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Is Medicare for All the Answer? Assessing the Health Reform Gestalt as the ACA Turns 10

Nicole Huberfeld

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IS MEDICARE FOR ALL THE ANSWER?

ASSESSING THE HEALTH REFORM GESTALT AS THE ACA TURNS 10

Nicole Huberfeld*

"You keep using that word. I do not think that word means what you think it means."[1]

* Professor of Health Law, Ethics & Human Rights & Professor of Law, Boston University. Thanks to: Houston Journal of Health Law & Policy for hosting this symposium and to the contributors and attendees, especially Seth Chandler, for valuable feedback; participants in the Medicaid Matters session at Health Law Professors Conference 2019; members of the 2020 CHSTM Malingering and Social Welfare Policy Working Group; the University of Connecticut Law School faculty workshop participants; the University of Miami School of Law Legal Theory workshop participants; and Claudia Bennett for excellent research assistance. Thanks always DT and SRHT. Mistakes are all mine. nlh@bu.edu.

[1] Inigo Montoya, THE PRINCESS BRIDE (Act III Communications, Buttercup Films, the Princess Bride Ltd. 1987). (The villain Vizzini repeatedly proclaims events "Inconceivable!" - they occur anyway.).

INTRODUCTION

The expression "Medicare for All" ("M4A") was on repeat as presidential primary candidates discussed health reform, yet few using this language appeared to understand precisely what Medicare is, how it works, or which aspects of health care could be affected by such a law. In fact, the plans presented in the many bills before the 116th Congress generally do not implicate Medicare as it currently exists but appear to draw on the magic of the word "Medicare" to capture the public's desire for health reform.[2] Even before the novel coronavirus pandemic, polls showed health care at the top of public concerns for the 2020 election[3] and indicated that voters of all political

[2] Ryan Struyk & Grace Sparks, *Health care is the top issue for Iowa caucus goers, entrance polls show*, CNN (Feb. 4, 2020), https://www.cnn.com/2020/02/03/politics/iowa-caucuses-entrancepolls/index.html?utm_campaign=KHN%3A%20Daily%20Health%20Policy%20Report&utm_source=hs_email&utm_medium=email&utm_content=82850893&_hsenc=p2ANqtzKOeHJuqF8KBqHetJ8s0s3jS3XxkPamYT9spRu3Mkgf7ZqxalgL4280dnn21Dwyten_MnhDpipDjm3Ro_CbLxuyusAwQ&_hsmi=82850893.

[3] Pew Research Center, *Public's policy priorities for 2019*, PEW (Feb. 4, 2019), https://www.pewresearch.org/fact-tank/2019/02/04/state-of-the-union-2019-how-americans-see-major-national-issues/pp_2019-01-24_political-priorities_0-02/; KFF, *Poll: Strong Initial Support for a Public Option, But Arguments Can Significantly Shift Views*, KAISER FAM. FOUND. (July 30, 2019), https://www.kff.org/health-reform/press-release/poll-strong-initial-support-for-a-public-option-but-arguments-can-significantly-shift-views/.

stripes are both interested in health reform and expect government to be involved, especially lower income individuals.[4] But, when asked about the desirability of government-sponsored universal health insurance coverage, answers very much have depended on the phrasing of the questions,[5] highlighting enduring confusion about health care in the United States.[6]

It is striking that Americans are debating major health reform when the Patient Protection and Affordable Care Act (ACA) – President Obama's signature legislation and a health reform effort on a scale not seen in decades –just turned ten years old. The ACA changed the American baseline principle from exclusion to inclusion – as I have called it elsewhere, a principle of universality – and effectively kick-started a conversation about health care expectations, which now appear to include universal coverage.[7] But, the ACA also ratcheted up health care complexity by expanding disparate features of private and public insurance, exacerbated by the crazy quilt of

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[4] Samantha Smith, *Many lower-income Republicans see ensuring health coverage for all as a government responsibility*, PEW (Mar. 23, 2017), https://www.pewresearch.org/fact-tank/2017/03/23/many-lower-income-republicans-see-ensuring-health-coverage-for-all-as-a-government-responsibility/ ("Lower-income Republicans are both more likely to say they approve of the Affordable Care Act and to say the government is responsible for ensuring health care coverage than higher-income Republicans. Three-in-ten of those with family incomes of $30,000 or less say they approve of the law, and about half (52%) say the government has a responsibility to ensure health care coverage. This compares with just 11% of Republicans with household incomes of $75,000 or more who approve of the law, and 18% of this same group who say the government has a responsibility to ensure that all Americans have health care coverage."); Jocelyn Kiley & Pew Research Center, *Most continue to say ensuring health care coverage is government's responsibility*, PEW (Oct. 3, 2018), https://www.pewresearch.org/fact-tank/2018/10/03/most-continue-to-say-ensuring-health-care-coverage-is-governments-responsibility/.

[5] *Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage*, KAISER FAM. FOUND (Apr. 03, 2019), https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/.

[6] Drew Altman, *Voters are tuning out the health care debates*, AXIOS (June 3, 2019), https://www.axios.com/voters-are-tuning-out-the-health-care-debates-a3056cab-6ab2-4f5e-9ee4-113fa038ae72.html (focus groups indicated voters have not heard of Medicare for All and related proposals but are concerned about paying medical bills and "navigating" health care).

[7] Nicole Huberfeld & Jessica Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C. L. REV. 1, 3 (2016); Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 67 (2015).

implementation that has occurred in the wake of four trips to the U.S. Supreme Court in less than nine years (soon to be five).[8]

Somewhat paradoxically, while the ACA pioneered universal health insurance coverage, it did so by building new scaffolding around an old foundation.[9] The ACA regulates various aspects of private and public insurance to craft universal coverage. For example, it cultivates state-based individual health insurance markets (weak markets when the law was enacted); regulates health insurance practices that had excluded subscribers, such as lifetime caps and preexisting condition exclusions; builds on existing public programs, such as Medicare and expanding eligibility for Medicaid; and uses arrangements like employer sponsored health insurance (ESI) to preserve existing coverage for the middle and upper class. The ACA's complex regulatory mechanisms did little to alter the fragmented health care landscape and may have worsened it by enhancing the existing legacy programs, simultaneously improving and complicating access to care.[10]

Measured by its primary goal of universal insurance coverage, studies show that the ACA has been largely successful. The ACA sharply decreased uninsurance rates, improved access to care, reduced health disparities, decreased financial strain in low-income households, and rendered economic benefits for both states and health care providers.[11] The demand for health reform that arose in 2019

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[8] Abbe R. Gluck & Nicole Huberfeld, *Federalism under the ACA: Implementation, Opposition, Entrenchment*, *in* THE TRILLION DOLLAR EXPERIMENT (Emanuel & Gluck, eds. 2020); Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012); King v. Burwell, 135 S. Ct. 2480 (2015); Burwell v. Hobby Lobby Stores Inc., 573 U.S. 682 (2014); Maine Community Health Options v. United States, 590 U.S. (Apr. 27, 2020). Additionally, the case commonly called *Texas v. United States* will be heard by the Supreme Court in the October 2020 term. *See* Texas v. United States, No. 19-10011 (5th Cir. Dec. 20, 2019), https://www.ca5. uscourts.gov/opinions/pub/19/19-10011-CV0.pdf (declaring individual mandate an unconstitutional exercise of the tax power without a penalty and remanding to the district court for complete severability analysis); petition for certiorari in *California v. Texas* granted March 2, 2020, Docket No. 19-840.

[9] A more fitting term is *near-universal* because undocumented noncitizens were excluded, and other immigrants have a five year waiting period for most programs. *See generally* Pub. L. No. 111-148, §1323(f)(3), 124 Stat. 119, 184 (2010).

[10] For a survey of the health care system's fragmentation, *see generally* EINER ELHAUGE, THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS (2010).

[11] Larisa Antonisse, Rachel Garfield, Robin Rudowitz & Madeline Guth, *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, KAISER FAM. FOUND. (Mar.

could therefore seem puzzling: why did this broad cry for health reform exist so soon into the ACA's implementation? And what does the public want?

The ACA wove universal coverage from already delicate fabric. While the law's implementation was interrupted by *NFIB v. Sebelius*, I posit the law could not have eliminated some of the coverage, access, and cost problems of our health care non-system that pre-existed the ACA's enactment. A core set of ideas that underlie most social programs but are especially salient in health care – such as equitability and administrative simplicity – have proven difficult to address in this landscape of legacy programs, entrenched interests, and path dependence. Given the ACA that we have (rather than the law that was intended), the most important policy question may be whether the ACA can and should be improved upon or whether something new is the best answer.

This paper first offers a very brief overview of the ACA and suggests that to avoid repetition of this hundred-year battle, lessons must be learned from the ACA's enactment and implementation, contextualized by historic weak spots in American health policy. Part II surveys the structure and approach of the major federal and state health reform bills proposed in 2019-20, placing them on a spectrum of disruption relative to the current health care landscape.[12] This analysis exposes the fact that most of the energy was directed toward filling the gaps of the ACA by facilitating a new public insurance product, what many call a "public option," to be sold on the exchanges. This part reveals that only one bill calls for a true Medicare for All, if that term

17, 2020), https://www.kff.org/ medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-august-2019/; Nicole Huberfeld, *Rural Health, Universality, and Legislative Targeting*, 13 HARV. L. & POL'Y REV. 241 (2018) (almost all rural hospital closures have occurred in Medicaid nonexpansion states over the last decade).

[12] The term "disruptive innovation" describes business breakthroughs that "disrupt" existing business markets. This paper does not adopt *The Innovator's Prescription*'s use of the term "disruption" nor espouse the book's notion that the market will cure all medical delivery and accessibility issues if only innovation is allowed to shake up overly-regulated markets. *See generally* CLAYTON M. CHRISTENSEN, JEROME H. GROSSMAN & JASON HWANG, THE INNOVATOR'S PRESCRIPTION: A DISRUPTIVE SOLUTION FOR HEALTH CARE (McGraw Hill ed., 2009) (asserting technology will "disrupt" traditional medical care, building on Christensen's book *The Innovator's Dilemma*). For a health policy review of *The Innovator's Prescription*, see J.D. Kleinke, *Perfection in Power Point*, 28 HEALTH AFFS. 1223 (2009).

means a comprehensive, single-payer, government-provided public insurance program. The paper then highlights the distance between law and policy (and politics) by evaluating constitutional implications of the major proposals. Finally, the paper considers whether these proposals capture the health reform gestalt, which seems to be a cry for simplification, fairness, equitability, and lower costs, i.e., a demand for true universal coverage and the protections it affords. This demand was intense before the novel coronavirus outbreak, but the urgent need for a more equitable and inclusive health care system has been thrown into sharp relief by the double disaster of this health and economic crisis.

I. Measuring the ACA on Its Own Terms

The ACA experienced newfound heights of popularity as it approached the ten year mark, yet demand for health reform less than one decade after the enactment of such major legislation demands examination.[13] First, consider the ACA's goals, as enacted. The ACA codified a norm of near-universal coverage[14] by working to improve access to care through health insurance.[15] This norm was intended to

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[13] *Health Tracking Poll: The Public's Views on the ACA*, KAISER FAM. FOUND. (Apr. 3, 2020), https://www.kff.org/interactive/kff-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable Unfavorable&aRange =twoYear.

[14] Remarks of Vice President Biden at the signing of the ACA: "You have turned, Mr. President, the right of every American to have access to decent health care into reality for the first time in American history. … a man named Barack Obama put the final girder in the framework for a social network in this country to provide the single most important element of what people need—and that is access to good health—and that every American from this day forward will be treated with simple fairness and basic justice." Joe Biden, Vice President, United States of America, Remarks at the signing of the Patient Protection and Affordable Care Act (Mar. 23, 2010) https://www.obamalibrary.gov/sites/default/files/uploads/documents/Signing%20of%20the%20Health%20Insurance%20Reform%20Bill%202010%20%28TRANSCRIPT%29.pdf.

[15] President Obama remarks at signing of the ACA: "And we have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care." Barack Obama, President, United States of America, Remarks at the signing of the Affordable Care Act (Mar. 23, 2010) https:// www.obamalibrary.gov/sites/default/files/uploads/documents/Signing%20of%20the%20Health%20Insurance%20Reform%20Bill%202010%20%28TRANSCRIPT%29.pdf.

end the century-plus debate about who gets care in the U.S.,[16] a goal President Obama declared when he addressed Congress in 2009:

> I return to speak to all of you about an issue that is central to that future – and that is the issue of health care. I am not the first President to take up this cause, but I am determined to be the last. It has now been nearly a century since Theodore Roosevelt first called for health care reform. And, ever since, nearly every President and Congress, whether Democrat or Republican, has attempted to meet this challenge in some way. A bill for comprehensive health reform was first introduced by John Dingell Sr. in 1943. Sixty-five years later, his son continues to introduce that same bill at the beginning of each session.[17]

It is true that nearly every president from Theodore Roosevelt forward has had to address health policy.[18] Instead of ending this long debate, the ACA foregrounded a national conversation about universal coverage, including whether health care is a right that can be actualized within our deeply fragmented system.[19]

The ACA addressed a wide variety of issues, but the centerpiece was tackling ever increasing uninsurance for low-income households and part-time workers with new national standards. Medicaid eligibility was expanded by eliminating states' choice regarding

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[16] President Obama remarks at the ACA signing: "I'm signing this bill for all the leaders who took up this cause through the generations—from Teddy Roosevelt to Franklin Roosevelt, from Harry Truman, to Lyndon Johnson, from Bill and Hillary Clinton, to one of the deans who's been fighting this so long, John Dingell…." Barack Obama, President, United States of America, Remarks at the signing of the Affordable Care Act (Mar. 23, 2010) (transcript available at the Barack Obama Presidential Library, https://www.obamalibrary.gov/ sites /default/files/uploads/documents/Signing%20of%20the%20Health%20Insurance% 20Reform%20Bill%202010%20%28 TRANSCRIPT %29.pdf.

[17] Barack Obama, President, United States of America, Obama's Health Care Speech to Congress (Sept. 9, 2009) (transcript available at the N.Y. TIMES, https://www.nytimes.com /2009/09/10/us/politics/10obama.text.html?auth=login-email&login=email.

[18] Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare For?*, 70 STAN. L. REV. 1689, 1713 (2018).

[19] At least two Democratic candidates call *health care* a human right. Elizabeth Warren stated this during debates and on Twitter. *See, e.g.*, Elizabeth Warren, (@ewarren), TWITTER (June 26, 2019), https://twitter.com/ewarren/status/1144054259547299850. Bernie Sanders has stated many times that health care is a human right. *See, e.g.*, Bernie Sanders, (@BernieSanders), TWITTER (June 27, 2019), https://twitter.com/berniesanders/status /1144423468328542208 ?lang=en; Sen. Bernie Sanders, *Health Care Is a Right, Not a Privilege*, HEALTHCARE IS A HUMAN RIGHT (June 8, 2009, 4:08 PM), http://healthcareisahumanright.org/wp-content/ uploads/2015/04/Health_Care_Is_a_Right_Not_a_Privilege_Sen_Bernie_Sanders.pdf.

whether to cover the childless adults that had always been beyond Medicaid's historically "deserving" populations (children, pregnant women, very poor parents, the disabled, and the elderly).[20] Individual and small group insurance markets were created through new health insurance exchanges, meant to be run by the states with federal start-up money. The ACA also introduced rules for private health insurance, such as quality and patient protections, affordability standards, basic benefits, barring caps, ending price discrimination based on health status, and preventing coverage exclusions based on preexisting conditions. The Court's decision in *NFIB v. Sebelius* infamously upheld the requirement to purchase insurance as an exercise of the tax power but allowed states to opt out of Medicaid expansion as an overreach of the spending power (discussed further in Part III).[21] Effectively, *NFIB* took the Medicaid expansion's national baseline and pushed it back to the states. This had a spillover effect on the exchanges, which states pushed back to the federal government as a form of political protest against the ACA.[22]

Studies show the ACA has delivered on its design where states support implementation rather than thwart it.[23] The ACA achieved high rates of insurance coverage (more than 91%) despite states concentrated in the South and central Midwest resisting expansion.[24] More than 400 studies have linked Medicaid expansion with numerous health and other benefits.[25] For example, Medicaid

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20 The question of who deserves the support of social programs has long been tied to categories of deserving versus undeserving poor and questions of who is malingering. *See, e.g.*, Nicole Huberfeld, *Federalism in Health Care Reform*, *in* HOLES IN THE SAFETY NET: FEDERALISM AND POVERTY 197, 199-204 (Ezra Rosser, ed. 2019) (exposing the history of the term "able bodied.").

21 Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

22 *See generally* Gluck & Huberfeld, *What Is Federalism in Healthcare For?*, *supra* note 18. Bizarre because states invited more federal power into their "sovereign" borders when they refused to create their own exchanges.

23 Gluck & Huberfeld, *What Is Federalism in Healthcare For?*, *supra* note 18.

24 CENSUS BUREAU, U.S. DEP'T OF COM., REP. NO. P60-267(RV), HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2018 (2019), https://www.census.gov/library /publications /2019/demo/p60-267.html); *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Mar. 13, 2020), https://www.kff. org /Medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

25 Madeline Guth et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, KAISER FAM. FOUND. (Mar. 20, 2020), https://www.kff.org/medicai

expansion has been shown to increase coverage for both expansion and nonexpansion populations.[26] The increases in coverage have moved the needle on health disparities by improving coverage and access for historically vulnerable populations such as Black and ethnic minorities, people with low educational attainment, and low-income people. But, states like Indiana that implemented expansion waivers with limitations, such as imposing premiums, have created barriers to enrollment that decreased possible coverage and access to care for those who could enroll.[27] Reports show immediate disenrollment effects due to work requirements in expansion demonstration waivers. For example, in 2018, more than 18,000 people were disenrolled in Arkansas within three months, and no increase in employment occurred.[28]

Expansion state populations also evince improvements in underlying determinants of health, such as education, housing, food, transportation, income, and other factors.[29] For example, studies report that Medicaid expansion facilitates beneficiary financial stability, improving job stability, decreasing medical debt, and reducing use of high-interest payday loans.[30] One study found that expansion correlated with decreased evictions in California.[31] Others found that

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d/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/.

26 *See id.* at 2-3.

27 *Healthy Indiana Plan 2.0: POWER Account Contribution Assessment*, LEWIN GRP. (Mar. 31, 2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers /1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

28 Benjamin D. Sommers et al., *Medicaid Work Requirements — Results from the First Year in Arkansas*, 381 NEW ENG. J. MED. 1017 (2019), https://www.nejm.org/doi/pdf/10.1056 /NEJMsr1901772 ?articleTools=true.

29 Kevin Griffith et al., *The Affordable Care Act Reduced Socioeconomic Disparities in Health Care Access*, 36 HEALTH AFFS. 1503 (2017).

30 Naomi Zewde & Christopher Wimer, *Antipoverty Impact of Medicaid Growing with State Expansions over Time*, 38 HEALTH AFFS. 132 (2019); Luojia Hu et al., *The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing*, 163 J. PUB. ECON. 99 (2018); Renuka Tipirneni et al., *Association of Medicaid Expansion With Enrollee Employment and Student Status in Michigan*, JAMA NETWORK OPEN, Jan. 2020, at 1, https://jamanetwork .com/journals /jamanetworkopen/fullarticle/2759843.

31 Heidi L. Allen et al., *Can Medicaid Expansion Prevent Housing Evictions?*, 38 HEALTH AFFS. 1451 (2019).

Medicaid expansion increases voter registration and participation in elections (and that disenrollment decreases voting).[32]

Providers in expansion states report improved financial stability, with fewer uninsured visits and corresponding declines in uncompensated care. This financial benefit has been significant in rural areas and in states that had high rates of uninsurance pre-ACA. Since 2010, more than 100 rural hospitals have closed but almost none are located in expansion states.[33] In addition, expansion states display financial benefits such as budget neutrality (or savings) and economic growth.[34] Furthermore, expansion states have decreased costs in some adjacent areas such as criminal justice, disability benefits, and behavioral health spending, in part because federal funds replaced state dollars but also in part because social determinants of health improved.[35] Also, studies link lower exchange premiums to Medicaid expansion.[36]

Some states have resisted implementing Medicaid expansion and the ACA writ large, and they have impeded information and policy diffusion, making it harder for their residents to understand and participate in events like open enrollment. As a result, nearly half of the nation's remaining uninsured are eligible for subsidies to purchase private insurance on the exchanges.[37] A "coverage gap" exists in

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32 Jake Haselswerdt & Jamila Michener, *Disenrolled: Retrenchment and Voting in Health Policy*, 44 J. HEALTH POL. POL'Y & L. 423, 426 (2019) (summarizing studies that indicate Medicaid and Medicaid expansion increase voting); *see also* Margot Sanger-Katz, *When Medicaid Expands, More People Vote*, N.Y. TIMES, Nov. 8, 2018; Jake Haselwerdt, *Expanding Medicaid, Expanding the Electorate: The Affordable Care Act's Short-Term Impact on Political Participation*, 42 J. HEALTH POL. POL'Y & L. 667 (2017).

33 *See generally* Nicole Huberfeld, *Rural Health, Universality, and Legislative Targeting*, 13 HARV. L. & POL'Y REV. 241 (2018) (documenting and exploring rural health disparities and the link between Medicaid expansion and hospital department or total closures).

34 Guth, *supra* note 25, at 9–10.

35 *Id*.

36 Aditi P. Sen & Thomas DeLeire, *The Effect of Medicaid expansion on Marketplace Premiums*, ASPE ISSUE BRIEF (Sept. 6, 2016), https://aspe.hhs.gov/system/files/pdf/206761/Mcaid ExpMktplPrem.pdf.

37 Jennifer Tolbert et al., *Key Facts about the Uninsured Population,* KAISER FAM. FOUND. (Dec. 13, 2019), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsuredpopulation/.

nonexpansion states, leaving uninsured at least two million people who are eligible for Medicaid under the ACA.[38]

Additionally, some sit near to, yet outside of, the ACA's regime. For these groups, private health insurance – ESI or otherwise – remains prohibitively expensive, even though they earn close to the American median income.[39] Individuals in this "near to" population include people covered by ESI who are low to middle income and must pay higher proportions of their earnings, which undercuts the financial protection insurance is meant to provide.[40] Some earn slightly more than 400% of the federal poverty level (FPL),[41] a group who are ineligible for tax subsidies to purchase insurance on exchanges and that experienced increased uninsurance from 2015-17.[42] Others are covered as the ACA intended but find that actuarially valid insurance is too expensive for their household income, or that they are under-insured.[43] Still others live in states with Medicaid demonstration

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38 Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults States that Do Not Expand Medicaid,* KAISER FAM. FOUND. (Jan. 14, 2020), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

39 CENSUS BUREAU, U.S. DEP'T OF COM., RELEASE No. CB19-141, INCOME, POVERTY AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2018 (2019), https://www.census.gov /newsroom/press-releases/2019/income-poverty.html (2018 median income was $63,179); Drew Altman, *Health Care Costs as Much as a New Car*, AXIOS (Aug. 28, 2019), https://www.axios.com/health-care-costs-insurance-premiums-deductibles -car-580fa6c8-0dd2-427b-8dda-c898d568e51e.html (reporting employer sponsored health insurance for a family of four costs as much as a VW Bug, but calling coverage "health care").

40 Gary Claxton et al., *How affordability of health care varies by income among people with employer coverage*, PETERSON-KAISER HEALTH SYS. TRACKER (Apr. 14, 2019), https://www.health systemtracker.org/brief/how-affordability-of-health-care-varies-by-income-among-people-with-employer-coverage/ ("lower income families spend a greater share of their income on health costs than those with higher incomes, and … health status of family members is associated with higher out-of-pocket expenses.").

41 OFF. OF ASSISTANT SEC'Y FOR PLAN. & EVALUATION, U.S. DEP'T OF HEALTH & HUM. SERVS., 2019 POVERTY GUIDELINES (2019), https://aspe.hhs.gov/2019-poverty-guidelines. (The poverty guidelines are updated in the Federal Register by the authority granted under 42 U.S.C. 9902(2). In 2019, the Federal Poverty Level (FPL) was $12,490 for one person, with $4,420 for each additional person.)

42 LINDA J. BLUMBERG ET AL., CHARACTERISTICS OF THE REMAINING UNINSURED: AN UPDATE 6 (2018), https://www.urban.org/sites/default/files/publication/98764/2001914character istics-of-the-remaining-uninsured-an-update_2.pdf.

43 Steven Findlay, *Health Insurance Costs Crushing Many People Who Don't Get Federal Subsidies*, AP NEWS (Dec. 14, 2018), https://apnews.com/9050e471ba4543998f5c075b14047dc4; Abby

waivers that complicate eligibility, enrollment, and benefits, which pushes thousands out where the law intended them to be inside the system.[44]

For years, the story has been that political resistance to the ACA undermined implementation, especially where states were supposed to take up the mantel. Polls showed public uncertainty about the law's existence, not to mention its goals and their realization.[45] Congress's "repeal and replace" efforts after President Trump's election reflected a sense that the ACA suffered from a lack of bipartisan support in its passage and that Republicans should try to repeal and replace a law perceived by some to be unpopular. Yet, grassroots support for the ACA emerged at the same time, evidenced by on-the-ground democratic action like state ballot initiatives to expand Medicaid.[46] This new story indicates despite the fracas, or maybe because of it, the ACA appears to have generated a durable expectation of universal coverage. This confronts the state politicians that have chosen to sit outside the ACA's reforms, such as Medicaid expansion. But, the current call for health reform also may indicate that flaws would have materialized even if implementation of the ACA were not disrupted by *NFIB*.

Goodnough, *Obamacare Premiums to Fall and Number of Insurers to Rise Next Year*, N.Y. TIMES (Oct. 22, 2019), https://www.nytimes.com/2019/10/22/us/politics/obamacare-trump .html.

44 For example, Kentucky, Indiana, Arkansas, New Hampshire and other states obtained Section 1115 demonstration waivers that complicate enrollment for the newly eligible by implementing work requirements, cost sharing, and other barriers to enrollment and access to care. *See Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KAISER FAM. FOUND. (Jan. 6, 2020), https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/. These efforts were halted by federal courts and appeals are pending. *See* Gresham v. Azar, Nos. 19-5094 & 19-5096 (D.C. Circuit Court of Appeals Feb. 14, 2020); Philbrick v. Azar, No. 19-773 (D.D.C. Jul. 29, 2019) (New Hampshire); Stewart v. Azar II, 366 F. Supp. 3d 125 (D.D.C. 2019) (second Kentucky decision); Gresham v. Azar, 363 F. Supp. 3d 165, 169 (D.D.C. 2019) (Arkansas decision); Stewart v. Azar I, 313 F. Supp. 3d 237, 243 (D.D.C. 2018) (Stewart I) (first Kentucky decision).

45 Matthew Sheffield, *Poll: Few Americans say they have benefited from key aspects of ObamaCare*, THE HILL (Apr. 4, 2019), https://thehill.com/hilltv/what-americas-thinking/437401-poll-few-americans-believe-they-have-personally-benefitted-from.

46 *See* Nicole Huberfeld, *Epilogue: Health Care, Federalism, and Democratic Values*, 45 AM. J. L. MED. 247, 251 (2019) (discussing the Maine, Montana, Utah, Idaho, and Nebraska ballot initiatives in the context of grassroots participation and politicians' efforts to thwart such initiatives).

Under the ACA, insurance coverage has improved measurably but falls short of universal. But, this is just one factor in the consensus that the work of health reform is not complete – affordability and complexity are also common complaints.[47] Would the ACA have delivered better on these problems if it were implemented as designed?[48] Abbe Gluck and I have concluded that the answer is yes.[49] But even if the ACA were implemented without *NFIB*'s interruption, the state of American health care, which still reflects the non-system that pre-dated the ACA, would remain irrational. The ACA was motivated by the glaring problem of coverage and did not vigorously tackle some other issues in American health care, which costs much more than the health systems of most wealthy nations yet delivers shorter life expectancy and perpetuates disparities for certain communities such as Black, indigenous, and people of color.[50] As one commenter memorably wrote, health insurance now costs as much as a small car.[51] In short, the public is prioritizing health reform so soon

47 Sarah Kliff, *8 Facts that Explain What's Wrong with American Health Care*, VOX (Jan. 20, 2015) https://www.vox.com/2014/9/2/6089693/health-care-facts-whats-wrong-american-insurance; Ashley Kirzinger et al., *Data Note: American's Challenges with Health Care Costs*, KAISER FAM. FOUND (June 11, 2019) https://www.kff.org/health-costs/issue-brief/data-note-americans-challenges-health-care-costs/; Emily Gee & Topher Spiro, *Excess Administrative Costs Burden the U.S. Health Care System*, CTR. AM. PROGRESS (Apr. 8, 2019), https://www.americanprogress.org/issues/healthcare/reports/2019/04/08/468302/excess-administrative-costs-burden-u-s-health-care-system/; Austin Frakt, *The Astonishingly High Administrative Costs of U.S. Health Care*, N.Y. TIMES (July 16, 2018), https://www.nytimes.com/2018/07/16/upshot/costs-health-care-us.html; Bill Siwicki, *Here are 6 Major Issues Facing Healthcare in 2019*, HEALTHCARE IT NEWS (Jan. 17, 2019), https://www.healthcareitnews.com/news/here-are-6-major-issues-facing-healthcare-2019-according-pwc.

48 *See generally* Gluck & Huberfeld, *supra* note 18 (detailing the first five years of the implementation of the ACA with emphasis on the structural and substantive differences in the federalism of the law as enacted compared to the law as implemented).

49 *Id.*

50 Steven H. Woolf & Heidi Schoomaker, *Life Expectancy and Mortality Rates in the United States, 1959-2017*, 322 JAMA 1996 (2019) (available at https://jamanetwork.com/journals/jama/article-abstract/2756187); *see also* ORG. ECON. COOPERATION & DEV., HEALTH AT A GLANCE 2019: OECD INDICATORS (2019), https://www.oecd-ilibrary.org/docserver/4dd50c09en.pdf?expires=1589998199&id=id&accname=guest&checksum=AC4537397D75ACC7E8AC3F3DCC07B31B.

51 Drew Altman, *Health Care Costs as Much as a New Car*, AXIOS (Aug. 23, 2019), https://www.axios.com/health-care-costs-insurance-premiums-deductibles-car-580fa6c8-0dd2-427b-8dda-c898d568e51e.html.

after the ACA because costs are high, complexity overwhelms, and truly universal coverage has not been achieved.

II. Features of Current Proposals

This part begins with a brief overview of Medicare as a point of comparison for a summary of the landscape of health reform proposals. I place the proposals on a spectrum of disruption relative to the existing health care system, spanning from a truly national public health insurance program to a state option to allow the uninsured to buy in to Medicaid. The details of each bill are less important here than the goals and structure of each proposal, what it would change or disrupt in the existing legislative landscape, and which major issues are confronted.[52] The bills introduced in the 116th Congress are discussed in order of public or private insurance orientation, which can also be characterized in terms of the bill's degree of disruption. I also include notable state-based reforms, as they build on Medicaid and are part of the current conversation. The word disruption admittedly has become overused, but here it aids in describing the degree to which these proposals move the path dependent American health care non-system away from existing frameworks.

A. Medicare Overview

Given the general misconceptions regarding the meaning of a Medicare for All plan, a brief overview of the actual Medicare program is a useful place to begin. Medicare is an American national social insurance program, covering everyone who has paid into Social Security for forty quarters at age 65 and those who are permanently disabled whether elderly or not.[53] Medicare provides health insurance benefits that are generally deemed essential but also incomplete in scope (discussed below).[54] Medicare was created to cover the nation's

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[52] *See Compare Medicare-for-all and Public Plan Proposals*, KAISER FAM. FOUND. (May 15, 2019), https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/.

[53] 42 U.S.C. §§ 1395 – 1395lll (2015).

[54] Due in part to "medical necessity" definition and historic concepts of 'comprehensive' coverage. 42 U.S.C. § 1395y(a)(1)(A) (2015). The ACA updated Medicare's medical necessity

elderly because they were impoverishing themselves and their families to obtain medical care in the years after World War II.[55] Prior federal grant-in-aid programs boosting state medical welfare programs proved inadequate to the task of delivering consistent medical care and failed to stem the increasing rate of impoverishment.[56] States did not consistently adopt those federal grant programs, even when they grew more generous; and, even when states did, benefits were not consistently delivered. The elderly successfully lobbied for a nationalized program, and politicians were ready to hear their complaint; Medicare was the answer.

Medicare is not quite the program the national conversation paints it to be, and at least three salient features are not being discussed. First, while Medicare is a federal program with no state governance or policymaking, it is regionally administered by private insurance companies that contract with the Department of Health and Human Services (HHS) to manage the program. Contractors have had a role in Medicare from the beginning of the program in 1965. Likewise, regional administration always has been a feature of the program. Second, private health insurers, *i.e.* managed care organizations, have been delivering the distinct Medicare benefits through Medicare "Part C" since 1997.[57] Other forms of private insurance also have worked with Medicare. For example, when prescription drugs were added in 2003 ("Part D"), the drug coverage was provided solely through stand-alone, privately run drug insurance plans, a new commercial insurance creature, and the Secretary's authority was limited regarding certain key features of Part D such as price negotiation.[58] Third, Medicare is a product of its enactment era, providing hospital benefits and some outpatient benefits but never covering all of the

definition. Pub. L. No. 111-148, §4103, applicable to services furnished on or after Jan. 1, 2011; §4103(e), set out as a note under 42 U.S.C.A. §1395l (2015).

55 *50th Anniversary of Medicare and Medicaid*, LBJ PRESIDENTIAL LIBR., http://www.lbjlibrary.org/50th-anniversary-of-medicare-and-medicaid (last visited Sept. 1, 2020).

56 ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA 24-31 (Free Press 2d ed. 2004).

57 Balanced Budget Act of 1997, Pub. L. No. 105–33, 111 Stat. 251 (1997).

58 42 U.S.C. § 1395w–111(i) (The Secretary of HHS is forbidden to negotiate drug prices, what some call the "non-interference clause.").

medical needs or costs for the elderly.[59] Medigap is a private insurance product, regulated by HHS,[60] that supplements and complements Medicare's benefit structure and is purchased by approximately 29% of Medicare beneficiaries.[61]

In short, Medicare is not the government-only, universal, uniform, and comprehensive public insurance program many believe it to be. The missing pieces are important, because Medicare always had a role for private insurance and never included comprehensive benefits. As such, the phrase "Medicare for All" is confusing because the proponents of this idea seem to mean something more complete and inclusive than Medicare. What is meant by these words is a question that must be answered before anyone can determine whether Medicare for All is the future of health reform.

Current proposals do not reflect precise use of the word Medicare but rather something more atmospheric, meaning some kind of legislative reform that offers more in the way of national public insurance. "Medicare" is used as a public relations tool, knowing it is a politically popular program that could draw in public support;[62]

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[59] DANIEL J. SCHREINER, CTR. MEDICAID & MEDICARE SERVS., OFFICE OF THE MEDICARE OMBUDSMAN: IMPROVING MEDICARE FOR BENEFICIARIES 2010 REPORT TO CONGRESS 2 (2010), https://www.cms.gov/media/68976; FRED RICCARDI, JULIE CARTER & RACHEL BENNETT, MEDICARE RTS. CTR., MEDICARE TRENDS AND RECOMMENDATIONS: AN ANALYSIS OF 2017 CALL DATA FROM THE MEDICARE RIGHTS CENTER'S NATIONAL HELPLINE 3, 5 (2019), https://www.medicarerights.org/pdf/2017-helpline-trends-report.pdf (beneficiaries' complaints about costs in Medicare); Sean Williams, *Medicare's Biggest Problem Is Probably Not What You Think,* MOTLEY FOOL (July 11, 2018), https://www.fool.com/retirement /general/2016/02/21/medicares-biggest-problem-is-probably-not-what-you.aspx (explaining Medicare's complexities); Martine G. Brousse, *Medicare Part C is No Advantage for Providers,* NERD WALLET (Sept. 10, 2014), https://www.nerdwallet.com/blog/health /medicare-advantage-part-c-providers/ (reporting complaints about hidden costs in Part C plans).

[60] 42 U.S.C. § 1395ss (2015).

[61] Juliette Cubanski et al., *Sources of Supplemental Coverage Among Medicare Beneficiaries in 2016*, KAISER FAM. FOUND. (Nov. 28, 2018), https://www.kff.org/medicare/issue-brief/sources-of-supplemental-coverage-among-medicare-beneficiaries-in-2016/ (Four in five Medicare beneficiaries have supplemental coverage of some kind; about 30% have ESI to supplement Medicare and 22% have Medicaid coverage.).

[62] SANDERS.SENATE.GOV, *Summary of the Medicare for All Act*, https://www.sanders .senate.gov /newsroom (follow "Directions" hyperlink; then click the magnifying glass search icon in the right corner and search "Sanders, 14 Senators Introduce Medicare for All", scroll down to the bottom of the page and select "For a summary of the Medicare for All Act, click here") (directly available at https://www.sanders.senate.gov/download/medicare-for-all-2019-

"Medicare" also indicates federal government-run, uniform public insurance. Some use "Medicare" to signal public insurance available to everyone or to indicate exclusion of private insurance. Others use it to signal (or seek) administrative ease. At a high level of generalization, "Medicare" has become the proxy for a few concepts: universal coverage, programmatic and administrative simplification, lower patient costs for coverage and care, greater equity, and (perhaps) one single public payer for health care.

B. Medicare for All −Single Payer Models

At one end of this spectrum are two Medicare for All bills, each proposing a uniform, public health insurance program for all United States residents −a national, government run "single payer" model of health care finance. The two bills are Representative Jayapal's "Medicare for All Act"[63] and Senator Sanders's "Medicare for All Act."[64] Both bills create a federal, public, health insurance program, but the bills have key differences too – highlighting that even M4A does not have one meaning in legislative proposals trying to create the same kind of program.[65]

1. Actual Single Payer

Jayapal's bill establishes a new national health insurance program that covers all residents, beginning at birth, which would be phased in over two years.[66] Immigrants are included and citizenship status is not a barrier, though the bill tasks HHS with ensuring that medical tourism to the U.S. does not take advantage of the program. The bill forbids private insurers and employers' self-funded plans from

summary?id=FA52728F-B57E-4E0D-96C2-F0C5D346A6E1&download=1&inline=file).

63 Medicare For All Act of 2019, H.R. 1384, 116th Cong. (2019) (available at https://www.congress.gov/116/bills/hr1384/BILLS-116hr1384ih.pdf).

64 Medicare For All Act of 2019, S. 1129, 116th Cong. (2019) (available at https://www.congress.gov/bill/116th-congress/senate-bill/1129/text).

65 Micah Johnson et al., *Medicare for All: An Analysis of Key Policy Issues*, 39 HEALTH AFF. 133, 135 (2020) (for a rundown of some key features of the two bills, the chart at Exhibit 1 is especially useful).

66 Katie Keith, *Unpacking the House Medicare-For-All Bill*, HEALTH AFF. (Mar. 3, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190302.150578/full/.

duplicating the outlined and rather generous Medicare for All insurance benefits so that if private insurance continued to exist, it could not compete with Medicare for All. The bill does not rely on private insurers to administer the program. Regional federal offices would be established to administer the program, rejecting Medicare's contractor system.

Jayapal's is the most comprehensive public insurance proposal in terms of benefits. For example, and perhaps most unusually, the bill includes long-term care in the list of covered services. Many are surprised that Medicaid, not Medicare, covers the great majority of long-term services and supports, including nursing home care for the elderly, and this issue is often the elephant in the room when health reform is debated. The bill also uniquely draws on core, distinctive Medicaid concepts, such as the comprehensive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requirements for children.[67] The bill would also permit states to provide additional benefits beyond what the national Medicare for All program covers.[68] But, Medicaid would not exist as a separate public program because this bill creates one federal payer for health care. Many have questions about how funding would work for these proposals, but only one payment plan exists so far, and it is discussed below.

2. Very Nearly Single Payer

Senator Sanders's bill is substantially similar to Jayapal's. This bill uses the name Medicare purposefully as a PR tool[69] and builds on existing Medicare by expanding benefits, decreasing out of pocket costs by eliminating co-payments and deductibles, and lowering the age of eligibility to birth during a four-year phase-in period. Private insurers and employer self-insurance plans are prohibited from competing with the national program. Both bills eliminate the 2003 prohibition on HHS negotiating prescription drug prices for Medicare Part D.[70]

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67 H.R. 1384 § 201a(12) (2019).

68 H.R. 1384 § 201(e) (2019).

69 SANDERS.SENATE.GOV, *supra* note 62.

70 Medicare at 50 Act, S. 470 § 3, 116th Cong. (2019) (available at https://www.congress

A notable difference from Jayapal's bill is that Medicaid remains for the limited role of covering institutional long-term care. The Sanders bill does not address whether HHS would retain demonstration waiver authority (section 1115 of the Social Security Act, of which Medicare and Medicaid are also part), which states have used to circumvent federal rules.[71] Otherwise, Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) as they currently exist would end, and Medicare would become the only public insurance program for U.S. residents for all other medical care. Veterans and Native Americans would retain distinct federal medical programs.

Senator Sanders has advocated for single-payer public health insurance for many years with few co-sponsors, but this bill became co-sponsored by many senators, some of whom were candidates vying for the Democratic nomination, such as Senators Cory Booker, Kirsten Gillibrand, Kamala Harris, and Elizabeth Warren.[72] For Democrats who were trying to capture the party's nomination, Medicare for All became an early litmus test[73] – even though the candidates did not seem to understand deeply what it means and may have been tripped up by the high stakes, and highly technical, early policy issue. For example, Senator Harris wavered on whether private insurance would have a role in a Medicare for All program,[74] seemingly not appreciating the current system or Senator Sanders's advocacy for a new single payer system with no private insurance. Critics jumped at

.gov/bill/116th-congress/senate-bill/470/text).

71 S. 1129 Sec. 1947. Medicare for All Act, S. 1129, 116th Cong. §204 (2019)("Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting the following section after section 1946:"STATE PLAN FOR PROVIDING INSTITUTIONAL LONG-TERM CARE SERVICES "Sec. 1947. (a) In General…").

72 *See, e.g.*, Alexander Burns, *Gillibrand Drops Out of 2020 Democratic Presidential Race*, N.Y. TIMES (Aug. 28, 2019), https://www.nytimes.com/2019/08/28/us/politics/kirsten-gillibrand-2020-drop-out.html (Gillibrand dropped out of the primaries race on Aug. 28, 2019, before the third primary debate).

73 *See, e.g.*, Astead W. Herndon, *Elizabeth Warren Isn't Talking Much About 'Medicare for All' Anymore*, N.Y. TIMES (Jan. 1, 2020), https://www.nytimes.com/2020/01/01/us/politics/elizabeth-warren-medicare-for-all.html (reporting some candidates backing off of the idea).

74 Dan Diamond & Christopher Cadelago, *Kamala Harris' new health plan: 'Medicare for All'-with private insurers*, POLITICO (July 29, 2019), https://www.politico.com/story/2019/07/29/ kamala-harris-medicare-for-all-1438631.

this misunderstanding, but Harris was not alone; Senator Booker and others had similar moments, like most Americans trying to understand how health care works.[75]

The structure of M4A, whether a Jayapal or a Sanders plan, would be highly disruptive to the health care landscape. Senator Warren laid out the cost of a single-payer proposal in broad strokes using a few major revenue buckets, with numbers projected over ten years.[76] These figures include: reduction in administrative costs from eliminating private insurance and keeping federal administrative spending at 2.3%, payment reform that caps provider reimbursements at 110% of current Medicare rates with adjustments for rural and teaching hospitals, preventing consolidation between providers, and limiting drug costs (Warren appears to measure these reforms at $350 billion); redirecting state and local spending on health care to M4A ($6 trillion); employer taxes to replace ESI ($9 trillion) with possible supplemental taxes on employers if funding falls short; increased wages due to decreased employment benefits that are taxable ($1.15 trillion); better tax enforcement ($2.5 trillion); taxing the wealthy ($3.2 trillion all together); limits on defense spending ($798 billion); and immigration reform that creates more taxable income ($400 billion).[77] Warren's plan claims the total cost would be less than $52 trillion over ten years, and by her team's calculation, maintaining the current system would cost more than $52 trillion over the same period.[78]

Whether or not this price tag is a sound estimate,[79] it is safe to assume that system-wide financial shifts would occur in a national

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[75] Emily Stewart, *Cory Booker had a confusing answer about health care in his first 2020 press conference*, VOX (Feb. 1, 2019, 5:00 PM), https://www.vox.com/policy-and-politics/2019/2/1/18207383/cory-booker-2020-medicare-for-all.

[76] Elizabeth Warren, *Ending the Stranglehold of Health Care Costs on American Families*, (@teamwarren), MEDIUM (Nov. 1, 2019), https://medium.com/@teamwarren/ending-the-stranglehold-of-health-care-costs-on-american-families-bf8286b13086 (last visited Nov. 27, 2019).

[77] *Id.*

[78] Jacob Pramuk, *Elizabeth Warren says she would not raise middle-class taxes for $52 trillion health-care plan,* CNBC (Nov. 1, 2019), https://www.cnbc.com/2019/11/01/elizabeth-warren-releases-plan-to-pay-for-medicare-for-all.html.

[79] *Cf.* LINDA J. BLUMBERG ET AL., URB. INST. & COMMONWEALTH FUND, FROM INCREMENTAL TO COMPREHENSIVE HEALTH INSURANCE REFORM: HOW VARIOUS REFORM OPTIONS COMPARE ON COVERAGE AND COSTS 11 (2019), https://www.urban.org/sites/default/files/2019/10/15

single-payer program. For example, the federal government no longer would forgo the $200 billion it exempts from employer and employee wage taxes. It is not clear whether dollar-for-dollar wage replacement occurs, *i.e.*, that employers relieved of the expense of ESI correspondingly raise wages to the level that health insurance costs the employer.[80] Assuming employers pay employees higher wages upon ceasing ESI, a new stream of taxable employee income would increase the flow collected by the federal government and by states with income taxes. Correspondingly, the 56% of the nonelderly population that has ESI[81] would not pay thousands of dollars per year in premiums and other out of pocket costs to private corporations. Rather, a new tax structured something like the Social Security tax is likely to occur. Providers would be subject to government-negotiated payment rates, perhaps like the complex algorithms Medicare currently uses. For example, the Warren plan proposes to pay health care providers slightly more than Medicare does now, which would be helpful to Medicaid and other safety net providers but a possible loss for providers primarily serving private insurance populations. Whether all providers could thrive within a more heavily negotiated payment system is an open question.[82] Advocacy groups for providers have formed.[83] Providers that struggle, such as rural hospitals and

/from_incremental_to_comprehensive_health_insurance_reform-how_various_reform_options_compare_on_coverage_and_costs.pdf.

80 *See* Austin Frakt, *Would Your Wages Rise Under 'Medicare for All'?*, N.Y. TIMES: THE UPSHOT (Feb. 3, 2020, 12:00 AM), https://www.nytimes.com/2020/02/03/upshot/wages-medicare-for-all.html (summarizing on the debate about the replaced wages question).

81 Michelle Long et. al., *Trends in Employer-Sponsored Insurance Offer and Coverage Rates, 1999-2014*, KAISER FAM. FOUND. (Mar. 21, 2016), https://www.kff.org/report-section/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014-issue-brief/ (last visited Apr. 23, 2020).

82 Priyanka Dayal McCluskey, *Bucking industry line, some hospital chiefs see benefits of Medicare for All*, BOS. GLOBE (Nov. 26, 2019), https://www.bostonglobe.com/business/2019/11/26 /bucking-industry-line-some-hospital-chiefs-see-benefits-medicare-for-all/W00HUadCViVYBbOyajclvL/story.html (exploring the question of whether hospitals uniformly reject a single payer approach).

83 *See* Alex Gangitano, *Top lobbying groups dive into 'Medicare for All' debate*, THE HILL (June 28, 2019, 01:04 PM), https://thehill.com/business-a-lobbying/450901-top-lobbying-groups-part-of-medicare-for-all-debate; *see also* Adam Cancryn, *The Army Built to Fight 'Medicare for All'*, POLITICO (Nov. 25, 2019, 05:08 AM), https://www.politico.com/news/agenda/2019 /11/25/medicare-for-all-lobbying-072110 (reporting on Partnership for America's Health Care Future, a health care industry lobbying cooperative "designed to overwhelm not just the

community health centers, may be squeezed the most, so some are beginning to acknowledge their specific needs.[84] But, many criticize the costs of American health care as senselessly high, especially relative to America's health outcomes.[85] Some price de-escalation is not inherently dangerous to the continued existence of all health care providers.[86] This paper cannot offer a complete analysis with so many details still to be decided, but rather I highlight immediate foreseeable changes, which indicate why the M4A bills would be the most disruptive to implement.

C. Medicare Expansion

Two bills expand Medicare eligibility for people over age 50 not eligible for other insurance coverage, a group that had trouble gaining insurance coverage before the ACA. I call this concept "Medicare expansion," rather than the more common "Medicare buy in," because Medicare eligibility would be expanded in similar fashion to Medicaid expansion under the ACA. It seems the root of this idea is in the ACA's expansion successes (and failures).

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swelling Medicare for All movement, but every single Democratic proposal that would significantly expand the government's role in health care.").

84 *See generally* Nicole Huberfeld, *Rural Health, Universality, and Legislative Targeting*, 13 HARV. L. & POL'Y REV. 241 (2019).

85 *See generally*, ELIZABETH ROSENTHAL, AN AMERICAN SICKNESS (Penguin Books ed., 2018) (cataloging for public reading the high costs of American health care and proposing plans of action for laypeople); Gerard F. Anderson et al., *It's the Prices Stupid: Why The United States Is So Different From Other Countries*, 22 HEALTH AFFS. 89 (2003); Bradley Sawyer & Cynthia Cox, *How does health spending in the U.S. compare to other countries?*, PETERSON-KAISER FAM. FOUND. (Dec. 7, 2018), https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/; *OECD Health Statistics 2019*, ORG. FOR ECON. COOP. & DEV., (Jan. 13, 2020), https://www.oecd.org/els/health-systems/health-data.htm ("At 17.1%, the United States spent the highest share of GDP on health in 2017, while Turkey allocated around 4.2% of its GDP in the same year.").

86 Emily Rappleye, *Princeton economists: Physicians are 'taking money away from the rest of us'*, BECKER'S HOSP. REV. (Jan. 8, 2020), https://www.beckershospitalreview.com/hospital-physician-relationships/princeton-economists-physicians-are-taking-money-away-from-the-rest-of-us.html (economists Ann Case and Angus Deaton called physicians an untouchable "rent-seeking conspiracy.").

Senator Stabenow's "Medicare at 50 Act"[87] permits people aged 50-64 to buy into the existing Medicare program and does not dislocate other portions of the health care system. The bill provides subsidies much like the tax credits available to individuals purchasing insurance in the exchanges.[88] It also prevents states from using Medicare expansion to purchase insurance for Medicaid-eligible populations (cost-shifting to the federal government that states have tried in the past).[89] Stabenow's bill also enables HHS to negotiate Part D drug prices.[90]

Representative Higgins's related bill, the "Medicare Buy-In and Health Care Stabilization Act," is substantially similar.[91] This bill expands Medicare eligibility to people aged 50-64, allows variation in premiums for these younger enrollees, and makes Medicare expansion coverage available to be purchased through exchanges like qualified health plans.[92] In addition, this bill reverses actions the Trump administration has taken to undermine the exchanges, such as reinvigorating risk corridor payments and reinstating and enhancing cost sharing reductions for all exchange plan participants, which would help to stabilize the exchanges while adding this new Medicare-eligible population.[93] Like the Stabenow plan, the Higgins bill would not eliminate private insurance or other public insurance programs. The Higgins bill uniquely creates a Medigap public option, a new kind of Medigap coverage that could be purchased by the Medicare expansion population and traditional beneficiaries.

Both bills connect Medicare expansion to the existing ACA rules for purchasing qualified health plans (QHPs) on the exchanges, thereby increasing the number of individuals purchasing insurance through the exchanges and potentially fortifying exchange structures. It is difficult to predict what impact the private insurers offering QHPs

87 *See generally* Medicare at 50 Act, S. 470, 116th Cong. (2019).

88 *Id.* at § 2(f).

89 S. 470, 116th Cong. § 2(g)(4).

90 *Id*. at § 3.

91 *See generally* Medicare Buy-In and Health Care Stabilization Act of 2019, H.R. 1346, 116th Cong. (2019).

92 *Id.* at § 3(h).

93 H.R. 1346, 116th Cong. §§ 7–8.

would experience. Existing plans could lose enrollment to Medicare, but they could also raise prices so that lower income subscribers are compelled to purchase the public option, which would improve private insurers' risk pools. QHPs, alternatively, could participate in Medicare expansion as Part C plans, which allow commercial managed care organizations to deliver Medicare benefits within flexible parameters. All plans seem likely to have shifting subscribers. Some enrolled in QHPs might move to a Medicare expansion product, but if QHPs opt to become Medicare expansion insurers, then some insurers in the exchanges would have a steady number of enrollees. Insurers that do not currently provide Part C plans might be incentivized to do so.

These bills could be moderately disruptive because they invite a new population into Medicare, expanding eligibility for that public program in a novel way. From an insurance market perspective, Medicare expansion appears to be an option that, aside from Medicare for All, is least like what exists in the current health care system because it adds a significant population to the one truly national, fairly uniform health insurance program. On the other hand, Medicare expansion could be argued to be non-disruptive because so many health care providers already participate in Medicare, and this would simply invite more, younger people to be covered by that familiar program. The disruption is less likely to be on the provider side and more likely on the commercial insurance market side. The cost of Medicare expansion may be comparable to Part C, which historically has been more expensive than traditional Medicare because private insurers have higher administrative costs and pay providers more.[94] But Medicare expansion would be covering a population that has had a hard time obtaining ESI and, at least initially, could be sicker and thus more expensive to cover. Over time, this cost dynamic would smooth out. No price estimate exists yet for these bills.

[94] *See generally*, David U. Himmelstein et al., *Health Care Administrative Costs in the United States and Canada*, 172 ANNALS INTERNAL MED., 134–142 (2020) (describing and analyzing differences in administrative costs for private insurance in the U.S. and Canada).

D. New Public Insurance Options

A handful of bills create a "Public Option," meaning publicly created and sponsored health insurance that competes with existing public and private health insurance options, though which plans remain varies by the bill. At the maximalist end, the public option replaces other public insurance and some private insurance. At the minimalist end, the public option is sold in competition with QHPs offered through the exchanges. In short, this would be a federal, government-run insurance plan, sold as a competitor in the same markets. This category includes five bills, some of which rely on the brand name of Medicare but do not involve the existing Medicare program.

The "Medicare for America Act" takes a maximalist approach to a public option and is sponsored by Representative DeLauro (with no Senate related bill).[95] This bill creates a federally run health plan that will operate as a QHP to be offered through health insurance exchanges but morphs into a public plan to which all lawful residents are entitled at birth and supplants Medicaid, Medicare, and most private insurance (nongroup and small group, exchanges are phased out). ESI remains a source of coverage, and some people with qualifying coverage (largely through ESI) could opt out of the public plan.[96] State agencies responsible for administering Medicaid would be in control of enrollment in each state.[97] State laws that could interfere with the public plan are preempted. Those earning less than 200% of the FPL would not pay premiums or cost sharing; those earning 200-600% of the FPL would pay premiums on a sliding scale; those earning more would have premiums capped at 8% of income.[98] Medicare for America would simplify both existing public insurance and publicly-sponsored private insurance (Medicare, Medicaid, tax-credit supported small and nongroup insurance, exchanges) but leaves

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95 *See generally* H.R. 2452, 116th Cong. (2019).

96 *Id.* at § 2202(b)(4)(A).

97 *Id.* at § 2202(b)(1).

98 Tricia Neuman et al., *10 Key Questions on Public Option Proposals*, KAISER FAM. FOUND. (Dec. 18, 2019), https://www.kff.org/health-reform/issue-brief/10-key-questions-on-public-option-proposals/.

employers in the health insurance game. This approach sustains and modifies the hybrid public/private insurance scheme, administratively simplifying it and making the public insurance more inclusive (enrollment eventually becomes automatic at birth). States retain a role in health policy by administering the expanded Medicare program and by having an option to cover those not eligible for Medicare for America (namely undocumented immigrants).

The next four bills all create a new "public option" similar to the public option debated when the ACA was drafted: the Choose Medicare Act, an identical bill sponsored by Senator Merkley and Representative Richmond;[99] Medicare-X Choice Act, an identical bill sponsored by Senator Bennet and Representative Delgado;[100] Keeping Health Insurance Affordable Act, sponsored by Senator Cardin;[101] and the Consumer Health Options and Insurance Competition Enhancement Act (CHOICE Act), an identical bill sponsored by Representative Schakowsky and Senator Whitehouse.[102] "Public option" in these bills means creating a new, federally-run public health insurance plan, available for purchase on the exchange, with some variation in features. For example, the Choose Medicare Act and the Medicare-X Choice Act would increase the federal premium tax subsidies for all exchange participants. The Cardin bill and the Merkley/Richmond bill increase the income level at which individuals can receive tax credits, up to 600% of the FPL.[103] All of the plans operate by adding a new public plan to exchange markets with some differing eligibility. For example, the Keeping Health Insurance Affordable Act and the CHOICE Act are the narrowest bills, adding one federal plan to the exchange with no enhanced subsidies. The Medicare-X bill adds

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99 *See generally* Choose Medicare Act, S. 1261, 116th Cong. (2019); *see also* H.R. 2463, 116th Cong. (2019).

100 *See generally* Medicare-X Choice Act of 2019, S. 981, 116th Cong. (2019); *see also* H.R. 2000, 116th Cong. (2019).

101 *See generally* Keeping Health Insurance Affordable Act, S. 3, 116th Cong. (2019).

102 *See generally* Consumer Health Options and Insurance Competition Enhancement Act H.R. 2085; *see also* S. 1033 (Consumer Health Options and Insurance Competition Enhancement Act, "CHOICE Act").

103 *See generally* H.R 3590, 111th Cong. (2010) (enacted) (Patient Protection and Affordable Care Act); *see also* 26 U.S.C. § 36B (2010) (Tax subsidies are available for those earning 100-400% of FPL).

a public plan to the exchange, phasing it in first in single insurance issuer and high cost areas before rolling out the public option nationwide, but this bill also enhances subsidies and makes the public option available to small groups (including small employers). The Choose Medicare Act creates "Medicare Part E" for anyone not already eligible for public insurance, and, uniquely, allows employers to offer Part E as a purchased health plan or to use Part E to administer self-insured plans[104]

These four bills all rely on current Medicare participating providers to take part in the public option at Medicare payment rates. All four give the Secretary of HHS authority to negotiate drug prices. The CHOICE Act allows (but does not require) states to advise the Secretary on cost control measures[105] Currently this is the only bill to give states a formal role in the public option (aside from possibly running the exchange on which the public option is sold, a role offered to states under the ACA). None affect the Medicaid program directly.

These plans tinker with the ACA's private insurance structures, providing the public option that was hotly and briefly debated before it became clear that politicians in 2008 had little taste for a new federally-run public health insurance mechanism – the fight shaped up to be too big. Now, these minimalist public option plans seem almost conservative compared to the maximalist bills capturing much of the conversation.[106]

The public options proposed in these bills would operate much like Medicare when it was enacted in 1965 – a new government-run insurance plan slotting into the field of health insurance products. At first glance, this approach does not seem as disruptive as Medicare for All or Medicare Expansion plans. Rather, a public option adds a new,

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104 *See generally* Neuman et al., *supra* note 98.

105 Keeping Health Insurance Affordable Act, *supra* note 101.

106 Another interesting variation, which reflects some of the backpedaling from the early M4A push, is candidate Pete Buttigieg's "Medicare for all who want it," which also fits in this model. This plan would automatically enroll people eligible for the version of a public option he proposes and retroactively enroll those who seek health care without knowing they are covered. PETE 2020, MEDICARE FOR ALL WHO WANT IT: PUTTING EVERY AMERICAN IN CHARGE OF THEIR HEALTH CARE WITH AFFORDABLE CHOICE FOR ALL 4 (2019), https://web.archive.org/web/20200218065540/https://storage.googleapis.com/pfawebapp/documents/MFAWW_I_white_paper_FINAL.pdf.

yet somewhat familiar, possibility for insurance purchasers because it does not require existing actors to behave differently. Health insurance carriers may scale their pricing to be competitive with a public option. Alternatively, private insurers could raise rates to push undesirable subscribers toward a public option. Conversely, some subscribers may prefer the lower cost and (possibly) lower risk public option, which is likely to offer broader benefits than private insurance does, especially tempting for anyone with chronic conditions, high costs, or other factors causing unpredictable medical expenses. This could lead to a softened adverse selection (many would not be opting for insurance at the moment of illness, given coverage under the ACA). A public option could be more disruptive in private insurance markets that have just one or two insurers. Also, some worry that any public option would displace market dominant insurers and tip the scales toward public insurance rather than our current hybrid of public and private insurance.[107]

Whether a public option remains a contained choice or becomes the proverbial camel's nose under the tent, a public option does not simplify the current system, and it is difficult to predict how it would affect the high cost of medical care overall because no real estimates exist. (The Medicare for America Act is an exception, as it starts like a public option but veers closer to the Medicare for All bills as implementation progresses.)

E. Medicaid Buy In

The State Public Option Act is an identical bill sponsored by Senator Schatz and Representative Luján.[108] This bill creates a new state-delivered option within Medicaid to offer Medicaid coverage to uninsured individuals who do not otherwise qualify for Medicaid expansion eligibility. States could require this newly eligible population to pay "actuarially fair" premiums, copayments, and

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[107] Helen A. Halpin & Peter Harbage, *The Origins and Demise of the Public Option*, 29 HEALTH AFFS. 1117–124 (2010) (tracing the origin of the public option idea leading to the ACA and the political arguments for and against it).

[108] S. 489 & H.R. 1277, https://www.congress.gov/bill/116th-congress/senate-bill/489/ related-bills.

deductibles.[109] The bill also renews the ACA's temporary increase in Medicaid payment levels for primary care physicians and expands the types of providers who receive the increased payments.[110] The bill eliminates the Hyde Amendment's restriction on HHS's ability to pay for abortions and makes all reproductive care mandatory for states to cover in Medicaid.[111]

The State Public Option Act both builds on and reinforces the ACA's Medicaid expansion, restarting federal supermatch payments (100% federal funding) to expansion hold-out states for the first three years of expansion.[112] It also allows states to cover their entire uninsured population through Medicaid buy-in, even if the uninsured are eligible to purchase insurance through an exchange. Enrollment for the Medicaid buy-in could be limited to the exchange open-enrollment period rather than the traditional permanent open enrollment of Medicaid.

The Medicaid-based public option could shift some low-income individuals from private insurance or ESI to Medicaid coverage, but the number would be low in states that have already expanded Medicaid eligibility. Some of the individuals who are eligible for tax credit assisted purchase of insurance on an exchange may opt instead for Medicaid, as it has much lower out-of-pocket costs. The Medicaid Act has largely forbid cost sharing (like copays), and premiums are rarely allowed. The "actuarially valid" cost of this plan is too vague to evaluate.

The structure of this bill is different from the other bills and from existing insurance possibilities because it fashions a Medicaid-based "public option" that, like traditional Medicaid, relies on states to choose to implement this new policy. To a degree, this approach targets frustrations of low to middle income individuals who cannot afford the high out-of-pocket costs of private insurance plans on the

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109 S. 489 & H.R. 1277, § 2(d).

110 S. 489 & H.R. 1277, § 4. Senate Bill 489; House Bill 1277 § 4. The ACA increased primary care payments to Medicare levels to incentivize physicians to take newly covered beneficiaries.

111 S. 489 & H.R. 1277, § 6. Senate Bill 489 § 6. House Bill 1277 § 6. Most of the bills eliminate the Hyde Amendment or make reproductive health care more broadly accessible in some way.

112 S. 489 & H.R. 1277, § 5. *See also* Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 451 (2011) (coining "supermatch," the ACA's 100% match initiated to help states with the newly eligible beneficiaries).

exchanges – anyone who could buy insurance on an exchange could choose the Medicaid public option – and the idea appears popular in polling.[113] But, states that have resisted exercising the options in Medicaid historically, or that have opted out of ACA Medicaid expansion (often the same states), are unlikely to take up a new public option even though it is the most federalism-centric, or state-inclusive, of the current bills. As is discussed below, the constitutional structure of this bill is not straightforward for the simple fact that states are given a key role in governance.

F. State-based Measures

A few states have considered creating a form of public option rather than wait for Congress. So far, Washington is the only state to enact a state-based public insurance plan, called Cascade Care, enacted in 2019.[114] Cascade Care will be sold starting in 2021 through the exchange, which is state-run, and it does not actually create a public health insurance program. Rather, Washington will contract with private insurers to administer Cascade Care's "standardized health plans" as defined by state law, and the state will control the terms of the plans to achieve goals like managing costs, such as, capping payments to providers at 160% of Medicare reimbursement rates. Insurers participating in Cascade Care are not required to offer plans state-wide. This kind of attempt at price control may offer a model for other states or for the federal government if it creates a public option, but the program is too new to know if its rate controls will be effective, well received by providers, or otherwise successful.

Colorado's governor signed similar legislation on May 17, 2019.[115] HB 1004 focuses on providing a public insurance option for rural and

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113 *Health Tracking Poll – January 2019: The Public On Next Steps For The ACA And Proposals To Expand Coverage*, KAISER FAM. FOUND. (Jan. 23, 2019), https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019/.

114 *See generally* S.B. 5526, 66th Leg., Reg. Sess. (Wash. 2019) (available at https://app.leg.wa.gov/billsummary? BillNumber=5526&Initiative=false&Year=2019); *see also* Austin Jenkins, *Will Washington State's New 'Public Option' Plan Reduce Health Care Costs?*, NPR (May 16, 2019), https://www.npr.org/sections/healthshots/2019 /05/16/723843559 /will-washington-states-new-public-option-plan-reduce-heath-care-costs.

115 H.B. 19-1004, Gen. Assemb, Reg. Sess. (Colo. 2019) (available at https://leg.

mountain communities, which have higher costs for insurance coverage and, often, just one plan available. The bill directs state agencies to complete a proposal for implementing the bill by November 2019.[116] Other states have had similar bills gain traction but either have not been enacted or only started studies. For example, Nevada's "Sprinklecare" (sponsored by Assemblyman Mike Sprinkle) was structured as a Medicaid buy in, but Governor Brian Sandoval vetoed it. Sprinkle revived the bill in 2019 when a new governor took office.[117] New Mexico's legislature considered bills that operate like a Medicaid buy-in but without federal funding, and a task force is studying the policy.[118] Massachusetts had a public option bill that was not enacted.[119] Connecticut had a public option bill working through the legislature in 2019 that was defeated by insurance industry lobbying.[120] A handful of other states have taken similar actions.[121]

A few states have attempted to craft intra-state single payer, but none have succeeded so far. For example, Vermont's "Green Mountain Care" was to be the first state-run public health insurance plan that would eliminate other forms of health insurance within the state, but

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colorado.gov/bills/hb19-1004); *see also* Scott Miller, *Colorado Gov. Polis signs landmark health care legislation in Vail*, POST INDEP. (May 18, 2019), https://www.postindependent.com /news/colorado-gov-polis-signs-landmark-health-care-legislation-in-vail/.

116 Associated Press, *Colorado lawmakers OK bill to develop public health insurance option*, DENVER POST (Apr. 23, 2019, 5:12 PM), https://www.denverpost.com/2019/04/23/colorado-public-health-insurance-option/.

117 Jessie Bekker, *Nevada Assemblyman Sprinkle to take another shot at Medicaid buy-in law*, LAS VEGAS REV. J. (Feb. 2, 2019), https://www.reviewjournal.com/news/politics-and-government/2019-legislature/nevada-assemblyman-sprinkle-to-take-another-shot-at-medicaid-buy-in-law-1588235/.

118 H.B. 416, 54th Leg., 1st Sess. (N.M. 2019), https://www.nmlegis.gov/Sessions/19% 20Regular/bills/house /HB0416.pdf; S.B. 405, 54th Leg., 1st Sess. (N.M. 2019), https://www.nmlegis.gov/Sessions/19%20 Regular/bills/senate/SB0405.pdf.

119 S. 697, 191st Sess. (Mass. 2019) (available at https://malegislature.gov/Bills/191/SD40).

120 Harris Meyer, *Cigna helps shoot down Connecticut public-option bill*, MOD. HEALTHCARE (May 30, 2019), https://www.modernhealthcare.com/insurance/cigna-helps-shoot-down-connecticut-public-option-bill.

121 *See* Heather Howard, *Map: State Efforts to Develop Medicaid Buy-In Programs*, ST. HEALTH & VALUE STRATEGIES (June 4, 2019), https://www.shvs.org/state-efforts-to-develop-medicaid-buy-in-programs/; *see also* Sabrina Corlette et al., *States Seek to Improve Affordability, Expand Coverage with "Public Option" and Medicaid Buy-in Proposals*, GEO. U. HEALTH POL'Y INST. (Jan. 2020), https://Georgetown.app.box.com/s/hxb7k4 wx9ood1t3a8he0h53qqonqurps.

the governor dropped the plan claiming it was unattainable with the state's limited budget.[122] California's repeated single payer bills have passed the legislature only to be vetoed or stall, though Governor Newsome proposed covering undocumented immigrants and supports a single payer approach.[123] Colorado's single-payer ballot measure, Amendment 69, failed in 2016.[124]

While states are playing a role in health reform, the impetus is that the Trump administration's policy is to undermine the law of the ACA and its plan for universal coverage.[125] After the ACA, this is not the policy space that the nation was supposed to be exploring. Though a handful of states are worth watching for stopgap and forward-thinking measures, this minority does not indicate that health reform is shifting to the states.[126] To the contrary, states are also testing out anti-universality approaches with the encouragement of the Trump administration, such as work requirements and block grants under Medicaid.[127]

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122 Sarah Kliff, *How Vermont's single-payer health care dream fell apart*, VOX (Dec. 22, 2014), https://www.vox.com/2014/12/22/7427117/single-payer-vermont-shumlin; Amy Goldstein, *Why Vermont's single-payer effort failed and what Democrats can learn from it*, WASH. POST (Apr. 29, 2019), https://www.washingtonpost.com/national/health-science/why-vermonts-single-payer-effort-failed-and-what-democrats-can-learn-fromit/2019/04/29/ c9789018-3ab8-11e9-a2cd-307b06d0257b_story.html?noredirect=on.

123 Sophia Bollag, *Saying no to the nurses: California Democrats aren't pushing government-run health care this year*, SACRAMENTO BEE (Feb. 27, 2019), https://www.sacbee.com/news/politics-government/capitol-alert/ article226819984.html; *see also* Katy Grimes, *Newsom Proposes State-Funded Health Coverage for Illegal Immigrants*, CAL. GLOBE (Jan. 9, 2019), https://californiaglobe.com/governor/newsom-proposes-state-funded-health-coverage-for-illegal-immigrants/.

124 Dylan Matthews, *Single-payer health care failed miserably in Colorado last year. Here's why.*, VOX (Sept. 14, 2017), https://www.vox.com/policy-and-politics/2017/9/14/16296132/colorado-single-payer-ballot-initiative-failure.

125 *See* Exec. Order No. 13765, 82 Fed. Reg. 8351 (Jan. 20, 2017).

126 *See, e.g.*, Sara R. Collins & Jeanne Lambrew, *Federalism, the Affordable Care Act, and Health Reform in the 2020 Election*, COMMONWEALTH FUND (July 29, 2019), https://www.commonwealthfund.org/publications/fund-reports/2019/jul/federalism-affordable-care-act-health-reform-2020-election (detailing how a federalism structure has weakened the ACA's reforms).

127 *Healthy Adult Opportunity Fact Sheet*, CTR. FOR MEDICARE & MEDICAID SERVS. (Jan. 30, 2020), https://www.cms.gov/newsroom/fact-sheets/healthy-adult-opportunity-fact-sheet (federal policy guidance inviting block grant proposals from states for expansion population).

G. Medicaid for All

No formal Medicaid for All bill or other proposal exists, except in academic writing and opinion pieces.[128] Medicaid has achieved what I have called in other work "unplanned universality"[129] by incrementally and gradually but consistently responding to state and market failures to cover low-income populations' health needs. Medicaid is statutorily capable of providing emergency coverage and is more flexible for natural disasters, epidemics, and other surprise events than other forms of both public and private insurance.[130] Medicaid covers around 21% of the population[131], a percentage that reaches nearly a quarter of the population if complete Medicaid expansion occurred under the ACA. Medicaid covers more than 73 million lives, including nearly half of all births, a third of all children, two-thirds of long-term care costs, a fifth of Medicare beneficiaries, and nearly half of people with disabilities.[132] Medicaid is a program that is designed to assist the poor in particular ways, such as covering care retroactively when beneficiaries enroll and covering transportation for medical services because low-income individuals often have limited means of transport. Medicaid for All does not appear to be a serious proposal, in part because the program's stigma is so sticky. The ACA has lessened the stigma to a degree, because so many people have become outspoken about their need for Medicaid

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128 Michael Sparer, *The Best Replacement for Obamacare Is Medicaid*, N.Y. TIMES (May 18, 2017), https://www.nytimes.com/2017/05/18/opinion/obamacare-repeal-medicaid.html; Lindsay Wiley, *Medicaid for All?: State-Level Single-Payer Health Care*, 79 OHIO ST. L. J. 843 (2018); Joyce Frieden, *You've Heard of Medicare for All—How About Medicaid for More?*, MEDPAGE TODAY (Sept. 13, 2019), https://www.medpagetoday.com /publichealthpolicy /medicaid/82147 (surveying state efforts to expand Medicaid coverage).

129 Nicole Huberfeld, *Rural Health, Universality, and Legislative Targeting*, 12 HARV. L. & POL'Y REV. 501 (2018) (describing Medicaid as "unplanned universalism").

130 Sara Rosenbaum & Stephen Warnke, *Opinion: Even with 'Medicare for all,' we'll still need Medicaid*, L.A. TIMES (Sept. 16, 2019, 3:00 AM), https://www.latimes.com/opinion /story/2019-09-11/medicare-for-all-bernie-sanders-debate-medicaid-public-health.

131 *See Medicaid State Fact Sheets*, KAISER FAM. FOUND, (May 27, 2020), https://www.kff.org /interactive/ medicaid-state-fact-sheets/.

132 *Medicaid in the United States*, KAISER FAM. FOUND. (Oct. 17, 2019), https://www.kff.org /interactive/medicaid-state-fact-sheets/.

coverage, and because of factors such as higher education students being covered by Medicaid.[133] Yet, while Medicaid has a core set of strong statutory principles, and its flexibility in spending and coverage must be enveloped in any new approach to health reform, Medicaid results in variable coverage, access, and cost because states have so much flexibility in the program. Variability often leads to inequity in health care, and this is a predictable outcome for a federalism structure.

Each of the reform proposals responds in some way to gaps remaining in health care finance, access, and cost that the ACA began to address. Most notably, these bills seek to increase the role of government in health care finance, at the minimalist end, as a risk-bearing market participant and, at the maximalist end, by replacing health insurance mechanisms that currently exist. None are anywhere near the time-worn bugaboo of "socialized medicine," the classic model of which is the British National Health Service in which government runs the entire system, including employing providers and paying for care.[134] All bills would affect the status quo to some degree. Few achieve administrative simplicity. While reports indicate that the public's taste for M4A fluctuates, the drive for another kind of public insurance is consistent.[135] To that end, the next part evaluates the policy features of these bills from a constitutional perspective.

III. Distance between Policy and Constitutionality

For years, Senator Sanders alone called for Medicare for All, so each of the Democratic candidates responding to his plan is a remarkable signal. The host of health reform bills before the 116th Congress also indicate that the needle has moved on public and

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133 Sallie Thieme Sanford, *Health Reform and Higher Ed: Campuses as Harbingers of Medicaid Universality and Medicare Commonality*, 47 J.L. MED. & ETHICS 79 (2019).

134 *60 Years Ago – American Medical Association president told Scranton crowd fight 'Socialized Medicine'*, THE TIMES-TRIBUNE (Jan. 21, 2020), https://insurancenewsnet.com/oarticle/60-years-ago-american-medical-association-president-told-scranton-crowd-fight-socialized-medicine.

135 *See* Paige Winfield Cunningham, *The Health 202: Medicare-for-all goes MIA on the 2020 trail. Only Bernie Sanders remains a purist*, WASH. POST (Jan. 13, 2020, 7:08 AM), https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2020 /01/13/the-health-202-medicare-for-all-goes-mia-on-the-2020-trail-only-bernie-sanders-remains-a-purist/5e1796cf602ff16e78f3e28a/.

perhaps political expectations.[136] The ACA's constant presence at the center of political conversation, somewhat ironically, appears to have embedded its norm, making insurance coverage at least near-universal.[137] Democrats' debates indicated that candidates were trying to figure out how far to move toward single payer whether to jump on board or build something with similar goals achieved differently, mostly by agreeing that government-sponsored health insurance is necessary but differing with regard to its reach.[138]

Also, remarkably, both Sanders and Warren campaigned on the idea that health care is a human right.[139] Other candidates favor universal coverage and would advance it with some version of Medicare for All, Medicare expansion, or a public option, with differences in particulars rather than principles.[140] For example, Senator Harris's proposal included a comprehensive disability care plan and built on Medicare Part C.[141] Pete Buttigieg's proposal called for universal coverage and allowed private insurance to remain, calling his plan "Medicare for all who want it," and focusing attention on the plight of rural health and Native Americans.[142] Vice President

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136 Lunna Lopes et al., *KFF Health Tracking Poll – January 2020: Medicare-for-all, Public Option, Health Care Legislation And Court Actions*, KAISER FAM. FOUND. (Jan. 30, 2020), https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2020/ ("majority of Americans favor a national Medicare-for-all health plan (56%) but a larger share favors a government-administered "public option" (68%). Notably, nearly half of adults (48%) favor both of these proposals…").

137 Gluck & Huberfeld, THE TRILLION DOLLAR EXPERIMENT, *supra* note 8.

138 Kevin Uhrmacher et al., *Where 2020 Democrats Stand on Medicare-for-all*, WASH. POST (Aug. 30, 2019), https://www.washingtonpost.com/graphics/politics/policy-2020/medicare-for-all /?noredirect=on.

139 Warren stated during the first primary debate and then wrote on Twitter: "Yes, I would support government-run insurance. Health care is a basic human right, and we fight for basic human rights. We need #MedicareForAll. #DemDebate." Elizabeth Warren (@SenWarren), TWITTER (June 26, 2019, 8:26 PM), https://twitter.com/ewarren/status/11440542595472 99850 ; Sanders stated: "…health care is a human right, not something to make huge profits on." Bernie Sanders (@BernieSanders), TWITTER (June 27, 2019, 9:19 PM), https:// twitter.com/berniesanders/status /1144423468328542208?lang=en.

140 Kevin Uhrmacher, et al., *supra* note 138.

141 *See* Caroline Kelly, *Harris unveils disability plan focusing on education and employment opportunities*, CNN (Aug. 29, 2019, 6:05 AM), https://www.cnn.com/2019/08/29/politics /kamala-harris-disability-plan/index.html.

142 *See* Tim Reid, *Democrat Buttigieg unveils healthcare plan for rural Americans, tribes*, REUTERS

Biden, the presumptive nominee as this paper goes to press, would maintain but improve on the ACA, filling gaps with a public option (available without cost to individuals who fall in the coverage gap); increasing tax credits and other financial supports for those purchasing insurance on exchanges; and other features like ending surprise billing, limiting drug prices, and eliminating the Hyde Amendment.[143] In reaction to the global pandemic, Biden also announced that he would expand Medicare eligibility to people age 60 to 64, promoting the idea of Medicare expansion five years earlier than the program has allowed.[144]

The details change regularly and are less consequential here than the themes. Across proposals, consistent ideas include: durable universal coverage that plugs gaps, reduces costs, and increases basic access (most make all residents eligible, including non-citizens); no or very low cost sharing; no or low premiums; specific targeting of prescription drug prices through government negotiation; and fortified access to reproductive care. These common issues suggest a public taste for change reminiscent of the drive for Medicare itself, when senior citizens decried the unpredictable implementation of federal grants-in-aid to states, which often did not deliver on the promise of federal funding because states used the money differently or not at all.[145] Conspicuously, unlike earlier health reform efforts, the proposals discussed have little taste for state "flexibilities" or "states rights" in securing universal coverage. This kind of call for uniformly accessible public insurance coverage has not occurred since Harry Truman attempted universal health insurance coverage after World War II.[146]

(Aug. 9, 2019, 6:04 AM), https://www.reuters.com/article/us-usa-election-buttigieg/democrat-buttigieg-unveils-healthcare-plan-for-rural-americans-tribes-idUSKCN1UZ15A.

143 *See* BIDEN FOR PRESIDENT, https://joebiden.com/healthcare/ (last visited Aug. 30, 2019).

144 Julie Rovner, *Biden's Health Play In A COVID-19 Economy: Lower Medicare's Eligibility Age To 60*, NPR (Apr. 11, 2020, 5:00 AM), https://www.npr.org/sections/health-shots/2020/04/11/832025550/bidens-health-play-in-a-covid-19-economy-lower-medicares-eligibility-age-to-60.

145 STEVENS & STEVENS, *supra* note 56 at 45-46 (States have resisted care for certain residents since the colonial period, relying on concepts of the deserving poor to refuse assistance to those deemed to be shirking the societal expectation of productivity); s*ee generally* Huberfeld & Roberts, *supra* note 7.

146 *See generally* Special Message from President Harry S. Truman to the Congress

A key question is whether the federal government has the power to address these policy desires. As this part shows, constitutional inquiry, political considerations, and policy complexity should be analytically separated to the degree possible. Perhaps, counterintuitively, a bill's degree of disruption does not automatically correspond to its constitutionality. The most disruptive bills are more straightforward from a constitutional perspective because they exercise pure federal spending. Involving the states in health reform will complicate any legislative effort because the Court enforced new limits on conditional federal spending in *NFIB v. Sebelius*, which cabined a mechanism that Congress has long used to influence state participation in federal policies (with the imprimatur of the Court).[147] This part addresses these questions, including issues that could arise from funding health reform with a "wealth tax."

A. Reliance on Spending Power

Many of the current bills would have Congress construct a federal spending program that operates as a new kind of public health insurance or that builds on Medicare by expanding eligibility. Either way, Congress would be spending federal money in crafting a national program, which would be an exercise of the power enumerated in the Spending Clause (sometimes called the "General Welfare Clause" and including the tax power too when so named) and spending for "the general welfare."[148]

The spending power is a broad source of authority for Congress, allowing it to enact laws that directly or indirectly establish national

Recommending a Comprehensive Health Program (Nov. 19, 1945) (available at https://teachingamericanhistory.org/library/ document/special-message-to-the-congress-recommending-a-comprehensive-health-program/).

147 For example, in *New York v. US*, the Court approved federal use of the spending power to influence state policymaking and differentiated use of money to influence state choices from the impermissible commands to states to act. *See New York v. United States*, 505 U.S. 144, 158, 167 (1992) (holding that Congress lacks power to force states to implement certain federally mandated regulations but can exercise the spending power to influence state law).

148 "Congress shall have power to … provide for …the general welfare of the United States….". U.S. CONST. art. I § 8 cl. 1. This is referred to as the General Welfare Clause— the taxing power and the spending power.

policy through federal money.[149] Congress can establish federal programs that are run by the federal government (like Medicare), but Congress can also establish federal policy and then choose to invite state or private actors to participate in the national law (like Medicaid). When Congress spends, it can create conditions for participating in the federal program that are subject to a five-part test asking if: the spending is for the general welfare; the conditions are clear and unambiguous; the conditions are related to the purposes of the federal spending; the conditions are constitutional; and forbidding Congress from crossing from influence to coercion when asking states to take federal money.[150] In other words, the Supreme Court has held that Congress is permitted to influence policymaking through federal spending but must adhere to the Court's rules, which are meant to ensure that federal spending creates no surprises in the conditions imposed on the funds and does not indirectly violate constitutionally-protected state or individual rights.

National programs to improve the public's health, provide access to medical care, or facilitate access through universal health insurance coverage surely constitute spending for the "general welfare." Indeed, health care has been a congressional project since the American Revolution, with the federal government incrementally adding national money and standards when states and markets fail.[151] Paradoxically, the Supreme Court has interpreted congressional constitutional authority broadly enough for Congress to create a national health insurance program since the Great Depression,[152] but it has not been a political possibility, underscoring that constitutional authority and political will are not the same.

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149 United States v. Butler, 297 U.S. 1, 66-67 (1936) ("the power of Congress to authorize expenditure of public moneys for public purposes is not limited by the direct grants of legislative power found in the Constitution…. the powers of taxation and appropriation extend only to matters of national, as distinguished from local, welfare.").

150 Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012); Arlington Central School District Bd. of Educ. v. Murphy, 548 U.S. 291 (2006); South Dakota v. Dole, 483 U.S. 203 (1987); Helvering v. Davis, 301 U.S. 619 (1937).

151 Gluck & Huberfeld, *What Is Federalism in Healthcare For?*, *supra* note 18, at 1706-19.

152 *See generally* United States v. South-Eastern Underwriters Association, 322 U.S. 533 (1944) (commonly cited for the proposition that Congress can exercise the commerce power to regulate the national insurance market. This would also include health insurance.); *see generally* Helvering v. Davis, 301 U.S. 619 (1937).

An example of peak General Welfare Clause power is Medicare, which has long been accepted, even lauded, as a national program that serves the general welfare.[153] Structurally, Medicare is a purely federal spending program, taxing payrolls to providing federal money and programmatic rules −with no role for states. Medicare bypassed the call for protecting states' rights in health care policy due to the elderly successfully convincing members of Congress that the unpredictable nature of state politics and budgeting were too dangerous for the elderly and their families.[154] The conditions Medicare places on federal funds – such as establishing rules for program participation, preventing fraud and abuse, creating algorithms for payment of benefits delivered, and the like – are established by the federal government and act on private parties. Those private parties include the health care providers who participate in, and are paid by, Medicare, the private insurance carriers who act as regional administrators, and the beneficiaries enrolled in the program. So long as Congress and HHS act reasonably in establishing rules for Medicare, and play by the rules created,[155] Medicare operates on a long constitutional leash. Medicare does have a federalist structure, as private health insurance companies have contracts with HHS to

153 The constitutionality of the Social Security Act, which was amended in 1965 to include Medicare, was at issue in *Steward Machine Co. v. Davis*, 301 U.S. 548 (1937) (unemployment benefits), and *Helvering v. Davis*, 301 U.S. 619 (1937) (old age benefits). The Supreme Court upheld the SSA in these decisions, recognizing a demonstrated need for collective action at the federal level and declaring the Hamiltonian (broad) view of the spending power as a separate enumerated power for Congress to be the settled interpretation. *See Steward Machine Co. v. Davis*, 301 U.S. 578, 599 (1937); *Helvering v. Davis*, 301 U.S. 640, 646 (1937). The Court also dismissed arguments that providing welfare to the elderly was reserved to the states. *Helvering* at 640-45. Emphasizing that the nation's industrialization was relevant to understanding congressional lawmaking, the Court wrote: "The problem is plainly national in area and dimensions. Moreover, laws of the separate states cannot deal with it effectively. Congress, at least, had a basis for that belief. States and local governments are often lacking in the resources that are necessary to finance an adequate program of security for the aged." *Id*. at 644.

154 STEVENS & STEVENS, *supra* note 56, at 45; *Federalizing Medicaid*, supra note 112, at 449.

155 *See, e.g.*, Azar v. Allina Health Services, 139 S. Ct. 1804, 1808 (2019) ("One way or another, Medicare touches the lives of nearly all Americans. Recognizing this reality, Congress has told the government that, when it wishes to establish or change a "substantive legal standard" affecting Medicare benefits, it must first afford the public notice and a chance to comment. 42 U.S.C. §1395hh(a)(2).").

administer the program on a regional level, but this is not classic American federalism, as states have no role.

A proposal for federal, public health insurance that covers the entire population ("single payer") in a form consistent with M4A bills would likely parallel Medicare's constitutional, governance, and structural path. Providing health insurance through tax revenue redistribution is within Congress's authority to spend for the general welfare, a political decision that the Court has left to the discretion of Congress.[156] Congress's ability to spend on this scale is relatively recent and tied to the Sixteenth Amendment, which allowed a federal income tax that freed Congress to spend in ways that could not have occurred before 1913.[157] The Sixteenth Amendment's timing helps to explain why the spending power was not defined through judicial analysis until 1936[158] (unlike the commerce power, the heart of one of the Supreme Court's first major opinions[159]). Accordingly, the first earnest push for national health insurance occurred when the Social Security Act was drafted.[160] The proposal was defeated quickly by the American Medical Association and Southern Democrats, who refused to open the door to the federal government lest it intervene in the segregation and suppression of African-American citizens, especially agricultural and domestic workers.[161] Federal health insurance was feared as a wedge through which desegregation could occur.[162] The

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156 South Dakota v. Dole, 483 U.S. 203, 207 (1987) (citing *Helvering v. Davis*, 301 U.S. 619, 640–641 (1937) ("In considering whether a particular expenditure is intended to serve general public purposes, courts should defer substantially to the judgment of Congress.").

157 U.S. CONST. amend. XVI. The Sixteenth Amendment exists in part because Prohibition significantly depleted federal tax revenue, as the federal sales tax on alcohol was a top source of federal tax revenue. *See* PROHIBITION (Florentine Films & WETA 2011) (available at https://www.pbs.org/kenburns/prohibition). It was also enacted to refute the *Pollock* decision by the Supreme Court, which struck down a federal income tax, discussed below.

158 *See generally* U.S. v. Butler, 297 U.S. 1 (1936) (first Supreme Court decision analyzing the nature of the spending power and holding spending is a plenary power rather than modifying the other enumerated powers in Article I section 8).

159 *See generally* Gibbons v. Ogden, 22 U.S. 1 (1824) (analyzing the nature of the commerce power as plenary in nature and not limited by the existence of state police power).

160 Nicole Huberfeld, *Federalizing Medicaid*, *supra* note 112.

161 Nicole Huberfeld, *Federalism in Health Care Reform*, HOLES IN THE SAFETY NET: FEDERALISM AND POVERTY 202 (Ezra Rosser, ed. 2019).

162 They were not wrong; Medicare desegregated hospitals when it was enacted in 1965 because

international embarrassment of having many elderly live in poverty and their families penurious for trying to provide medical care, the effective Kennedy/Johnson War on Poverty, and repeated failed attempts at pushing medical welfare to the states, made it so that social insurance for medical care became politically feasible in 1965. Medicare has been on secure constitutional footing because this law provides medical care to the elderly through a payroll tax built on the Social Security Act, which was the product of New Deal era decisions upholding federal laws that created new baselines in social programming and redistributive policy.[163]

One exception to the solid constitutional footing of single payer may be hidden within Warren's M4A payment plan, which seeks to claim money from the states to pay for a national single payer program. A lesson lies hidden in Medicare Part D. There, Congress created a new pharmaceutical drug benefit that assumed responsibility of drug costs for seniors, including dual eligibles (those who are both poor and elderly, thus enrolled in both Medicare and Medicaid). Drug coverage is a comfortable exercise of the spending power in providing for the general welfare of seniors, but Part D asked states to pay for part of dual eligibles' drug benefit to continue to participate in Medicaid.[164] This "clawback" also allowed HHS to withhold Medicaid funding if a state failed to pay.[165] States challenged the clawback as violating intergovernmental tax immunity and implicating anti-commandeering principles, but the Supreme Court denied their petition for original jurisdiction, and the states walked away from the litigation.[166] States argued they could not refuse to pay

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the Civil Rights Act of 1964 prevented federal funds from being used in segregated settings. WENDY MARINER, GEORGE ANNAS, NICOLE HUBERFELD & MICHAEL ULRICH, PUBLIC HEALTH LAW 236-37 (3d ed. 2019); *see also* DAVID BARTON SMITH, THE POWER TO HEAL: CIVIL RIGHTS, MEDICARE, AND THE STRUGGLE TO TRANSFORM AMERICA'S HEALTH CARE SYSTEM (VAND. U. Press, ed. 2016).

163 For a historical perspective on congressional authority to enact the SSA, *see* Larry DeWitt, *The 1937 Supreme Court Rulings on the Social Security Act*, SOC. SEC. ADMIN., https://www.ssa.gov/history/court.html (last visited May 24, 2019).

164 42 U.S.C.A. § 1396u-5 (c)(1)(A) (Westlaw through Pub. L. No. 116-140) (effective Dec. 20, 2019).

165 42 U.S.C.A. § 1396u-5 (c)(1)(C) (Westlaw through Pub. L. No. 116-140) (effective Dec. 20, 2019).

166 Texas v. Leavitt, 547 U.S. 1204 (2006) (mem.); Brief of Professors and Practitioners of Health

the clawback because HHS could withhold Medicaid funds and claimed they could not anticipate this condition on Medicaid funding, raising conditional spending questions that foreshadowed arguments in *NFIB v. Sebelius*.[167] States have benefitted from Part D and never returned to these claims, which were novel at the time. But, after *NFIB*, these theories could have more traction.

While single payer programs modeled after Medicare would be straightforward spending for the general welfare, a more difficult constitutional question arises if, as Senator Sanders has asserted, private insurance would be outlawed. The insurance market is long acknowledged to be within Congress's power to regulate interstate commerce under the Commerce Clause.[168] Congress gave the work of regulating insurance back to the states in 1945 by enacting the

Law as Amici Curiae in Support of Plaintiffs, Texas v. Leavitt, 547 U.S. 1204 (2006) (mem.) (No. 135) (explaining constitutional issues with the Part D clawback). *See also* Elizabeth Weeks, *Cooperative Federalism and Healthcare Reform: The Medicare Part D "Clawback" Example*, 1 ST. LOUIS U. J. HEALTH L. & POL'Y 79, 120 (2008) (describing the states' litigation and theories of the litigation); Nicole Huberfeld, *Clear Notice for Conditions on Spending, Unclear Implications for States in Federal Healthcare Programs*, 86 N.C. L. REV. 441, 445 (2008) (assessing the constitutionality of the clawback and finding it questionable).

167 *See* Nicole Huberfeld, *Clear Notice for Conditions on Spending, Unclear Implications for States in Federal Healthcare Programs*, 86 N.C. L. Rev. 441, 482 (2008).

168 United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533, 552-53, 561-62 (1944). Justice Black wrote: "Perhaps no modern commercial enterprise directly affects so many persons in all walks of life as does the insurance business. Insurance touches the home, the family, and the occupation or the business of almost every person in the United States." *Id*. at 540. The Court tackled *Lochner* era decisions that led the district court to conclude that the act of making an insurance contract is local and not subject to federal authority, finding that insurance companies – even in 1944 – were largely located in a few metropolitan centers (the five largest were located in New York City) and acted in a nationwide manner to use the money from all of the contracts of all of the individuals paying for insurance to create one risk pool for themselves, which was an indisputable web of interstate commerce according to the Court. The decision stated:

> Our basic responsibility in interpreting the Commerce Clause is to make certain that the power to govern intercourse among the states remains where the Constitution placed it. That power, as held by this Court from the beginning, is vested in the Congress, available to be exercised for the national welfare as Congress shall deem necessary. No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance.

Id. at 552-52.

McCarran-Ferguson Act.[169] This default approach of including states in health policy carried through to grant-in-aid programs, which morphed into Medicaid and maintained states' historical role in social programs. This later carried through to ERISA, which preempted state laws pertaining to employment benefits, but saved regulation of the business of insurance for states.[170] To be clear, these preservations of state power are not constitutionally required; rather, they are legislative choices and exist by the "grace" of Congress.[171] If Congress wants to regulate insurance, it has constitutional authority to do so, but it may be necessary to rescind parts of McCarran-Ferguson, or at least reconcile concurrent regulation. Also, the nature and scope of a new insurance market regulation is key because Congress does not have totally unfettered power to regulate insurance.

In 2012, when the Supreme Court refused to recognize the ACA's minimum essential coverage provision (the "individual mandate") as an exercise of commerce power to regulate the entire health care market nationwide, the Court restricted Congress's power over insurance markets to some degree.[172] The Court upheld the individual mandate as an exercise of the taxing power, reading the ACA not as a law requiring purchase of insurance but one penalizing failure to have insurance coverage.[173] This novel limitation on Congress's commerce

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169 McCarran Ferguson Act, 15 U.S.C.A §§1011-1015 (Westlaw through Pub. L. 116–140).

170 Employee Retirement Income Security Act, Pub. L. No. 93–406, § 514(b)(2)(A) (1974).

171 Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L. J. 534, 542 (2011) (describing state authority within federal statutory federalism structures as existing by the "grace of Congress").

172 Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012) (Chief Justice Roberts wrote for himself alone on this point, but the Joint Dissent agreed in principle that the individual mandate was not a proper exercise of the commerce power because Congress cannot force individuals to participate in a commercial market).

173 This interpretation is now at stake in litigation attempting to eliminate the ACA as wholly unconstitutional in the wake of Congress zeroing out the penalty for the individual mandate at the end of 2017. *Texas v. United States*, 340 F.Supp.3d 579 (N.D. TX., 2018) *aff'd*, 945 F.3d 355 (5th Cir., 2019), *reh'g denied en banc*, 949 F.3d 182 (5th Cir., 2020) *cert. granted*, sub nom. California v. Texas, 140 S.Ct. 1262 (Mar. 2, 2020); *see also* Nicole Huberfeld, *Texas v. U.S.: Another Day, Another Threat to the Affordable Care Act*, AM. CONST. SOC'Y BLOG (July 18, 2019), https://www.acslaw.org/expertforum/texas-v-u-s-another-day-another-threat-to-the-aca/ (detailing the history and context of the case in light of the 5th Circuit oral arguments); *see generally* Tax Cuts and Jobs Act of 2017, Pub. L. No. 115–97 (2017) (zeroing out the penalty for

power could affect analysis of a plan to outlaw private insurance as part of a single-payer program. The Court has held that Congress can outlaw products to be able to suppress or eradicate an illegal market, such as illicit drugs.[174] While health insurance has been regulated by federal and state governments (sometimes heavily), it has not been labeled an illegal product. If Congress were to outlaw private insurance to further a Medicare for All program, a legitimate reason to outlaw a longstanding legal product should exist and would likely be evaluated under the *Lopez* rubric.[175] No question exists as to whether Congress can regulate insurance; the issue would be whether Congress can eradicate private insurance. It is conceivable that legislative findings could point to features such as the steep cost of private insurance combined with practices designed to exclude undesirable subscribers from coverage, even after heavy regulatory action such as the ACA.[176] Congress would have an uphill battle justifying a decision to outlaw private insurance, and litigation would predictably ensue.

Limiting private insurance is just one possibility to configuring a single payer system. At least three mechanisms already exist. First, Medicare permits but regulates private insurers to sell Medigap coverage to beneficiaries, relying in part on states to regulate these supplemental insurance carriers through licensure and other usual insurance regulations.[177] Medicare proscribes types of plans and available benefits, so they supplement but do not compete with

failure to have insurance coverage).

174 Gonzales v. Raich, 545 U.S. 1 (2005) (example of the Controlled Substances Act as a permitted exercise the commerce power to outlaw all uses of marijuana, even medical use when the plants are grown in the backyard of a disabled patient who meets the terms of a state law allowing medical use).

175 United States v. Lopez, 514 U.S. 549 (1995). Congress can regulate channels of interstate commerce, instrumentalities of or persons or things traveling in interstate commerce, and those activities with a substantial effect on interstate commerce.

176 For example, insurers still try to sidestep mental health parity rules. *See* Graison Dangor, *'Mental Health Parity' Is Still An Elusive Goal In U.S. Insurance Coverage*, NPR (June 7, 2019, 5:00 AM), https://www.npr.org/sections/ health-shots/2019/06/07/730404539/mental-health-parity-is-still-an-elusive-goal-in-u-s-insurance-coverage.

177 Cristina Boccuti et al., *Medicare Enrollment and Consumer Protections Vary Across States*, KAISER FAM. FOUND. (July 11, 2018), https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/.

Medicare coverage.[178] Medigap is big business, not as large as ESI and other private insurance markets, but not minimal either.[179] Notably, this kind of supplementary private insurance market exists in other nations with single-payer systems, such as Canada and many European nations.[180] Second, Congress could invite private insurers to administer a single-payer program, effectively continuing the longstanding Medicare Administrative Contractor approach, which relies on private insurers to administer sub-national regions of the Medicare program.[181] This choice would include and specify a role for private insurers without outlawing them. A third possibility is that Congress could reject the Medicare Administrative Contractor approach, eliminating private insurers from administrative roles in a national program but permitting and regulating any new supplementary insurance markets. All of these approaches would be more likely to pass constitutional muster than outlawing private insurance outright, as they are more directly encompassed in Congress's spending power and the flexibility that authority affords for including or excluding private entities from a spending law.

B. Federalism's Complications

The governance structure of any of the possible spending programs – M4A, public option, or other - cannot be overlooked. The discussion above focuses on a pure federal spending program like Medicare, which is more straightforward, both constitutionally

178 42 U.S.C. § 1395ss (2015) (effective Jan. 3, 2016); *see also What's Medicare Supplement Insurance (Medigap)?*, CTR. FOR MEDICARE & MEDICAID SERVS., https://www.medicare.gov/supplements-other-insurance/whats-medicare-supplement-insurance-medigap (last visited May 25, 2020) (explaining basic features of Medigap for the public).

179 *See, e.g.*, Pa. McMurray, *Mark Farrah Associates Reports Year-over-year Medicare Supplement Market Growth of 3.8%*, BUS. WIRE (May 29, 2018, 10:11 AM), https://www.businesswire.com/news/home/20180529005111/en/Mark-FarrahAssociates-Reports-Year-over-year-Medicare-Supplement (reporting Medigap carriers "earned $29.9 billion in premiums and paid out $23.2 billion in claims during 2017." Also reporting "Medicare Supplement plans collectively earned approximately $31.3 billion in premiums and paid out $24.7 billion in claims during 2018").

180 *See, e.g.*, Sarah Kliff, *Private health insurance exists in Europe and Canada. Here's how it works.*, VOX (Feb. 12, 2019, 7:30 AM), https://www.vox.com/health-care/2019/2/12/18215430/ single-payer-private-health-insurance-harris-sanders.

181 42 U.S.C. § 1395kk–1 (2010) (effective Jan. 7, 2011); 42 C.F.R. § 421 (2009).

speaking and administratively, than a conditional spending program like Medicaid, which invites state participation in addition to acting on private entities. The layer of state governance makes for a much more complex constitutional calculus.

The Court established a test for conditional spending in *South Dakota v. Dole*, yet no decision applied the Tenth Amendment as a limiting principle on the spending power, even during the Rehnquist Court's federalism revolution, until *NFIB v. Sebelius*. In contrast to decisions like *Lopez*, which established a more restrictive analysis for congressional exercises of the commerce power, the spending power bothered certain Justices for having no analytical limits in the name of protecting state police power under the Tenth Amendment.[182] During the Rehnquist federalism revolution, Justice Kennedy lamented that the commerce power was being limited by the Tenth Amendment, but the spending power was not, and he warned that the spending power would be an end-run around limitations on commerce power.[183] The path changed in 2012, with *NFIB v. Sebelius*, when the Supreme Court held that an exercise of the spending power could be unconstitutionally coercive.[184] Though the Chief Justice's opinion for the plurality did not cite the Tenth Amendment in the coercion analysis, federalism is the soul of that decision.[185] Medicaid expansion was vulnerable to challenge because states were invited to co-administer two key features of the ACA, which opened federalism questions that had been asked in other litigation but never answered by the Court.[186]

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182 Nicole Huberfeld, *Clear Notice for Conditions on Spending*, *supra* note 166, at 452 n. 46, 454–55 (describing Justice Kennedy's desire to limit the spending power by applying the Tenth Amendment in the same way as the commerce power was limited); *see also* Nicole Huberfeld, Elizabeth Weeks & Kevin Outterson, *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U. L. REV. 1, 4–6, 47-50 (2013) (explaining why it was unsurprising that the Court addressed the spending power and boosted the coercion doctrine in *NFIB*).

183 *See* Nicole Huberfeld, *supra* note 166; *see also* Gluck & Huberfeld, *What Is Federalism in Healthcare For?*, *supra* note 18, at 1729 n. 193.

184 Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

185 *See generally* Huberfeld et al., *Plunging into Endless Difficulties*, *supra* note 182, at 46–50.

186 *Id*.

Medicaid has been described as a "classic" cooperative federalism program, meaning that the statute offers money to states to implement federal policy, but the program could not exist in a state that does not accept federal funding. All states have participated in Medicaid since 1982, which Congress knew when it made Medicaid expansion a mandatory element of the ACA's comprehensive insurance overhaul.[187] Congress also must have been aware that states readily accepted other expansions of Medicaid eligibility over time.[188] The ACA effected a similar expansion, wherein states were tasked with a mandatory expansion of Medicaid eligibility to nonelderly, childless adults regardless of other qualifying characteristics, intentionally including all of the nation's poor in Medicaid eligibility for the first time.[189]

A plurality of the Court (seven Justices had points of agreement, counting the joint dissent) agreed that Congress could not force ("coerce") states to expand Medicaid at the risk of losing all existing Medicaid funding. The plurality did not analyze Medicaid expansion in a straightforward fashion, *i.e.* by applying the four-part *Dole* test, and refused to create a rule for coercion. Rather, the Court decided that Medicaid expansion appeared too different from the Medicaid program that pre-dated the ACA; states could not have anticipated this kind of expansion of eligibility; and the threat of losing federal funding for the second largest item in states' budgets was a step too close to federal influence becoming coercion, calling expansion a "gun to the head" of states.[190] Roberts' opinion appeared to rely on the *Dole* principles of clear notice and germaneness, and added a fifth element of coercion (which had been dicta) to the *Dole* test.[191] In dissent, Justice Ginsburg argued that Congress operated well within its spending power to create Medicaid and to expand eligibility, and the ACA's expansion of Medicaid was no different than if Congress repealed Medicaid and re-enacted it as written in the ACA.[192] Would a

187 *Id*.

188 *Id*.

189 Nicole Huberfeld, *Federalizing Medicaid*, *supra* note 112, at 450.

190 Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 581 (2012).

191 Huberfeld et al., *Plunging into Endless Difficulties*, *supra* note 182, at 6, 46, 50-71.

192 *See* NFIB, 567 U.S. at 634 (Ginsburg concurring in part and dissenting in part).

"ritualistic" rescission and enactment be required for Medicare for All, Medicare expansion, or public option bills?[193] Surely not, though it may be a neater approach.

NFIB tells us that expanding insurance coverage is not intrinsically problematic. The Court's problem with Medicaid expansion was with Congress asking states to perform a national standard rather than using a purely federal approach. In a single payer or public option program, states do not need to be involved from a constitutional perspective, and current bills largely do not include states. A notable exception is contained in the Sanders bill, which keeps states acting in a limited but important function: to run institutional long-term care through a whittled down Medicaid program. States are already responsible for long-term care through Medicaid, which covers nearly two-thirds of all long-term services and supports.[194] A single-payer law initiating drastic reduction in eligibility, benefits, and other aspects of the Medicaid program would not negatively affect states in an obvious fashion, except to remove policy decisions from state politics and to reduce federal money that can be moved around in state budgets.[195] States do not have legal claims on such changes.[196] States are entitled to Medicaid funding under existing law, but they do not have formal power over federal funding decisions.[197] And, while the *NFIB* decision made it clear that states must be able to reject federal funds, the coercion doctrine (such as it is) does not constrain

193 *Id*.

194 U.S. DEP'T HEALTH & HUM. SERVS., ASSISTANT SEC'Y FOR PLAN. & EVALUATION, OFF. DISABILITY, AGING & LONG-TERM CARE POL'Y, AN OVERVIEW OF LONG-TERM SERVICES AND SUPPORTS AND MEDICAID: FINAL REPORT 14 (2018), https://aspe.hhs.gov/pdf-report/overview-long-term-services-and-supports-and-medicaid-final-report.

195 States are notorious for misusing federal funding, which is in part the reason that Medicaid itself became a federal program with spending conditions morphed from a less constrained 'grant in aid' program.

196 Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 630–31 (2012).

197 42 U.S.C. § 1396b (1996) (effective Jan. 6, 1997) ("the Secretary … shall pay to each State…"). This is the root of the legal problem with the Trump administration's proposed block grants. *See* Rachel Sachs & Nicole Huberfeld, *The Problematic Law And Policy Of Medicaid Block Grants*, HEALTH AFFS. BLOG (July 24, 2019), https://www. healthaffairs.org/do/10.1377/hblog 20190722.62519/full/; Nicole Huberfeld, *Medicaid block grants would gut law and cut care*, THE HILL (Jan. 31, 2020, 1:30 PM), https://thehill.com/opinion/healthcare/480860-medicaid-block-grants-would-gut-law-and-cut-care.

Congress's ability to change direction with federal policy.[198] Under the Sanders bill, no *new* state-based responsibility for spending replaces the largely eliminated Medicaid program. States like receiving Medicaid's generous federal money and have found many ways to use and divert it over time, but it would be difficult for states to protest so long as they continue to receive adequate federal funds for long-term care.

The DeLauro bill, "Medicare for America," is more constitutionally complicated because it keeps states in the health care governance game by having state Medicaid agencies run enrollment for Medicare expansion. The Court has held that treating the states like federal administrators may be deemed impermissible commandeering, like when Congress asked states to administer background checks for firearms purchases.[199] But, if Medicare for America offers money to states for administering new enrollment (much in the way that HHS currently pays for states' Medicaid administrative costs), and states can opt out with a federal backstop (like the ACA's exchanges), then this structure could be constitutionally permissible.

The State Public Option Act also suffers from federalism complications. While a Medicaid model for health reform should keep federalism enthusiasts happy because states retain a key role, it also raises flags for the federalism issues elevated in *NFIB v. Sebelius*. The federalism key to the ACA's governance structure has demonstrated that states are effective at negotiating for their policy preferences within a federal statutory scheme, which is a plus for federalism unto itself. But, federalism's divided governance is not the optimal approach for a program meant to cover populations universally or uniformly or equitably, principles that help strengthen social programs and to simplify them administratively.[200]

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198 As Justice Ginsburg stated, states do not have a right to federal money, unless a statute makes it so (Medicaid is a statutory entitlement for states and beneficiaries). *Nat'l Fed'n of Indep. Bus. v. Sebelius v. Sebelius*, 567 U.S. 519 (2012) (Ginsburg, concurring in part and dissenting in part).

199 Printz v. United States, 521 U.S. 898 (1997).

200 *See* Theda Skocpol, *Targeting within Universalism: Politically Viable Policies to Combat Poverty in the United States, in* THE URBAN UNDERCLASS 411 (Christopher Jencks & Paul E. Peterson eds., 1991).

The bottom line is that choosing federalism in health reform governance is a predictably complicating factor. This is true constitutionally and for implementing health policy. As Abbe Gluck and I have concluded, federalism enables political expediency for negotiating new laws and policies, and it facilitates state sovereign acts; but, it is less clear whether federalism serves health policy goals in any consistent fashion.[201] Rather, federalism is a predictable trade-off, leading to variability in the implementation of national policy goals that sometimes dips below the national baseline. This variability is not inherently good or desirable, despite classic federalism tropes expressing the value of "experimentation," and needs to be studied much more thoroughly.

C. The Wealth Tax Question

A different complication may exist with a method proposed to fund expanded public health insurance: a "wealth tax." A wealth tax could raise questions about the meaning of the "direct tax" limitation on Congress's broad taxing power.[202] Under typical proposals, a tax would be imposed on total assets, or net worth, creating a new way to regularly collect tax revenue.[203] For example, Senator Warren proposed to tax "All household assets … including residences, closely held businesses, assets held in trust, retirement assets, assets held by minor children, and personal property with a value of $50,000 or more" and a "2% annual tax on household net worth between $50 million and $1 billion and a 4% annual Billionaire Surtax (6% tax overall) on household net worth above $1 billion."[204] This "Ultra-

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201 Gluck & Huberfeld, *What Is Federalism in Healthcare For?*, *supra* note 18, at 1784–95.

202 U.S. CONST. art. 1, § 2, cl. 3; *id.* at § 9, cl. 4; *see, e.g.*, Kyle Sammin, *Here's Why Elizabeth Warren's Wealth Tax Is Completely Unconstitutional*, THE FEDERALIST (Aug. 8, 2019), https://thefederalist.com/2019/08/08/heres-elizabeth-warrens-wealth-tax-completely-unconstitutional/ (arguing a wealth tax is a direct tax); *cf.* JOHN R. BROOKS & DAVID GAMAGE, WHY A WEALTH TAX IS DEFINITELY CONSTITUTIONAL (2020), https://ssrn.com/abstract=3518506.

203 For a dissection of approaches to a wealth tax and possible pitfalls, see Miranda Perry Fleischer, *Not So Fast: The Hidden Difficulties of Taxing Wealth, in* WEALTH: NOMOS LVIII 261 (Jack Knight ed., 2017).

204 *Ultra-Millionaire Tax*, WARREN DEMOCRATS, https://elizabethwarren.com/plans/ultra-millionaire-tax (last visited Jan. 13, 2020).

Millionaire Tax" would be paid in addition to other tax obligations. Likewise, candidate Tom Steyer supported a wealth tax, proposing: "anyone worth 32 million dollars or more will pay 1 cent more on the dollar. At 500 million, that goes up to 1 and a half cents. And at 1 billion dollars, that number hits 2 cents. Over a decade, that's 1.7 trillion dollars in tax revenue — which will go towards things like fixing health care…."[205]

A wealth tax is different from the constitutionally-sanctioned federal income tax,[206] as it addresses the fact that not all households accumulate personal wealth through wages. Some hold real estate, business resources such as stocks, or other property that is not the usual work-based payment subject to annual income tax accounting but, rather, derives from assets that are taxed upon specified events such as sale of the asset or death of an asset holder (*e.g.*, estate taxes).

These are far from the first proposals to raise questions about the Direct Tax Clauses. For example, a tax on horse carriages created the first Supreme Court ruling on this issue, *Hylton v. U.S.*, in 1796.[207] More recently, during the 1996 presidential election, flat tax proposals to reform the Internal Revenue Code reawakened the question of what constitutes a "direct tax."[208] In the following presidential campaign cycle, Donald Trump proposed a wealth tax on those with net worth above $10 million, believing such a tax could eliminate the national deficit.[209] None of these proposals came to fruition, and it is hard to say if a wealth tax would have traction now, but it is helpful to understand why this question arises as funding plans are discussed for health reform proposals.

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205 *We Need a Wealth Tax*, TOM 2020, https://2020.tomsteyer.com/wealth-tax/ (last visited Jan. 13, 2020).

206 U.S. CONST. amend. XVI.

207 Hylton v. United States, 3 U.S. 171 (1796).

208 *See, e.g.*, Arlen Specter, *How a Flat Tax Can Be Middle-Class Friendly*, N.Y. TIMES (July 18, 1995), https://www.nytimes.com/1995/07/18/opinion/l-how-a-flat-tax-can-be-middle-class-friendly-189095.html; Daniel Mitchell & William Beach, *How the Armey-Shelby Flat Tax Would Affect the Middle Class*, HERITAGE FOUND. (Mar. 12, 1996), https://www.heritage.org/node/20613/print-display (discussing the Armey, Forbes, and other flat tax proposals).

209 Dawn Johnsen & Walter Dellinger, *The Constitutionality of a National Wealth Tax*, 93 IND. L. J. 111, 112 (2018).

Three constitutional provisions are relevant to the debate: Article I, section 8 enumerates legislative powers, with the first clause stating that Congress "shall have power to lay and collect Taxes, Duties, Imposts and Excises to pay the Debts and provide for the common Defence and general Welfare of the United States."[210] The General Welfare Clause exists because the Articles of Confederation demonstrated the impossible weakness of a central government that cannot raise its own revenue.[211] So, Congress's taxing power was written broadly, but it was worrisome to representatives of Southern states, which assumed slavery would be taxed out of existence. As such, an exception to the power to tax was written into Article I, section 2, clause 2, and section 9 clause 4. These "Direct Tax Clauses" limit congressional authority as part of the "three-fifths compromise," credited with keeping the Constitutional Convention on track by protecting slavery.[212] The three-fifths compromise allowed slaves to be counted for purposes of apportioning the House of Representatives, which benefited Southern states but also made it so they could be taxed at higher rates if "direct taxes" on property or people were imposed because of their large enslaved populations.[213] Section 9, clause 4 states, "No Capitation, or other direct, Tax shall be laid, unless in Proportion to the Census or enumeration herein before directed to be taken."[214] So, taxes are to be uniform across the nation, unless they are deemed direct, in which case they are to be apportioned according to the census.

Professor Ackerman argued before the current health reform debate that the first, narrow, Supreme Court decision, *Hylton*, is the correct interpretation of the Direct Tax Clauses because the clauses were meant to limit congressional authority regarding slavery and did

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210 U.S. CONST. art. I, § 8, cl. 1.

211 States were to provide revenue by taxing their residents, but no recourse existed when they refused to comply. *See generally* Bruce Ackerman, *Taxation and the Constitution*, 99 COLUM. L. REV. 1 (1999) (exploring the history of wealth taxes and the meaning of the apportionment provisions in the Constitution).

212 *Id*. at 9-13.

213 U.S. CONST. art. I, § 2. This fear was reflected too in U.S. CONST art. I, § 9, c1. 1, which limited import taxes on each enslaved person to $10.

214 U.S. CONST. art. I, § 9, cl. 4.

not to speak to taxing mechanisms writ large.[215] He and other scholars note that the direct tax language was neither fully understood nor explained by the Framers.[216] Scholars argue that *Hylton* speaks with the Framers' voices because the Court's opinions were written by justices who happened to be three constitutional convention delegates and one state ratifier.[217] Also, relevant to the narrow interpretation argument is the Thirteenth Amendment, which eradicated the three-fifths clause, and the Fourteenth Amendment, which rendered freed slaves citizens (and whole persons) and thus affected apportionment.[218] The Reconstruction Amendments did not specifically amend the Direct Tax Clauses, so the question remained as to what constitutes a direct tax and whether apportionment was required.

Early in the *Lochner* Era, the Court issued a broader interpretation of the Direct Tax Clauses, holding in *Pollock* that income tax is a direct tax.[219] The Sixteenth Amendment reversed the *Pollock* decision, and reverted the Court to a narrow view of the Direct Tax Clauses, but did not directly address *Pollock*'s treatment of a tax on bonds as a direct tax.[220]

In *NFIB*, the Court was asked to declare the shared responsibility payment for the minimum essential coverage provision (the tax penalty for the "individual mandate") an impermissible direct tax. In rejecting the argument, Chief Justice Roberts offered a quick tour of the direct tax and noted, "Even when the Direct Tax Clause was

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215 Ackerman, *supra* note 211, at 51–55; *see also* Johnsen & Dellinger, *supra* note 209, at 115; Calvin H. Johnson, *A Wealth Tax Is Constitutional*, A.B.A. TAX TIMES (Aug. 8, 2019), https://www.americanbar.org/groups/taxation/publications/abataxtimes_home/19aug/19aug-pp-johnson-a-wealth-tax-is-constitutional/.

216 Ackerman, *supra* note 211, at 11. ("The delegates' desire to evade divisive theoretical debate became even clearer when the basic clause linking representation and 'direct taxation' returned to the floor on August 20: 'Mr. King asked what was the precise meaning of direct taxation? No one answered.'"); *see also* Johnsen & Dellinger, *supra* note 209, at 118 (both quoting Madison's notes from the convention).

217 *See* Ackerman, *supra* note 211, at 21; Johnsen & Dellinger, *supra* note 209, at 122–24. A counter narrative is that the early Supreme Court was weak and would not have struck down this important new congressional power. *See also* Sammin, *supra* note 202.

218 Ackerman, *supra* note 211.

219 Pollock v. Farmers' Loan & Trust Co. (*Pollock I*), 157 U.S. 429 (1895); Pollock v. Farmers' Loan & Trust Co. (*Pollock II*), 158 U.S. 601, 637 (1895).

220 Ackerman, *supra* note 211, at 48.

written it was unclear what else, other than a capitation (also known as a "head tax" …), might be a direct tax."[221] Addressing *Hylton*'s narrow interpretation, Roberts wrote:

> The Court was unanimous, and those Justices who wrote opinions either directly asserted or strongly suggested that only two forms of taxation were direct: capitations and land taxes. That narrow view of what a direct tax might be persisted for a century. … In 1895, we expanded our interpretation to include taxes on personal property and income from personal property, in the course of striking down aspects of the federal income tax. *Pollock*. That result was overturned by the Sixteenth Amendment, although we continued to consider taxes on personal property to be direct taxes.[222]

NFIB conveyed the common understanding that the direct tax exception should be read narrowly, with the *Pollock* case being an outlier and functionally overruled.

In short, much debate yet little case law exists to explain the meaning of the requirement for apportionment for direct taxes. The few scholars to examine this question perceive little limitation on congressional taxing authority and argue these clauses should be read narrowly because of history and because the apportionment requirement leads to absurd results (explicitly rejected in *Hylton*).[223] Also, *Pollock* is widely considered to have lost precedential value because of the Sixteenth Amendment and being part of the *Lochner* Era decisions that were overruled in broad strokes during the New Deal and later.[224] To the extent the Direct Tax Clauses could be applicable to a modern wealth tax plan, tax scholars argue that careful drafting makes compliance possible.[225] What does the meager record mean for a wealth tax proposal now? Litigation, to be sure.

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221 Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 570 (citing Springer v. United States, 102 U.S. 586, 596–598 (1881)).

222 *Id*. at 570–71(citing Pollock v. Farmers' Loan & Trust Co., 158 U.S. 601, 618 (1895)).

223 *See* Johnsen & Dellinger, *supra* note 209, at 119 n. 37, for a helpful rundown of the scholars and tax experts who have addressed the direct tax clauses.

224 Lincoln Fed. Union v. Northwestern Iron & Metal, 335 U.S. 525 (1949) (overruling *Lochner* explicitly).

225 *See generally* Brooks & Gamage, *supra* note 202; Miranda Perry Fleischer, *supra* note 203.

Involving states in health reform could open a national policy effort to constitutional as well as implementation challenges, a hard-won lesson from the ACA.[226] But, even without state participation, other complicating factors exist. Constitutional clarity does not translate to political or policy action. If anything, the bigger the disruption, the greater the chances of a constitutional exercise of congressional power − and the lower the chances of political success − an inverse relationship, at least before early 2020 (pre-Covid-19). Many knowledgeable stakeholders, including prior Obama administration officials who were deeply involved in negotiating and implementing the ACA, have stated that Medicare for All is a good idea but not a realistic goal.[227] Some assert that the ACA is the right hybrid and worthy of fortification, reasoning that a public/private approach makes sense, and offering reasoning such as American historical reliance on private actors in health care.[228] Some reason M4A is not politically feasible given how big the fight over the ACA was and continues to be. And, some think a federal single-payer approach could overlook important flexibilities built into Medicaid for poor populations.[229]

IV. Assessing the Gestalt

So what was behind the cry for health reform as the ACA passed its tenth signing anniversary? The call for reform that grew in 2019 seemed surprisingly intense given that the ACA's key elements did not begin implementation until January 1, 2014.[230] The circus of

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226 *See generally* Gluck & Huberfeld, *What Is Federalism in Healthcare For?*, *supra* note 18; *see also* Gluck & Huberfeld, *Federalism under the ACA*, *supra* note 8.

227 *The ACA at 10*, SOLOMON CTR. HEALTH L. & POL'Y AT YALE L. SCH., https://law.yale.edu/solomon-center/events/affordable-care-act-10 (last visited Mar. 15, 2020). Many Obama officials and stakeholders stated this sentiment during their remarks at this conference.

228 Gluck & Huberfeld, *Federalism under the ACA*, *supra* note 8.

229 *See, e.g.*, Sara Rosenbaum & Stephen Warnke, *Opinion: Even with 'Medicare for all,' we'll still need Medicaid*, L.A. TIMES (Sept. 12, 2019, 3:00 AM), https://www.latimes.com/opinion/story/2019-09-11/medicare-for-all-bernie-sanders-debate-medicaid-public-health; Sara Rosenbaum, *Medicaid's Remarkable Endurance*, PUB. HEALTH POST (Nov. 12, 2018), https://www.publichealthpost.org/research/medicaids-remarkable-endurance/.

230 Enactment occurred March 23, 2010, but the biggest implementation date – including Medicaid expansion, health insurance exchange operation, and other major regulatory

constant political fighting and public confusion is not the whole story, because on the other hand, conversation and grassroots support have surged, evidenced by pushback against the 2017 efforts to repeal the ACA and continued calls to make the system more accessible, less expensive, and simpler. To decipher why the ACA is under a new microscope, this paper has explored the basic features of major reform proposals and the kinds of constitutional questions that could arise. But what does the gestalt mean for future laws addressing health reform? Is the problem the ACA's core conceptual features? Governance architecture? Or is it a bigger question of our societal capacity to achieve the basic goals of equitability, fairness, administrative simplicity, and lower costs?

Part of the tumult may be related to the ACA's structure, rather than its goals, a somewhat hidden piece of the puzzle. I have written elsewhere about the problems of accountability and public confusion that the law's federalism structure engendered, in addition to the health policy questions that arise from using federalism as a tool of health reform.[231] These issues were exacerbated by the flipped federalism of the law's implementation, which made it so the law's key features were never implemented as designed.[232] Implementation through flipped federalism contributed not only to slow-moving Medicaid expansion but also to public confusion about the law and its impact, including whether it still exists. Despite weaknesses in implementation, the ACA has had measurable impact on low-income individuals, discussed in Part I, suggesting that the goals were not the problem.[233] After all, measured on its own terms, the ACA's goal of universal coverage has been successful in states that have not fought implementation of the law, yet public awareness of the ACA's impact was fairly low until the threat of repeal occurred in 2017.

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features – was January 1, 2014. Patient Protection and Affordable Care Act, Pub L. No. 111–148, 124 Stat. 119 (2010) (codified as amended throughout U.S. Code).

231 *See* Gluck & Huberfeld, *What is Federalism in Healthcare For?*, *supra* note 18, at 1784–88; *see also Epilogue*, *supra* note 46.

232 *Id.* at 1724–30.

233 Jesse C. Baumgartner, Sarah R. Collins, David C. Radley, & Susan L. Hayes, *How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care*, COMMONWEALTH FUND (Jan. 16, 2020), https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access.

One goal the ACA did not tackle with any urgency or depth was the high cost of American medical care. A sense of outrage emerges in polling and in media reports that consistently points to the problematic cost of care.[234] The high cost of care thwarts access, even for those who are insured.[235] The political efforts to limit pharmaceutical costs and to end surprise billing, both seemingly popular across the aisle, have lost momentum, with surprise billing popping up in a variety of bills, possibly moving toward pushing responsibility for keeping costs down to patients through price transparency, but overall taking on only a small corner of the large problem of cost.[236] For example, no proposal directly addresses waste in health care; some studies indicate that waste could be excised to find cost reductions in failure of care delivery and care coordination, overtreatment or low value care, pricing failure, fraud and abuse, and

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234 Ashley Kirzinger, Bryan Wu & Mollyann Brodie, *Kaiser Health Tracking Poll – February 2018: Health Care and the 2018 Midterms, Attitudes Towards Proposed Changes to Medicaid*, KAISER FAM. FOUND. (Mar. 1, 2018), https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2018-health-care-2018-midterms-proposed-changes-to-medicaid/ (reporting that Medicaid is "seen favorably" by the vast majority of those polled and that despite improved views of the ACA, many polled put the cost of care first in their list of concerns for the 2018 election). While the public remains skeptical that work requirements promote health and sees them as a cost cutting measure. *See id*. Politicians and administration officials claim work requirements promote "self sufficiency." *See, e.g.*, Audrey Dutton, *Idaho Gov. Little signs bill to put work requirements on Medicaid expansion*, IDAHO STATESMAN (April 9, 2019), https://www.idahostatesman.com/news/politics-government/state-politics/article 2290 18249.html. But polls depend on the framing of the question. *See* JB Wogan, *Do Americans Support Work Requirements? Depends on How You Ask.*, GOVERNING (Feb. 9, 2018), https://www.governing.com /topics/health-human-services/gov-work-requirements-cap-toll-medicaid.html (cataloging poll responses to work requirement related questions).

235 *See* Sarah Kliff, *"Am I a bad person?" Why one mom didn't take her kid to the ER — even after poison control said to.*, VOX (May 10, 2019, 9:00 AM), https://www.vox.com/health-care/2019/5/10/18526696/health-care-costs-er-emergency-room; Gary Claxton et al., *How does cost affect access to care?*, PETERSON KAISER HEALTH SYS. TRACKER (Jan. 22, 2019), https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/.

236 *See, e.g.*, Dan Diamond, *Congress' effort on surprise medical bills is flagging*, POLITICO PULSE (Sept. 10, 2019, 10 AM), https://www.politico.com/newsletters/politico-pulse/2019/09 /10/congress-effort-on-surprise-medical-bills-is-flagging-735491 (reporting stalled surprise billing efforts and attack ads). Price transparency is argued to be an important aspect of consumer choice in well-functioning markets, but patients are not consumers and health care is far from being a functioning market. *See generally* Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963) (class articulation of reasons that health care is not a market and can never be).

administrative complexity.[237] Adding to high cost complaints is the fact that a quarter of large employers offer only high-deductible health insurance to their employees, indicating that even those who obtain ESI are paying high premiums and must have substantial personal savings to pay medical costs.[238] Further, low to middle-income families struggle to obtain, keep, and use ESI, which is unavailable to most low-income households.[239]

In short, the conversation repeatedly returns to cost, and it should not be surprising, with stories such as parents waiting in hospital parking lots to see if a child's illness is a life-threatening emergency or a passing event.[240] Those proposing health reform have noticed, and single-payer proposals appear to assume, that a new public finance mechanism would negotiate payments in the same way that Medicare creates reimbursement algorithms. Eradicating out-of-pocket costs like copayments and deductibles, as some bills do, would address one part of the cost problem, but high prices are everywhere.[241]

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[237] William H. Shrank, Teresa L. Rogstad & Natasha Parekh, *Waste in the US Health Care System,* 233 JAMA 1501, 1504 (2019).

[238] Shelby Livingston, *Fewer employers offering high-deductible plans as only option*, MODERN HEALTHCARE (Aug. 13, 2019, 2:33 PM), https://www.modernhealthcare.com/insurance/fewer-employers-offering-high-deductible-plans-only-option?utm_campaign=KHN%3A%20Daily%20Health%20Policy%20Report&utm_source=hs_email&utm_medium=email&utm_content=75680650&_hsenc=p2ANqtz9mL9Sl7okXawKJldDpl7DIme3ctDgd6XnZsdO3FHX53497ES1OrXj9NOF8UjDuqh920gicg87IttUour05H7xkjzJs0g&_hsmi=75680650 (25% down from 39% in 2017).

[239] ESI has been decreasing for the last twenty years and has become nearly unattainable for people earning less than 400% of FPL. *See, e.g.*, Matthew Rae, Gary Claxton, Larry Levitt & Daniel McDermott, *Long-Term Trends in Employer-Based Coverage*, PETERSON-KAISER HEALTH SYS. TRACKER (Jan. 30, 2019), https://www.healthsystem tracker.org /brief/long-term-trends-in-employer-based-coverage/#item-start.

[240] *See, e.g.*, Sarah Kliff, *"Am I a bad person?" Why one mom didn't take her kid to the ER — even after poison control said to*, VOX (May 10, 2019), https://www.vox.com/health-care/2019/5/10/18526696/health-care-costs-er-emergency-room.

[241] *See, e.g.*, Matthew Perrone, *Doctors don't always know what patients will owe for meds*, AP NEWS (Aug. 28, 2019), https://www.apnews.com/c578b4e69291495fb46e97da4fa9f290?utm_campaign=KHN%3A%20Daily%20Health%20Policy%20Report&utm_source=hs_email&utm_medium=email&utm_content=76224480&_hsenc=p2ANqtz0DlPwpprn6bIGoCK4XScl9dphk_dudL9C9aGuWiwiH5-oDtYFI9YAjri_hNOz8sZoDvbo8VMQ62Y_TRvBkgB_l994iw&_hsmi=76224480 (reporting on studies showing the central role of costs in preventing patients from obtaining many kinds of medical care); Himmelstein et al., *supra* note 94.

Another problem with the ACA's plan is the financial aid cutoff at 400% of the FPL. People at that earning level find ESI is expensive and yet earn too much for federal tax credits to purchase insurance on an exchange. This may partially drive a sense of legislative inequity that provides some support for the Trump administration's policy encouraging work requirements in Medicaid and other conditions that appear to make Medicaid look more like private insurance.[242] Work requirements predictably lead to disenrollment in all social programs, and low-income individuals are very unlikely to be able to gain health insurance through employment benefits.[243] These are the kinds of problems that led to the insurance reforms in the ACA and are clearly designed to undermine the law, even though the law has become popular.[244] This disconnect between public opinion and political action calls for deeper understanding, because it highlights the ongoing pushback against the ACA's universalism but also the growing expectation of universal coverage.

Turning to the conversation about universal coverage, the U.S. is in a unique position among industrialized nations: it is the last nation to adopt a universal coverage policy.[245] Part of the reason that U.S. policy has been different is that the human rights upheaval that swept most of Europe after World War II was largely bypassed in the U.S.[246]

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242 Polls have shown when people learn that most who are able to do so are already working, support for work requirements disintegrates. *See, e.g.*, Dylan Scott, *America's Medicaid work requirement paradox, explained by 2 polls*, VOX (Feb. 5, 2018, 3:50 PM), https://www.vox.com/health-care/2018/2/5/16975574/medicaid-work-requirement-paradox-polls (exploring the differences in polls regarding work requirements and concluding that people polled do not think access to health care should be cut off, especially when they learn that most people in social programs who are able to work do so).

243 *See, e.g.*, Matthew Rae, Gary Claxton, Larry Levitt & Daniel McDermott, *Long-Term Trends in Employer-Based Coverage*, PETERSON-KAISER HEALTH SYS. TRACKER (Jan. 30, 2019), https://www.healthsystemtracker.org/brief/long-term-trends-in-employer-based-coverage/#item-start.

244 Gluck & Huberfeld, *What Is Federalism in Healthcare For?*, *supra* note 18, at 1724–25; *see also* Gluck & Huberfeld, *Federalism under the ACA*, *supra* note 8.

245 *See* Vice President Biden Remarks, *supra* note 14.

246 *See, e.g.*, David Sloss & Wayne Sandholtz, *Universal Human Rights and Constitutional Change*, 27 WM. & MARY BILL RTS. J. 1183 (2019) (tracing phases of implementation of human rights and theorizing federalization of human rights in the U.S. after World War II despite U.S. reticence to ratify and implement human rights treaties); *see also* Ann Elizabeth Mayer, *Reflections on the Proposed United States Reservations to CEDAW: Should the Constitution Be an*

Other nations rewrote constitutions to reflect the principles outlined in the Universal Declaration of Human Rights (UDHR), which includes an explicit right to health; the U.S. Constitution remained unchanged. The United States has not signed, or has signed but not ratified, key treaties implementing aspects of the UDHR, such as the International Covenant on Economic, Social and Cultural Rights, which explicates the right to health.[247] Human rights experts argue that the Constitution has become an excuse that keeps the U.S. from implementing human rights principles within its own borders, even as it has promoted universal human rights abroad.[248]

For example, the enactment of Medicare and Medicaid in 1965 illuminate the longstanding, historical disagreement over health as a human right versus health as a private good. Medicare desegregated hospitals through the tool of federal spending power, but Medicaid baked "states rights" into the health policy cake. This federalism structure was a contradiction in the new federal law, which was designed with core statutory protections for poor people on one hand but allowed states to continue policy control over medical care for their poor populations through state flexibilities (exercised through "options" in Medicaid) and other policymaking tools left to states.[249] If Medicaid did not contain specific federal statutory requirements, some states would not have provided the new public insurance to non-white residents.[250]

Obstacle to Human Rights, 23 HASTINGS CONST. L.Q. 727, 741–54 (1996) (describing American constitutional exceptionalism and its role in the history of rejecting human rights treaties).

247 International Covenant on Economic, Social & Cultural Rights art. 3, Dec. 19, 1966, 993 U.N.T.S. 83 (1967), https://treaties.un.org/doc/Publication/MTDSG/Volume%20I/Chapter%20IV/IV-3.en.pdf

248 *See, e.g.*, Mayer, *supra* note 242. Ruth Macklin accuses the US of violating human rights as a wealthy nation that chooses not to provide a health care system that affords reasonable access to medical care for all residents. RUTH MACKLIN, AGAINST RELATIVISM: CULTURAL DIVERSITY AND THE SEARCH FOR ETHICAL UNIVERSALS IN MEDICINE 245 (Oxford U. Press ed., 1999).

249 STEVENS & STEVENS, *supra* note 56.

250 One powerful example is the EPSDT requirement, a very specific set of benefits for children enrolled in Medicaid, which exists because the state Medicaid administrators in Southern states have bluntly said that without this obligation, non-white children would never be appropriately examined by the mostly white doctors. *See* Sara Rosenbaum email to Nicole Huberfeld, cited in Gluck & Huberfeld, *What Is Federalism in Healthcare For?*, *supra* note 18, at n.82 (email on file with author).

The Medicaid expansion experience thus far has echoed the history of the program, with some states implementing and improving on the federal rules (for example by expanding Medicaid beyond the ACA) and others seeking to test the baseline of the law.[251] It is not a surprise that states like Texas, Mississippi, and Alabama still have not expanded eligibility, because they have long resisted federal health policies designed to improve access to care for the poor. These states are missing a crucial tool for addressing the coronavirus pandemic, as non-elderly adults earning below 100% of the FPL have no insurance options in expansion holdout states, yet many residents are suffering from the double disaster of coronavirus and the economic downturn triggered by the pandemic. The novel coronavirus outbreak starkly illuminated the deeply entrenched disparities experienced by Black, indigenous, and people of color in these states, including much higher infection and death rates from COVID-19. While the racial differences in infection and mortality from COVID-19 exist nationwide, they are especially steep in states that have resisted the ACA's principle of universality.[252]

Failed health reform efforts are bound to be repeated if lessons for what works and why are not learned. For example, if federalism invites irregularity into a program designed to create a national baseline, why is federalism still a default approach in health reform? Abbe Gluck and I have concluded in other work that federalism serves purposes such as political expediency and state sovereignty, but it is not at all clear that a federalism structure serves health policy goals such as equitability or administrative simplicity. Congress built

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251 Gluck & Huberfeld, *What Is Federalism in Healthcare For?*, *supra* note 18.

252 *See*, *e.g.*, Jesse Baumgartner et al., *How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care*, Commonwealth Fund (Jan. 16, 2020), https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access; Eboni G. Price-Haywood et al., *Hospitalization and Mortality among Black Patients and White Patients with Covid-19*, 382 NEW ENG. J. MED. 2534 (2020), https://www.nejm.org/doi/pdf/10.1056/NEJMsa2011686?articleTools=true. This study found "In a large cohort in Louisiana, 76.9% of the patients who were hospitalized with Covid-19 and 70.6% of those who died were black, whereas blacks comprise only 31% of the Ochsner Health population." *Id*. at 2534. Louisiana was late to Medicaid expansion, starting in 2016 rather than 2014 after an election ousted an anti-ACA governor. *See also* Monica Webb Hooper et al., *COVID-19 and Racial/Ethnic Disparities*, 323 JAMA 2466 (2020) (data about race-based disparities in COVID infection rates, symptoms, and deaths).

federalism into the key features of the ACA, and now we can say that as implemented, federalism has both undermined and facilitated the law's goal of universal coverage. But we see now that the federalism structure of Medicaid is worsening access to care during a pandemic. The pandemic also spotlights problems with the decentralized, federalism-based structure of public health for data gathering, risk reduction, and for achieving at least minimal baselines in health care and health outcomes.[253] While some of the bills before Congress would reduce the role of states in health policymaking, many rely on what exists now, with the addition of a public option to fill the coverage gap. We should question whether continued construction of scaffolding around an old foundation that fails many thousands of people, and the same populations repeatedly, is the right path forward.

CONCLUSION

It appears the ACA roused a sleeping giant of a conversation, a one hundred year old debate over universal coverage. The ACA attempted to fix a major problem with health care −lack of access due to widespread inability to pay −through creating near-universal health insurance coverage. The law addressed other issues, such as funding public health and improving it through measures such as free preventive care and menu labeling; new kinds of payment in Medicare and Medicaid, such as accountable care organizations; and many other smaller solutions to problematic features of the health care landscape. But, in 2009, the big game was universal coverage through insurance reform.

Economists Anne Case and Angus Deaton created a stir when they described the cost of health care as a "poll tax" because the cost is so high that it is effectively a tax that all U.S. residents pay.[254] This

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253 *See generally* Nicole Huberfeld, Sarah H. Gordon, David K. Jones, *Federalism Complicates the Response to the COVID-19 Health and Economic Crisis: What Can Be Done?*, 45 J. HEALTH POL., POL'Y & L. 951 (2020).

254 Heather Long, *Every American family basically pays an $8,000 'poll tax' under the U.S. health system, top economists say*, WASH. POST (Jan. 8, 2020), https://www.washingtonpost.com/business/2020/01/07/every-american-family-basically-pays-an-poll-tax-under-us-health-system-top-economists-say/. "Despite paying $8,000 more a year than anyone else, American families do not have better health outcomes, the economists argue. Life expectancy

unusual descriptor points to the same issue: many Americans cannot afford the care they need, which is brought into sharper relief by the amount of money paid both individually and collectively ($11,072 per person in 2018).[255] The ACA did not take a hard look at the cost of care. The gestalt reflects frustration with policy leaders' unwillingness to scrutinize the reasons that care is so expensive, especially given ongoing access issues, and relative to other developed nations' cost of care and measures of health. The U.S. has the dubious distinction of paying the most but being the least healthy among wealthy nations.[256]

A related question is whether the U.S. will follow global norms and treat health (not just health care) as a human right with the serious legislative effort that would entail.[257] The presidential primary debates suggested the answer could be affirmative, but pronouncements surrounding the signing of the ACA started the buzz that America was treating health as the next civil right, which means that it has taken ten years for the public to begin to embrace this principle. Recognizing health as a human right does not necessitate only government action or exclusion of private entities, and models exist in other nations that

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in the United States is lower than in Europe. 'We can brag we have the most expensive health care. We can also now brag that it delivers the worst health of any rich country,' Case said." *Id*. Case and Deaton are known for their work on so-called diseases and deaths of despair. *See, e.g.*, Anne Case & Angus Deaton, *Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century*, 112 PROC. NAT'L ACAD. SCI., 15078 (2015) (identifying "deaths of despair" by documenting increasing mortality for middle-aged, white Americans and linking the trend to an "epidemic of pain, suicide, and drug overdoses"); Anne Case & Angus Deaton, *Mortality & Morbidity in the 21st Century*, BROOKINGS PAPERS ON ECON. ACTIVITY, Spring 2017, at 397, 398 (amending and updating their 2015 work).

255 Rabah Kamal, et al., *How has U.S. spending on healthcare changed over time?*, PETERSON-KAISER FAM. FOUND. HEALTH SYS. TRACKER (Dec. 20, 2019), https://www.healthsystemtracker .org/chart-collection/u-s-spending-healthcare-changed-time/#item-nhe-trends_total-national-health-expenditures-us-per-capita-1970-2018.

256 Gerard F. Anderson, Peter Hussey & Varduhi Petrosyan, *It's Still the Prices Stupid: Why the US Spends So Much on Health Care, And a Tribute to Uwe Reinhardt*, 38 HEALTH AFFS. 87 (2019), https://www.healthaffairs.org/doi /10.1377/hlthaff.2018.05144; *OECD Health Statistics 2019*, ORG. ECON. CO-OPERATION & DEV.,https://www.oecd .org/health/health-data.htm (last visited Jan. 20, 2020).

257 The human rights phrase is "framework legislation." *See General Comment No. 14, The right to the highest attainable standard of health (article 12)*, Part IV, Committee on Economic, Social and Cultural Rights of the United Nations Office of the High Commissioner (2000), http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCu W1AVC1NkPsgUedPlF1vfPMJ2c7ey6PAz2qaojTzDJmC0y%2B9t%2BsAtGDNzdEqA6SuP2r 0w%2F6sVBGTpvTSCbiOr4XVFTqhQY65auTFbQRPWNDxL.

have demonstrated through regulated private markets that private players can participate well in a universal coverage scheme.[258] But America has progressed in an almost backwards fashion from these other nations, allowing private markets to develop to the point of requiring governmental intervention to function, whereas other nations have operated from a baseline of inclusion for decades.

Single-payer health insurance is easily a constitutional exercise of Congress's spending power, as would be a public insurance plan sold through the exchanges to fill coverage gaps. But, retaining divided governance (federalism) and other difficult debates that affect powerful stakeholders, such as methods and rates of payment or outlawing private insurance, raise harder constitutional questions. Nevertheless, the bottom line is that the legal questions are more straightforward than the policy and political questions. It appears that patience has worn thin on distracting political hurdles, especially in light of the persistent health disparities so painfully on display during the novel coronavirus pandemic. Administrative complexity, inequity, and high prices have been building this crescendo for quite a while.

[258] Roosa Tikkanen, *Variations on a Theme: A Look at Universal Health Coverage in Eight Countries*, COMMONWEALTH FUND (Mar. 22, 2019), https://www.commonwealthfund.org /blog/2019/ universal-health-coverage-eight-countries; Gerard F. Anderson, et al., *Reevaluating 'Made in America'—Two Cost-Containment Ideas from Abroad*, 368(24) NEW ENG. J. MED. 2247 (2013) (comparing cost controls in Germany and Japan to US). +