lowering the net costs of health care from all sources, especially spending through government programs. Relatedly, proposals seek to reduce the financial drain of health care on individuals and households by lowering out-of-pocket spending on premiums, deductibles, copays, coin-

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tum from the political left currently coalesces around three intertwining objectives: Improving population health, achieving universal and equitable access to care, and controlling health care costs — both for the country and for households.

Proponents of federal Medicare and Medicaid expansions point to evidence that America spends more on health care than its economic peer nations, but does not deliver better health outcomes at the population level.²³ The version of Medicare for All introduced in the U.S. House in January 2019 would require annual data collection and reporting on population health outcomes and disparities, state-by-state.²⁴ State-level reforms also target better health outcomes at the population level.²⁵

Focusing on improvement in population health outcomes and identifying the social determinants that influence those outcomes points to the related objective of establishing meaningful, equitable access to good health care. Universal coverage for all Americans is a top priority for supporters of a national health plan,²⁶ and was a goal of the ACA.²⁷ The stated objec-

tures, and uninsured care. The ACA’s multi-payer reforms slowed the growth in health care spending for the first time in decades, but its very limited progress controlling costs for individuals and households has opened the door to wider support for single-payer reforms.³⁰

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II. Social Solidarity's Mismatch with Fixtures of American Health Care Law

Although the ACA advanced an ethic of social solidarity in health care, realization was frustrated by four legal fixtures of the U.S. health care system that stand in tension with social solidarity: (1) our federal system of dual sovereignty between the national and state governments, (2) the subdivision of responsibility for health care costs among a multiplicity of payers; (3) our historical reliance on private ordering and private markets for health coverage; and (4) an abiding emphasis on individual liberties and personal responsibility. We refer to these existing features as “fixtures” because structural and political entrenchment, as well as longstanding normative commitments, make them difficult to displace. These four fixtures of federalism, fiscal pluralism, privatization, and individualism tend to work against social solidarity in health care in distinctive ways, which next-step health reforms must confront.

A. Federalism

Health care regulation in America must account for both state and federal policymakers and their fluid, regionally-sensitive political relationships. In particular, the sovereign powers of states within the American federal system — and the prevailing narratives of deference to them — have shaped the trajectory of health care regulation in ways that divide (and thereby undermine social solidarity) on a national scale and diverge from other countries' experiences. This “federalism” fixture we have identified refers to both the American system of dual sovereignty between the national and state governments established by the Constitution,³³ and the political and jurisprudential narratives of comity and deference to state authority that drive federal policies and their implementation.³⁴ The duality and malleability of American federalism arms opponents of solidarity in health care with legal weapons to challenge both the establishment of nationwide reforms in the name of deference to states, and to challenge the establishment of individual state reforms in the name of preemptive national uniformity.

Solidarity and federalism can coexist, as they do in other countries, and the U.S. Constitution's federalism structure is not unavoidably antithetical to social solidarity.³⁵ The Constitution's enumeration of federal legislative power ostensibly limits the federal regulatory spheres,³⁶ while the Tenth Amendment reserves the mass of un-enumerated regulatory powers to state governments.³⁷ When Congress makes federal law within its enumerated spheres, the Supremacy Clause subordinates conflicting state laws through preempt-

tion.³⁸ Modern constitutional jurisprudence comfortably extends federal legislative power to cover the establishment of a universal, nationwide health plan and the levy of various taxes to fund it.³⁹ On that same constitutional foundation, federal law has built the dominant share of the existing health care regulatory infrastructure since World War II, through Medicare, Medicaid, ERISA, HIPAA, and the Affordable Care Act.⁴⁰

American federalism's delicate political accounting for state autonomy has obstructed the path toward a full embrace of social solidarity. Federal reforms do not necessarily need to cede power to state preferences or rely on state implementation, but Congress frequently does so voluntarily to achieve limited political consensus.⁴¹ Even with such concessions, resistant states or other opponents of federal policies have not been shy about challenging the boundaries of federalism through litigation. Courts' inconsistent reliance on a narrative of comity and deference to states has further complicated efforts to establish national protections.⁴²

Deference to states' autonomy, even within a federally-funded regulatory infrastructure, can entrench existing disparities between states and the populations that inhabit them. The Medicaid program, for example, employs a cooperative federalism design in which states choose whether to implement the program and may negotiate states of some of the terms on which they will receive funding. Statutory waivers enabled some states to pursue more expansive solidarity models and extend coverage to all low-income residents. The federalism narrative of state autonomy versus federal coercion in *NFIB v. Sebelius*, by contrast, enabled states governed by those hostile to solidarity to reject the ACA's federal Medicaid expansion and emboldened them to negotiate waivers that undermine social solidarity goals, such as imposing work requirements.⁴³

Other key features of the ACA intentionally deferred to state authority in the process of national reform,⁴⁴ diluting the statute's universal coverage strategy. Reliance on state implementation of the exchanges and the provision of a waiver for states to deviate from certain national protections in the name of “State Innovation” serve as two prominent examples,⁴⁵ while the resort to state definitions for federal essential health benefits represents another.⁴⁶ Political bargains struck in the spirit of voluntary deference to the states have spurred opportunistic variations in policy and exacerbated some interstate disparities,⁴⁷ offsetting gains in health equity produced by more durable federal baselines.⁴⁸ For example, in 2018 HHS issued guidance stating that it would base state waiver decisions on a measure of whether the state plan would preserve a

level of “access to” coverage, rather than actual enrollment in coverage.⁴⁹ Those solidarity-diluting concessions do not insulate federal statutes from direct attacks through state litigation, either, as illustrated by state attorney general litigation against the ACA.⁵⁰

These developments illuminate the federalism fixture’s pliability. Federalism can be wielded in ways that reinforce state autonomy or deny it.⁵¹ Similarly, state power does not act intrinsically for or against social solidarity, but depends on the preferences of those wielding it. State autonomy may frustrate federal law’s efforts to establish nationwide protections. But the preemptive power of federal law can hinder state experimentation with solidarity-enhancing policies. For example, the federal Employee Retirement Income Security Act of 1974 (ERISA) preempts states from enforcing regulations that impermissibly “relate to” the employer-sponsored health benefits, a major deterrent to states wishing to pursue their own solidarity-enhancing reforms.⁵²

B. Fiscal Pluralism

Fiscal pluralism is another distinctive fixture of American law that influences the attainability and shape of social solidarity when it comes to Americans’ health. By “fiscal pluralism,” we mean a tendency to divide costs associated with Americans’ sickness and health into separate, fiscally disintegrated categories. Sometimes referred to as “fragmentation,” we refer to this phenomenon as “pluralism” to highlight the underlying tendency toward division, which produces fragmentation. Fiscal pluralism impedes the realization of solidarity by giving decisionmakers — providers, patients, caretakers, and policymakers — economic incentives to ignore the impact of their choices on benefits and burdens in fiscal categories for which they are not responsible. (In economic terms, it creates positive and negative externalities.)

Consider the division of responsibility for health care costs incurred by individuals who become sick. States pay a share of health care costs incurred by Medicaid enrollees and lose income tax revenues not paid by sick residents or caretakers who forego paid work in favor of care work.⁵³ The federal government pays a large share of health care costs for Medicare enrollees⁵⁴ and pays a significant share of health care costs for Medicaid beneficiaries, TRICARE beneficiaries, ACA enrollees, and employees enrolled in group health plans (which are subsidized in part by federal tax expenditures).⁵⁵ Private companies pay a large share of health costs for employees and their dependents via health benefits. Though employers pass much of this cost on to employees in the form of reduced wages, the employees subsidize each other’s

costs. Patients pay a significant share of their health care costs through cost sharing, in addition to secondary costs of illness including lost wages and reduced resources for housing, transportation, or nutrition.⁵⁶ Finally, loved ones of patients pay a significant share of health care costs through unreimbursed care work, as well as contributions toward financing uncovered or unaffordable treatments.⁵⁷

Consider also the different division of responsibility for upstream health investments which might reduce the costs of cure and sickness among numerous actors and categories. Although governments (state and federal) may fully fund health care investments, they choose piecemeal which investments to pursue. Government costs are often further fragmented at the level of individual actors or programs. Federal budgeting rules, for example, treat “mandatory” expenditures on programs like Medicare and Medicaid as distinct from “discretionary” expenditures on programs like the SUPPORT Act’s funding for substance use disorder treatment and recovery.⁵⁸ These rules require that increases in mandatory spending be offset by decreases in mandatory spending, and that increases in discretionary spending similarly be offset by discretionary decreases.⁵⁹ Similarly, state spending is often separated by department and program; Elizabeth Weeks’ recent work has shown the many different dimensions on which states and localities have been impacted financially by the opioid crisis.⁶⁰ Moreover, individuals, families, employers, and charitable organizations pursue a variety of health investments.⁶¹

This fiscal pluralism encompasses byproducts of other fixtures of American law. Federalism divides between federal and state; privatization divides between government and the market; emphasis on individual rights and responsibilities facilitates the continuing invisibility of care work relative to other more visible components of patient care.⁶² Fiscal pluralism nonetheless takes a form distinct from the other fixtures and captures a descriptive account of the health care finance system that opponents of single-payer reforms raise as normative support for the status quo. Pluralism can be desirable in certain contexts: in a market where unification means competition-stifling monopoly; to particularly vulnerable populations, who may benefit from distinctive treatment and a separate “risk pool” in order to receive care tailored to them and promote equity; to classical liberals who favor the idea of an autonomous, independent individual as a societal building block; and to experimentalists who see in pluralism the potential for continual learning and improvement through diversity.⁶³

C. Privatization

Preference for private markets over government intervention is the foundation of the US economy, a fixture of American law, and an obstacle in the path of social solidarity in American health care. Collective choice of the goods and services essential for human well-being, and collective financing to secure such goods and services, is typically viewed as an exception requiring justification, rather than the norm.

Most Americans are covered by private health insurance,⁶⁴ and most of them pay for coverage jointly with an employer as a fringe benefit. The longstanding favorable tax treatment of these benefits subsidizes private insurance.⁶⁵ ERISA also encourages large private employers to offer health benefits by shielding them from state regulation.⁶⁶ The ACA doubled down on private health insurance as the predominant model. Rather than further extending public programs, the ACA established new tax credits for the purchase of private coverage on the exchanges.⁶⁷ In addition, the ACA's employer mandate⁶⁸ and restriction of premium-assistance tax credits to households that lack access to affordable employer-based coverage strengthened the link between health insurance and employment.

Private health insurance companies play an important role in public programs, too. From its inception in 1965, Medicare has relied on private insurers to issue coverage determinations governing which goods and services are covered for which patients and to process claims for reimbursement.⁶⁹ The Balanced Budget Act of 1997 took privatization of Medicare further by giving beneficiaries the option of enrolling in one of many government-contracted private health plans.⁷⁰ When Medicare benefits were expanded to include prescription drugs in the Medicare Modernization Act of 2003, Congress dictated that these benefits could only be provided through fully privatized plans.⁷¹ Currently, about one-third of Medicare beneficiaries are enrolled in private Medicare Advantage plans. And for the two-thirds of beneficiaries enrolled in traditional Medicare, day-to-day coverage decisions are made by private insurance companies.

Private health insurance companies play an even bigger role in Medicaid, with about 70% of all Medicaid enrollees covered by Medicaid Managed Care plans,⁷² the vast majority of which are run by private insurance companies.⁷³ States first began to experiment with privatization via administrative waivers under Section 1115.⁷⁴ The Deficit Reduction Act of 2005 gave states the option of offering alternative Medicaid benefit packages — all of which are subject to far more flexible federal oversight and most of which are privately administered — for specified

groups of Medicaid beneficiaries without any need for a waiver.⁷⁵ When the ACA expanded Medicaid eligibility, it specified that the expansion population *must* be covered through alternative benefit plans.⁷⁶

Our fragmentary system of private and public administration has allowed lucrative and highly segmented private markets for health care goods, services, and coverage to thrive. By relying on private companies to make coverage determinations — even in public assistance programs — lawmakers have eschewed opportunities for deliberative, democratic, collective problem-solving on the essential question of which individuals will be allowed affordable access to which treatments for which conditions. Although underwriting reforms that restrict individualized rate-setting and eligibility determinations by private insurance companies have shifted us closer to collective financing based on a principle of mutual aid, the multitude of privately administered risk pools and reimbursement arrangements stymies the realization of true solidarity in American health care.

D. Individual Rights and Responsibilities

The emphasis on individual rights and its converse, personal responsibility, are another foundational aspect of American law. Both forms of individualism challenge the realization of social solidarity in health care; assertions of individual liberty have been used to limit the government's ability to effectuate universal health reforms, and notions of personal responsibility have enshrined individual cost-sharing as a central feature of health care consumption despite limiting access and affordability.

Without a positive right to health care under the U.S. Constitution, individual rights are expressed as the negative right to be free from government interference in health care decisions. The focus on individual liberties as a limitation on governmental regulation, however, has proven a formidable obstacle to health reform efforts intended to promote solidarity.

The fixture of individual liberty manifests as legal limits on Congress's ability to require individuals to participate in commerce, including the purchase of health coverage. In *NFIB v. Sebelius*, the Supreme Court held that Congress lacks the power under the Commerce Clause to enact the ACA's individual mandate, which required most people to purchase a minimum level of insurance coverage or else pay a penalty,⁷⁷ concluding, "The individual mandate forces individuals into commerce precisely because they elected to refrain from commercial activity. Such a law cannot be sustained under a clause authorizing Congress to 'regulate Commerce.'"⁷⁸ Although the Court upheld the individual mandate as a tax, Congress in 2017

effectively nullified the individual mandate by zeroing out the penalty.⁷⁹ The saga over the ACA's individual mandate illustrates the view that an individual's right to be free from federal governmental coercion supercedes Congress's authority to provide for comprehensive health coverage through commercial regulation.

In a similar vein, the clash between individuals' religious liberty and comprehensive health reform has generally been resolved in favor of the right to opt-out of health care obligations based on religious objections. In *Burwell v. Hobby Lobby*, the notion of individual religious liberty was extended to include the rights of closely held private corporations to opt-out of compliance with the ACA's so-called contraceptive mandate,⁸⁰ when covering contraception conflicted with the corporate owners' religious beliefs.⁸¹

Both *NFIB* and *Hobby Lobby* illustrate how an expansive notion of individual liberty, particularly in the commercial sphere, complicates and limits the regulatory mechanisms available to the federal government to achieve social solidarity in health care. Like vaccination's herd immunity, efficient health care financing and optimal population health are undermined by fragmentation and improved through universality, so recognizing a strong right for natural or corporate persons to opt-out of components of a national health care system — whether for ideological, commercial, or religious reasons — limits the ability of the federal government to effectuate solidarity in health care.⁸²

The flipside of individual liberty is an emphasis on personal responsibility that has driven a push for consumerism in health care. Giving individuals more “skin in the game,” so the theory goes, will make them more frugal consumers of health care and encourage them to make healthier choices.⁸³ Doing so also perpetuates anti-solidarity norms of actuarial fairness, even in government-financed health coverage that requires cost sharing. The ACA encouraged consumerism by continuing to fuel the rise of high-deductible health plans.⁸⁴ A consumer approach, however, ignores the realities that patients are largely unable to act as consumers due to widespread market failures and non-shoppability of health care and that many illnesses or conditions are not manageable with lifestyle changes.⁸⁵ As a result, though insurance coverage increased under the ACA, a growing number of people are underinsured, driving a health care affordability crisis.⁸⁶ Public opinion may be turning against consumerism as a panacea to health system dysfunction, but the narrative of personal responsibility and a stubborn faith in markets remain embedded in debates over how to distribute health care resources and control system costs.

III. Navigating the Fixtures toward Social Solidarity, American Style

The next steps in health reform, we argue, should shift focus from means (like “Medicare for All”) toward an embrace of social solidarity outcomes in health care as a shared goal. Social solidarity outcomes are those which result in the just distribution of the burdens and benefits associated with health according to a mutual aid principle.⁸⁷ Some might assume that the “means” of universal coverage will automatically produce solidarity in outcomes. But the fixtures we have identified in the United States make universal coverage more difficult to achieve and therefore a necessary but not sufficient tool for producing solidarity in outcomes. Any health reform proposal that aspires to put solidarity into practice must navigate, leverage, or overcome these four fixtures to be both feasible and durable. Doing so will produce a health system distinct from the comparator models established in other countries.⁸⁸ In other words, pursuing health reform through the maze of these fixtures may produce social solidarity, American style.⁸⁹

Confronting a fixture prompts policy choices, which manifest as selection of design options: (1) relative degrees of control by state versus federal governments (federalism); (2) financing derived from federal, state, and private sources (fiscal pluralism); (3) role of private entities (privatization); and (4) degree of choice in individual participation (individualism). Each set of choices presents trade-offs between individualism and social solidarity.

The policy choices in current proposals for expanding toward universal coverage confront the four fixtures to varying degrees and illustrate the influence of these four fixtures on American-style social solidarity in health care, as we explain in detail below. Figure 1 summarizes the degree of confrontation with each of the four fixtures among federal-level proposals for single-payer or public-option reforms, as compared to the ACA. Figure 2 summarizes the degree of confrontation for similar reforms proposed to be implemented at the state level.

A. State or Federal Control

Any legislation seeking to establish universal health care will confront the fixture of American federalism in deciding what ratio of federal and state authorities should administer it and what mix of regulatory baselines and regional variations to employ. A high degree of confrontation in federal legislative design relies heavily on federal authority and control, cedes little to state variation, and explicitly preempts or supplants existing spheres of state regulatory power. For this uniformity, a highly-confrontational design

Figure 1

Federal Health Reform Proposals' Confrontation with Four Fixtures

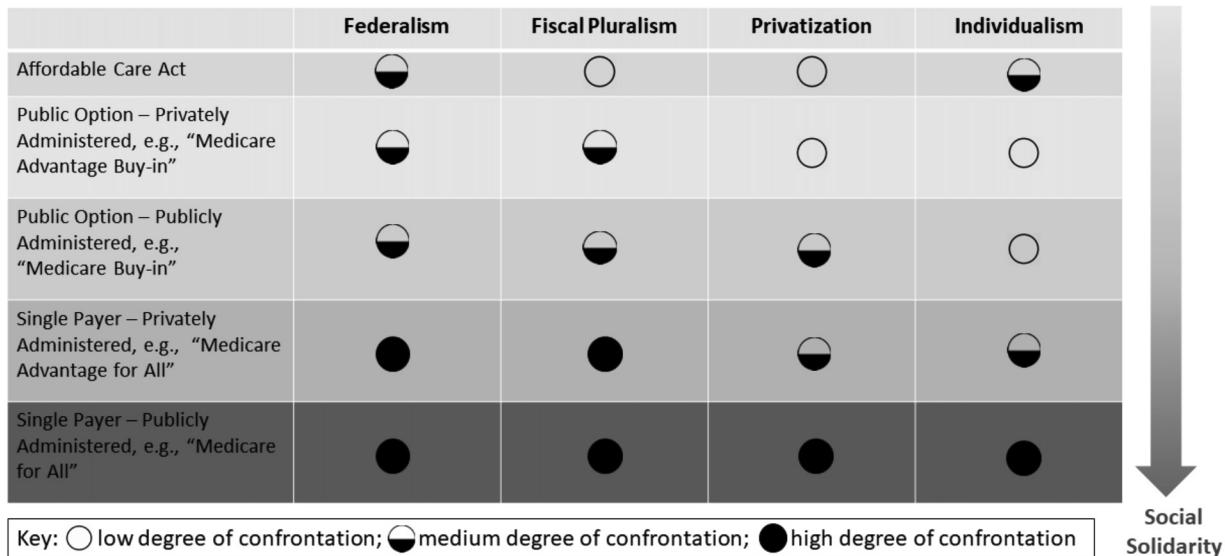
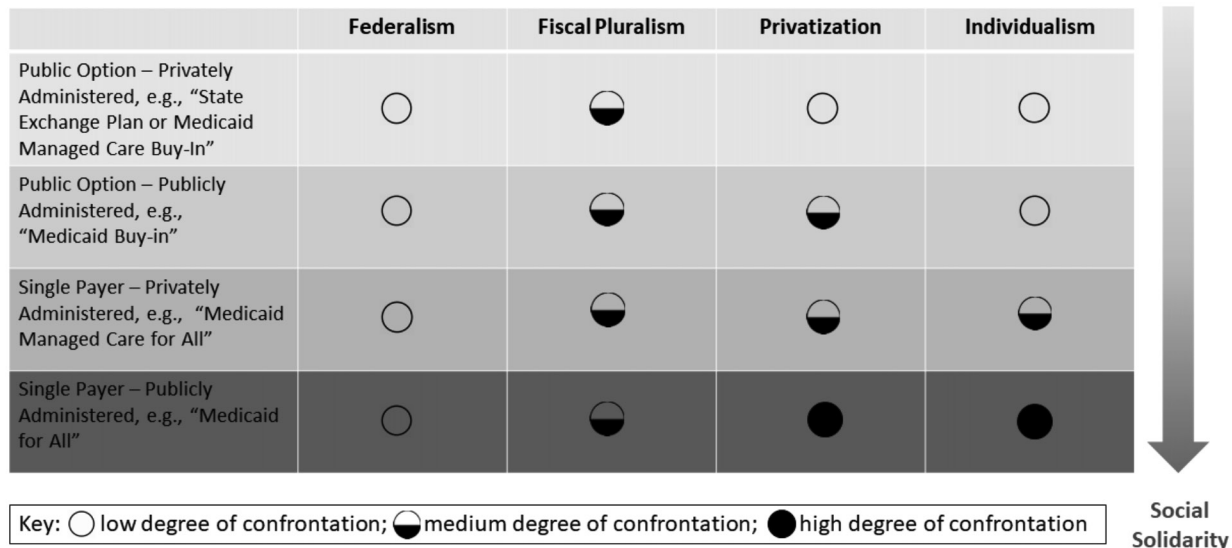


Figure 2

State Health Reform Proposals' Confrontation with Four Fixtures



trades away some of the accountability, adaptability, and potential for experimentation from shared state-and-federal control. Reforms with a low degree of confrontation with the federalism fixture, by contrast, mitigate their expansions of federal authority with state implementation, expressly preserve existing state authority, and fund state variations on federal policy by encouraging them to negotiate statutory waivers. For this cooperation and adaptability, a minimally-confrontational design trades away some

of the solidarity-enhancing potential of national standards.

The ACA’s incremental approach to the existing multi-payer system internalized federalism’s prevailing narratives, largely demurring to the federalism fixture, even as it enacted some important nationwide reforms. The portions of the ACA that confronted federalism by establishing strong nationwide rules — like the availability of subsidies to purchase insurance and the requirement that commercial insurers offer poli-

cies to anyone who can pay for it on the exchange — have had the greatest impact on overall population health and household cost-control. Those portions that invite state variation and negotiation, such as the Medicaid expansion (after *NFIB v. Sebelius*) and the waiver provision for “State Innovation,” have curtailed those gains in some states.⁹⁰

The national single-payer system contemplated in Medicare for All proposals confronts the federalism fixture directly in ways the ACA declined to do.⁹¹ Medicare for All would make federal finance and administration the sole source of health care payment.⁹² This would subsume most, if not all, of the Medicaid program and thereby eliminate a cooperative-federalism program in favor of a fully-federal one. “In addition to transferring fiscal responsibility” from state to federal control by shuttering Medicaid, “the [Medicare for All] proposals would shift the role of designing and implementing much of health policy from states to the federal government.”⁹³ Further, Medicare for All extends federal financing authority and control over the entire commercial market for health insurance, still regulated in significant part by state authorities. By eliminating private insurance, Medicare for All proposals directly confront federalism by eliminating this longstanding area of state regulation and source of state-by-state variation.⁹⁴

Proposals that preserve the multi-payer system, but add an option to buy into a public program confront federalism to a lesser degree by retaining the heavily state-regulated private insurance, while potentially expanding the portion of the population covered by programs under federal control. The choice of *which* government program to expand — Medicare buy-in versus Medicaid buy-in — also has implications for the degree of federalism confrontation. Medicare buy-in confronts federalism to a higher degree because it expands public participation in a program that is entirely under federal control. Medicaid buy-ins offer slightly more concession to state variability because they extend a program that already admits state-by-state variation. Federal legislation could alter the baseline structure of the Medicaid program to make a buy-in a mandatory feature of Medicaid, though such a provision would have to contend with the anti-state coercion precedent from *NFIB v. Sebelius*.⁹⁵ Medicaid buy-in proposals that would make a buy-in an optional feature for participating states⁹⁶ additionally accede to the federalism fixture and dilute the solidarity-enhancing effects of a public option.

To be feasible, universal reforms enacted at the *state* level — as illustrated in *Figure 2* — must adapt to the strictures of federalism, rather than confronting them directly.⁹⁷ Federal legislation may invite state partici-

pation through funding programs and by delegating implementation of other aspects of federal law. State legislation, however, generally has no mechanism to invite additional federal control except by incorporating existing federal standards. Similarly, states have few mechanisms to diminish federal control, except by complying with federal law. When state regulation treads on spheres of federal authority or contradicts duly-enacted federal law, preemption negates the state law.⁹⁸ State-level proposals for single-payer systems or state Medicaid buy-ins thus tend to work within of existing federal programs, using existing federal waiver provisions to “repurpose” federal funding streams⁹⁹ and seek federally-authorized variations.¹⁰⁰

B. Federal, State, or Private Financing

A central question in designing a health care system is “who pays?” Potential payers include individuals and families, employers, providers, the community, states, or the federal government. For example, most Americans are today enrolled in employer-sponsored insurance that is paid in part by them and in part by their employers.¹⁰¹ Meanwhile, half of births and nursing home stays are paid for in part by the states and in part by the federal government through the Medicaid program.

The “who pays” question is incomplete without also asking “and for what?” Our system separates health care coverage costs by types of risk and divides risk-bearing among entities. With high deductibles, individuals bear the risk for routine medical care. The risk of illness is divided between the insurance plan (which pays for most medical care, less cost sharing) and the sick individual and her family (who pay for cost sharing, lost wages, and home care as needed), and providers (to the extent that they cannot collect on patients’ bad debt). The risk of catastrophic illness, meanwhile, can be carved off and borne by another entity like a state or federal government, as seen in the ACA’s reinsurance program.

And that is just the risks related to individual illness. A health care system must account for still more risks and, again, divides these risks among entities. The risk that the individuals who enroll in a particular insurance plan will be unexpectedly unhealthy (known as adverse selection risk) is borne by default by whoever operates that plan (and so paid for by whoever pays for it). But this adverse selection risk can be carved off and borne by another entity; for example, the ACA’s risk corridors program put some such risk on the federal government.¹⁰² More broadly, the risk that an economic downturn will simultaneously increase demand for services and reduce revenue to pay for it by reducing individual incomes and the state and local

tax revenues they support (known as business cycle risk) drives the design of federal and state health care programs.

The fixtures of American law generally favor this division of responsibility for health care costs, though they do not do so uniformly. Standing alone, the individual rights and responsibility and privatization fixtures both tend to favor giving individuals full responsibility for their health care costs rather than dividing such costs among individuals, employers, states, and the federal government. Professors Silver and Hyman endorse a proposal grounded in these two fixtures: give each resident a voucher reflecting federal and state health care subsidies, but then leave it to the individual to bear full responsibility for how they choose to spend those subsidies and bear the costs associated with illness.¹⁰³ By contrast, the federalism and plural-

sible for lost wages and care work costs, in deference to the pluralism and individual rights and responsibilities fixtures. Second, again in deference to fiscal pluralism, Jayapal's proposal leaves fragmented responsibility for financing investments in the social determinants of health, concentrating only responsibility for the downstream medical costs that result from a lack of such investment.

Senator Sanders' similar Medicare for All proposal accommodates the fixtures to a greater degree than Jayapal's proposal in two ways. First, the Sanders proposal retains a role for states in financing health care costs; certain existing state contributions are locked in place through a maintenance of effort provision.¹⁰⁶ Second, the Sanders proposal includes nominal cost sharing in the form of limited copays for certain services.¹⁰⁷

Survey questions and political campaigns typically assume a stark distinction between “private insurance” and “government administered health plans.

In reality, the line between the two is not always clear. What does “government administered” mean in a market where about one-third of Medicare enrollees and nearly 70% of Medicaid enrollees are covered by private health insurance plans? Proposals to provide public health insurance modeled on expanding Medicare or Medicaid to all must grapple with the role of private insurers, especially in light of how deeply embedded they are in our existing public programs.

ism fixtures favor the dispersal of responsibilities evident in our current financing system, which assigns costs as well to states, employers, and providers.

Potential reforms all confront the fixtures by concentrating financial responsibility for health care costs to greater degrees than the status quo, though some fragmentation remains under all existing proposals. The most unitary proposal, Representative Jayapal's Medicare for All proposal, would concentrate responsibility for all direct costs of medical care in the federal government.¹⁰⁴ State contributions, employer contributions, and contributions by sick individuals through cost sharing would all be eliminated. Indeed, even provider responsibility for patient bad debt and costs incurred by the uninsured are eliminated, as the plan eliminates cost sharing and covers all residents, regardless of citizenship status or prior enrollment.¹⁰⁵

That said, the proposal's confrontation with the fixtures is incomplete in two ways. First, Jayapal's proposal leaves sick residents and their families respon-

Where the financing structure for Medicare for All confronts fiscal pluralism, the structure for the Affordable Care Act largely accommodated it by adding to the complex division of responsibility for health care costs in the American health care system. The law left in place the underlying multi-payer system and created in the exchanges a new financing mechanism paid for in part by individuals, administered in part by states, and operated largely through private insurance markets. The ACA sought to finance the costs of insurance in the individual market in part by forcing healthy individuals into risk pools with less-healthy individuals, but the individual mandate that facilitated this broader risk pooling also brought the law in conflict with notions of individual liberty.

The ACA's framework also maintained numerous institutions that disperse responsibility for health care costs: reliance on employer sponsored insurance to cover a plurality of residents, division of federal and state responsibilities and liabilities, cost sharing

borne by sick individuals (and providers when bills go unpaid), and a significant uninsured population (including non-citizen residents) whose care costs would be borne by providers (and perhaps reimbursed by the federal government indirectly through disproportionate share hospital payments). Current “public option” proposals would build on that framework, increasing the level of confrontation with the individual responsibility fixture somewhat by increasing the generosity of federal subsidies for premiums and cost sharing, without making any fundamental changes.¹⁰⁸

C. Public versus Private Administration

Survey questions and political campaigns typically assume a stark distinction between “private insurance” and “government administered health plans.”¹⁰⁹ In reality, the line between the two is not always clear. What does “government administered” mean in a market where about one-third of Medicare enrollees and nearly 70% of Medicaid enrollees are covered by private health insurance plans? Proposals to provide public health insurance modeled on expanding Medicare or Medicaid to all must grapple with the role of private insurers, especially in light of how deeply embedded they are in our existing public programs.

The ACA took a highly deferential stance toward the dominance of private insurance. It expanded eligibility for Medicaid, but specified that the newly-eligible population must be covered by alternative benefit plans, the vast majority of which are operated by private insurers. For people earning between one and four times the poverty line, the ACA offered subsidized private insurance, rather than public coverage. A proposal to create a public option that would compete for enrollment against private plans on the exchanges was dropped from the ACA in a political compromise.¹¹⁰

In contrast, some Medicare for All proponents confront privatization head-on by promising to eliminate private insurance.¹¹¹ But what does that mean in a system that currently relies on private insurance companies to administer public benefits? Would the traditional Medicare program continue to rely on private insurance companies to administer local coverage determinations and process claims? Would the (currently privatized) Medicare drug benefit be converted to a publicly-administered plan? Would Medicare Advantage plans continue to be offered to enrollees as an alternative to traditional Medicare?

More moderate reformers propose to open access to public programs while preserving — or even expanding — the role of privatized public coverage.¹¹² These approaches would technically enroll everyone in a single program while allowing private insurance plans to thrive within that program. Reform mod-

eled on “Medicare Advantage for All” could allow any citizen or lawful permanent resident to enroll in the privatized Medicare plan of her choice. It could do so with or without giving enrollees the option of choosing traditional Medicare. “Medicare Advantage Buy-In” could allow privatized, government contracted Medicare plans to be offered on the health insurance exchanges alongside direct-purchase private insurance. Private insurers would bid on contracts with the federal government to offer coverage in exchange for a combination of risk-rated, capitated payments by the government and premiums paid by enrollees. Similarly, proposals to open up privatized Medicaid coverage to all state residents (“Medicaid Managed Care for All”) or as an alternative to direct-purchase insurance on the state health insurance exchange (“Medicaid Managed Care Buy-In”) would be operationalized through a bidding process at the state level, followed by an open enrollment period in which residents choose from among multiple private plans and pay a premium to supplement state funding. Indeed, “public option” reforms scheduled to be implemented at the state level within the next two years direct state agencies to contract with private health insurers to offer privatized public coverage — *not* traditional Medicaid benefits — to buy-in enrollees.¹¹³

Proposals to open access to privatized public coverage to all or more Americans raise crucial questions. Foremost among them: what difference would it make? Does privatized public coverage offered pursuant to a government contract offer any advantages over directly-purchased private insurance with subsidized premiums? Can privatized public coverage serve the goals adopted by single-payer and public-option proponents? Can it move us closer to social solidarity in American health care? Perhaps the most promising aspect of privatized public plans is that they could allow state agencies or CMS to use the contracting process to take a more hands-on role in shaping how health care providers are paid by private health plans. Washington state’s public option legislation, initially specified that the state-contracted plan would compensate providers at Medicare rates, which are considerably lower than payments offered by most direct-purchase and employer-based plans. State lawmakers eventually “watered down” the proposal by adopting a cap at 160% of Medicare rates, but that still represents a significant change from the status quo.¹¹⁴ Setting aside the potential cost savings, in terms of social solidarity, public debate over appropriate reimbursement rates brings us closer to collective problem-solving regarding unsustainable health care price increases. But caps on the reimbursement rates government-contracted private health plans can pay to providers would be a

far cry from universal enrollment in a single, publicly administered, shared risk pool.

D. Degrees of Choice and Cost-Sharing

Health reforms must contend with the two sides of individualism — individual liberty and personal responsibility. The primary policy manifestations of this confrontation are the degrees of *choice* left to individuals to select their form of health coverage or opt-out altogether and of *cost-sharing* for individuals to retain some personal skin-in-the game for their health care consumption.

1. CHOICE

American-style social solidarity health reforms confront the fixture of individual liberty in the form of optionality and choice. The design question is whether everyone is automatically enrolled in the government health plan (e.g., Medicare for All) or whether they have the option of enrolling in the government plan (e.g., Medicare for All Who Want It).

The ACA contained both optional and universal components to its reforms. It preserved options for private coverage by providing a choice of regulated health plans on the exchanges. But the ACA took a universal approach for those eligible for Medicaid under the expansion. Non-immigrant adults between 19–64 years of age with incomes below 138% of the federal poverty level have little choice but to enroll Medicaid or forego coverage,¹¹⁵ because private coverage options are unaffordable.

There is a spectrum of choice in universal health reform design. At one end, everyone would be enrolled into a public plan covering standardized benefits and all providers. This universality is exemplified in Sanders' Medicare for All plan and also resembles the traditional fee-for-service Medicare. All babies would be automatically enrolled at birth, and everyone else would be transitioned from their current form of coverage over a period of time. This version reflects the greatest social and fiscal solidarity, with everyone in the country in one giant risk pool with the same benefits and coverage. To get around the Commerce Clause challenge the ACA's individual mandate faced in *NFIB v. Sebelius*, Congress would have to rely on its power to tax and spend to establish such a program, similar to Medicare.

At the other end of the choice spectrum, the public plan would be an option for anyone who wants to buy in, offered on the exchanges with more generous subsidies than such plans today. This is the design of the public option proposals of moderate 2020 Democratic candidates, including the nominee, Joe Biden.¹¹⁶ Individuals with employer-based coverage could choose to enroll in the public plan or remain in their private

employer plan, assuming their employer continues to offer it. Benefits would be standardized, so the public plan would compete with private health plans on price through more aggressive rate controls. The extent of disruption to the private health insurance market would depend on myriad design decisions, such as how broad the provider network, how deep the provider rate controls, how easy to enroll, whether employers must pay for it even if they offer private coverage, and whether it would preserve the same tax-advantage as current plans.¹¹⁷ Thus, a very comprehensive, broad-networked, cheaper plan, could form a glide path to single payer if it simply outcompetes private plans on breadth and price, causing private payers to exit the market. On the other hand, a public plan that has a narrow network, is not much cheaper, and offer fewer tax advantages than private coverage may exist alongside private coverage and preserve a multi-payer system indefinitely and do little to advance social solidarity.

On the dimension of choice, a middle-ground approach would resemble Medicare Advantage for All: a single universal government payer with regulated rates, offered through a choice of a variety of private plans to administer the benefits. Slight differences in benefits, provider networks, and premiums allow for differentiation and choice among competing plans.

Even among proponents of universal health reform, debates persist about the importance of preserving choices among health coverage options. One of the main critiques of single-payer among those on the center-left has been that privately insured individuals would lose the choice of keeping their private health coverage.¹¹⁸ Proponents of single-payer respond that the choice people want is the choice of providers, not health plans, and provider choices could increase under single-payer.¹¹⁹ Nevertheless, the notion of health insurance choice as a way to preserve individual liberty may be overblown, because the multi-payer status quo provides little choice to most people, including those for whom Medicaid is the only viable choice or individuals with an employer-selected health plan and a narrow provider network.¹²⁰

2. COST-SHARING

For the related fixture of personal responsibility, health reforms must contend with how much individuals must pay for their health care in the form of premiums, cost-sharing, or penalties for failing to maintain coverage. As noted above, the ACA embraced consumerism, and the vast majority of exchange plans feature high deductibles.¹²¹ Public option reform proposals largely follow the ACA's approach to cost-sharing, albeit with

more generous subsidies, constrained deductibles, and lower caps on out-of-pocket expenditures.¹²²

In response to a growing unaffordability crisis in health care, single-payer advocates have proposed plans that impose no cost-sharing,¹²³ and some plans (such as Medicare for All) even eliminate premiums.¹²⁴ The absence of patient cost-sharing or premiums are not a necessary feature of a single-payer plan. Other countries' single-payer systems impose modest cost-sharing or premiums, both to help pay for health care and to dampen overutilization driven by moral hazard, where individuals consume more third-party financed health care than they would if faced with the full costs.¹²⁵ Even if one is skeptical of the degree of moral hazard and the potential of consumerism, a system that lacks *any* cost-sharing for higher income individuals would lead to a spike in demand for health care services, not all of it medically necessary.

A middle-path would create a universal government-financed health plan that imposes cost-sharing for those who can afford it. The current Medicare system takes this approach, with significant cost-sharing for all but the poorest Medicare beneficiaries who are also eligible for Medicaid. Most non-dually-eligible Medicare beneficiaries finance their cost-sharing with private Medicare supplement plans. For budgetary reasons and to minimize moral hazard, an American-style single-payer plan could impose some level of cost-sharing for all but the lowest-income Americans, and private supplemental insurance would fill the gap. Most other countries with public universal coverage systems have a robust role for private, supplemental insurance to finance cost-sharing and non-covered services.¹²⁶

Social solidarity in health care does not require zero cost-sharing, but out-of-pocket costs should not be unaffordable to the point that people struggle to pay for necessary health care, go bankrupt, ration their medication, food, or shelter, or overly burden familial caregivers.¹²⁷ Cost-sharing, if modest and affordable, can promote social solidarity by encouraging prudent consumption of health care, but a universal system should not rely on consumerism to control health care costs because health care is not a normal consumer good.

Conclusion

For next-step health reforms to move us toward greater social solidarity in health care, reformers must contend with four legal fixtures — federalism, pluralism, privatization, and individualism — that have stymied the ACA and previous reform efforts. The path to universal health care in the United States is a winding one, as reforms must navigate the four fixtures

with confrontations, accommodations, compromises, and tradeoffs. Compromise within one fixture might require an offsetting confrontation with another fixture to secure overall progress toward solidarity outcomes.¹²⁸

For example, if the politically feasible next step is a public option proposal, then reformers should consider offsetting that compromise on fiscal pluralism with adjunct federalism reforms to confront the barriers deterring states from going further in pursuing state single-payer systems.¹²⁹ That offset might take the form of a federal statutory waiver to secure funding for state solidarity experiments, and a suspension of federal preemption for those experiments.¹³⁰ Similarly, if next-step reforms compromise on the privatization fixture, as in reliance on private administrators for public programs, then financing offsets for risk adjustment and reinsurance could advance solidarity in a privatized system by reducing incentives for health status discrimination.¹³¹ Other provisions that advance solidarity to offset compromises might include surprise billing regulation to mitigate the financial distress created by cost sharing,¹³² and upstream financial investments in public health and prevention to mitigate the disincentive for long-term investments created by pluralism and federalization.¹³³

Focusing on outcomes reveals that the “universal coverage” goal of the ACA is necessary, but not sufficient to realize social solidarity. The ACA, of course, did not achieve universal coverage with its segmented approach. But even if the ACA had secured a source of third-party funding for all Americans' health care costs, their segmentation into different risk pools and dispersal among different payers and state systems undermines solidarity and permits inequitable distribution within and between risk pools. The reality of compromise and tradeoff in navigating the four fixtures demands heightened vigilance to the ultimate outcomes of social solidarity. It also demands more ambitious goals which broadly encompass the just distribution of burdens and benefits in health care, not merely universal coverage or balancing cost, quality, and access to care. What emerges from this process is a distinctive version of social solidarity in health care, American-style.

Successfully navigating these fixtures ultimately demands a broader framework for assessing the means and ends of American health reform efforts, beyond the traditional “iron triangle” focus on cost, quality, and access to medical care, “universal coverage,” or even the “triple aim” of improving patient experience and population health while reducing per capita cost within the health care system. Such broader metrics may include *health justice* and *individual financial*

and social well-being (broadly understood to include financial security and opportunity), to ensure reforms justly distribute the burdens and benefits of health care, as well as contend with the social, racial, economic, or geographic health disparities that undermine solidarity. The moment for significant progress toward social solidarity in health care is upon us, and deft legal and policy navigation will maximize our ability to harness the moment.

Note

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 47. K. Griffith, L. Evans, and J. Bor, “The Affordable Care Act Reduced Socioeconomic Disparities In Health Care Access,” *Health Affairs* 36, no. 8 (2017): 1503-1510.
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 49. T. Jost, “Using the 1332 State Waiver Program to Undermine the Affordable Care Act State by State,” *Commonwealth Fund*, Oct. 30, 2018, available at <<https://www.commonwealthfund.org/blog/2018/using-1332-state-waiver-program-undermine-affordable-care-act-state-state>> (last visited June 30, 2020).
 50. E.g., *Texas v. U.S.*, 945 F.3d 355 (5th Cir. 2019) (Majority Opinion, IV.A.). The uncertainty generated by litigation challenges has undermined the ACA, despite that the majority of those attacks ultimately have failed. K. Keith, “Diverse Stakeholders Ask Supreme Court to Promptly Hear *Texas*,” *Health Affairs Blog*, January 19, 2020, available at <<https://www.healthaffairs.org/doi/10.1377/hblog20200118.227701/full/>> (last visited June 30, 2020).
 51. See R.P. Nathan, “Federalism and Health Policy,” *Health Affairs* 24, no. 6 (2005): 1458-1466, at 1459; F. Maltzman and C.R. Shipan, “Beyond Legislative Productivity: Enactment Conditions, Subsequent Conditions, and the Shape and Life of the Law,” in J.A. Jenkins and E.M. Patashnik, eds., *Living Legislation: Durability, change, and the Politics of American Lawmaking* (Chicago: Univ. of Chicago Press, 2012): 118.
 52. See E. Fuse Brown and E.Y. McCuskey, *supra* note 21.

53. See M.B. Lawrence, "Shared Federal Savings," *William & Mary Law Review* (forthcoming 2020).
54. As discussed in Part III.D., Medicare beneficiaries pay a significant share of the costs of their care.
55. See Lawrence, *supra* note 53.
56. A. Hoffman, "Reimagining the Risk of Long-Term Care," *Yale Journal of Health Policy, Law & Ethics* 16, no. 2 (2016): 151-231.
57. See Hoffman, *supra* note 56, at 175-176.
58. A. Schick, *The Federal Budget: Politics, Policy, Process* (Washington, DC: The Brookings Institution, 1995).
59. *Id.*
60. E. Weeks and P. Sanford, "Financial Impact of the Opioid Crisis on Local Government: Quantifying Costs for Litigation and Policymaking," *University of Kansas Law Review* 67, Symposium Issue (2019): 1061-1132.
61. L. M. Nichols and L.A. Taylor, "Social Determinants as Public Goods: A New Approach to Financing Key Investments in Healthy Communities," *Health Affairs* 37, no. 8 (2018): 1223-1230.
62. Martha Albertson Fineman, *The Autonomy Myth* (City: Publisher, 2004): at 38 ("Justice demands that society recognize that caretaking labor produces a good for the larger society. Equality demands that this labor must not only be counted, but also valued, compensated, and accommodated by society and its institutions ...").
63. M.C. Dorf, and C.F. Sabel, "A Constitution of Democratic Experimentalism," *Columbia Law Review* 98, no. 2 (1998): 267-473.
64. See E.R. Berchick, J.C. Barnett, and R.D. Upton, U.S. Census Bureau, Health Insurance Coverage in the United States: 2018 (November 2019), available at <<https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf>> (In 2018, 55.1% of Americans were covered by employer-based private health insurance, 10.8% by directly purchased private insurance, 17.8% by Medicare, and 17.9% by Medicaid) (last visited June 30, 2020).
65. J. Gruber, "The Tax Exclusion for Employer-Sponsored Health Insurance," *National Tax Journal* 64, no. 2 (2011): 511-30.
66. See *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995) ("The basic thrust of [ERISA's] pre-emption clause ... was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans."): 26 U.S.C. § 36B.
67. *Id.* at § 4980H.
68. Centers for Medicare and Medicaid Services, a federal government agency, issues national coverage determinations (NCDs), which take precedence over the local coverage determinations (LCDs) and individual reimbursement decisions made by MACs. But the day-to-day tasks of administering benefits are largely in the hands of MACs who bid for jurisdictional contracts. See 42 U.S. Code § 1395kk-1.
69. Balanced Budget Act of 1997, Pub. L. 105-33 (1997). See generally A. Connelly, K. Healy, H. Melnick and J. Roosevelt, Jr., "A New Look at Medicare Advantage: What Lawyers Need to Know to Advise or Contract with Medicare Advantage Plans Now," *Journal of Health & Life Sciences Law* 12, no. 1 (2018): 1-38; T.G. McGuire, J.P. Newhouse and A.D. Sinaiko, "An Economic History of Medicare Part C," *Millbank Quarterly* 89, no. 2 (2011): 289-332.
70. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 107-163 (2003).
71. Centers for Medicare and Medicaid Services, "2017 Share of Medicaid Enrollees in Managed Care — 2017," Data.Medicaid.gov (updated June 11, 2019), available at <<https://data.medicicaid.gov/Enrollment/2017-Share-of-Medicaid-Enrollees-in-Managed-Care/ikdz-jh6q>> (last visited June 30, 2020).
72. The data reported by CMS includes all Medicaid beneficiaries enrolled in managed care plans, including in Vermont. *Id.* Green Mountain Care, the sole Medicaid managed care organization in Vermont, is state administered. The state agency contracts directly with health care providers. See Medicaid.gov, "Managed Care in Vermont" (August 2014) available at <<https://www.medicicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/vermont-mcp.pdf>> (last visited June 30, 2020). Therefore, the data on enrollment in Medicaid Managed Care plans does not precisely reflect the percentage of Medicaid enrollees who are in privately administered plans.
73. Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to waive specific provisions of federal Medicaid law as part of a demonstration project that meets statutory criteria. 42 U.S.C. § 1315(a). See generally I.D. Buck, "Managing Medicaid," *Saint Louis University Journal of Health Law & Policy* 11, no. 1 (2017): 107-140; L. Hermer, "Medicaid, Low Income Pools, and the Goals of Privatization," *Georgetown Journal on Poverty Law Policy* 17, no. 3 (2010): 405-22.
74. Pub. L. 109-171.
75. 42 U.S.C. §1903(i)(26).
76. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 573 U.S. 682 (2014); 26 U.S.C. § 5000A.
77. *Id.* at 558.
78. Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, § 11081 (2017). The story doesn't end there — challengers have further asserted that with a zero-penalty, the individual mandate is unconstitutional because it is no longer a tax and is unsupported under the commerce clause. Litigation is pending whether the mandate, if unconstitutional, is severable from the rest of the statute and if not, whether the entire Act must fall. *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019), as revised (Dec. 20, 2019), as revised (Jan. 9, 2020).
79. 42 U.S.C. § 300gg-13. The ACA requires that health plans cover certain preventive services, including specific preventive services for women, without any cost-sharing by individuals. The U.S. Department of Health & Human Services issued a rule that all FDA-approved contraceptives would be covered by this mandate. 76 Fed. Reg. 46,621-01 (Aug. 3, 2011) (codified at 45 C.F.R. pt. 147).
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81. E. Sepper, "Contraception and the Birth of Corporate Conscience," *American University Journal of Gender, Society, Policy & Law* 22, No. 2 (2014): 303-342.
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85. T.S. Jost, "Affordability: The Most Urgent Health Reform Issue For Ordinary Americans," *Health Affairs Blog*, February 29, 2016, available at <<https://www.healthaffairs.org/doi/10.1377/hblog20160229.053330/full/>> (last visited June 30, 2020).
86. Cf. L.O. Gostin and L.F. Wiley, *Public Health Law: Power, Duty, Restraint* (UC Press, 3d. ed. 2016) 19 ("The critical questions at the intersection of public health and justice are which people in society are most vulnerable and at greatest risk, how best to reduce the risk or ameliorate the harm, and how to fairly allocate services, benefits, and burdens.")
87. T.S. Jost, *supra* note 5, at 433-441.

89. Cf. R. Dworkin, "Justice in the Distribution of Health Care," *McGill Law Journal*, 38, no. 4 (1993): 883-898, 898 (1993) ("[T]he question of health-care reform in America, including politically acceptable and fair health-care rationing, is ideologically leveraged. If we find, after all the fuss, that politically we can't do much to make the distribution of medical care more just, in spite of the apparent present opportunities to do so, then a pessimistic conclusion may be irresistible: we may abandon hope for any more widespread or general democratic concern for social justice. But if we do now make substantial and recognizable political progress in this one urgent matter, we may learn more, from the experience, about what justice itself is like, and we might find it to our taste, so that we can steadily, bit by bit, incrementally, fight the same battle in other areas ... Health might not be more important than anything else — but the fight for justice in health might well be.")
90. See J.C. Baumgartner, S.R. Collins, D.C. Riley, and S.L. Hayes, "How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care," *Commonwealth Fund* (Jan. 16, 2020), available at <<https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access>> (last visited June 30, 2020).
91. J. Oberlander, *supra*, note 22, at 1499 (describing "Medicare for all" as "the anti-ACA" because "it eschews instrumentalism and compromise, overturns the status quo, and disrupts most prevailing insurance arrangements").
92. E.g., S. Kliff and D. Scott, "We Read 9 Democratic Plans for Expanding Health Care. Here's How They Work," *Vox*, Jun. 21, 2019, available at <<https://www.vox.com/2018/12/13/18103087/medicare-for-all-explained-single-payer-health-care-sanders-jayapal>> (last visited June 30, 2020).
93. J. Tolbert, R. Rudowitz, and M. Musumeci, "How Will Medicare-for-all Proposals Affect Medicaid?" Kaiser Family Foundation, Sept. 12, 2019, available at <<https://www.kff.org/medicaid/issue-brief/how-will-medicare-for-all-proposals-affect-medicaid/>> (last visited June 30, 2020).
94. Note, however, that the choice of private administration versus public administration, discussed below, makes a small concession to state authority in that states retain control over the regulation of private insurance companies, under the McCarran-Ferguson Act.
95. 567 U.S. at 558.
96. S. Kliff and D. Scott, "We Read 9 Democratic Plans for Expanding Health Care. Here's How They Work," *Vox*, Jun. 21, 2019, available at <<https://www.vox.com/2018/12/13/18103087/medicare-for-all-explained-single-payer-health-care-sanders-jayapal>> (last visited June 30, 2020).
97. Fuse Brown and McCuskey, *supra* note 21.
98. *Id.*
99. L.F. Wiley, "Medicaid for All? State-Level Single-Payer Health Care," *Ohio State Law Journal* 79, no. 4 (2018): 843-98, at 76.
100. E.Y. McCuskey, "Agency Imprimatur and Health Reform Preemption," *Ohio State Law Journal* 78, no. 5 (2017): 1099-1167, at 1142-46.
101. J.R. Brooks, "Quasi-Public Spending," *Georgetown Law Journal* 104 (2016): 1057-1110. (Please provide missing info.)
102. 42 U.S.C. 18062.
103. C. Silver and D. Hyman, *Overcharged: Why Americans Pay Too Much for Health Care* (Washington, DC: Cato Institute, 2018).
104. H.R.1384 — 116th Congress (2019-2020), sec. 701, available at <<https://www.congress.gov/bill/116th-congress/house-bill/1384/text#HC411C736C645465E987DBCD6881A49B5>> (last visited June 30, 2020).
105. *Id.* sec. 105 (automatic enrollment of residents), 202 (no cost sharing).
106. S.1129 — 116th Congress (2019-2020), sec. 1947(c), available at <<https://www.congress.gov/bill/116th-congress/senate-bill/1129/text>> (last visited June 30, 2020).
107. *Id.* sec. 202.
108. E.g., J. Biden, "Health Care," available at <<https://joebiden.com/healthcare/>> ("I. Give Every American Access to Affordable Health Insurance,") (last visited June 30, 2020).
109. See, e.g., K. Pollitz et al., "What's The Role of Private Health Insurance Today and Under Medicare-for-All and Other Public Option Proposals?" Kaiser Family Foundation, July 30, 2019, available at <<https://www.kff.org/health-reform/issue-brief/whats-the-role-of-private-health-insurance-today-and-under-medicare-for-all-and-other-public-option-proposals/>> (last visited June 30, 2020).
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111. See R. Abelson and M. Sanger-Katz, "Medicare for All Would Abolish Private Insurance. There's No Precedent in American History," *New York Times*, March 23, 2019.
112. In 2019, Sen. Kamala Harris's campaign clashed with Sen. Bernie Sanders's campaign over whether such an approach can still claim the title "Medicare for All." See L. Zhou and T. Golshan, "You Can't Call This Plan Medicare for All: The Bernie Sanders Camp Pans Kamala Harris's Health Care Plan," *Vox* (July 29, 2019), available at <<https://www.vox.com/policy-and-politics/2019/7/29/20732261/bernie-sanders-kamala-harris-medicare-for-all-private-insurance>> (last visited June 30, 2020).
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115. As discussed in Part II, the Medicaid expansion population may be given some choice among Medicaid managed care plans, but these choices are quite constrained.
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122. Yglesias, *supra* note 117.
123. Fuse Brown and McCuskey, *supra* note 21.

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125. J.A. Nyman, "Is Moral Hazard Inefficient? The Policy Implications of a New Theory," *Health Affairs* 23, no. 5 (2004) 194-199; S.A. Glied, M. Black, W. Lauerman, and S. Snowden, "Considering "Single Payer" Proposals in the U.S.: Lessons from Abroad," *Commonwealth Fund*, Apr. 11, 2019, available at <<https://www.commonwealthfund.org/publications/2019/apr/considering-single-payer-proposals-lessons-from-abroad>> (last visited June 30, 2020).
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127. M.B. Lawrence, "The Social Consequences Problem In Health Care and How to Solve It," *Harvard Law & Policy Review* 13, no. 2 (2019): 593-660; E. Fuse Brown, "Irrational Hospital Pricing," *Houston Journal of Health Law & Policy* 14 (2014): 11-58.
128. *But cf.* A. Hoffman, "Health Care's Market Bureaucracy," *UCLA Law Review* 66, no. 6 (2019): 1926-2022 (arguing that belief in "technocratic tinkering" to cure the ills of a market-based system is mistaken).
129. *See* Fuse Brown and McCuskey, *supra* note 21; L.F. Wiley, *supra* note 92, at 843-899.
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131. In a risk adjustment program, such as in the ACA's exchanges and Medicare Advantage, insurers that enroll disproportionately sick individuals are reimbursed based on the increased cost associated with such individuals. *See* M.B. Lawrence, "Regulatory Pathways to Promote Treatment for Substance Use Disorder or Other Under-Treated Conditions Using Risk Adjustment," *Journal of Law, Medicine & Ethics* 46, no. 4 (2018): 935-938. Though difficult to do, effective risk adjustment mitigates the incentive insurers otherwise have to discriminate. T.G. McGuire, "Achieving Mental Health Care Parity Might Require Changes in Payments and Competition," *Health Affairs* 35, no. 6 (2016): 1029-1035. A reinsurance program assigns costs associated with the most expensive enrollees to a central payer, taking such individuals off insurers' balance sheets and thereby removing insurers' incentive to discriminate against them.
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