Privatized Public Health Insurance and the Goals of Progressive Health Reform

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What does a single-payer system or a public option look like in a country where more than one-third of Medicare beneficiaries and more than two-thirds of Medicaid beneficiaries are enrolled in privatized public health insurance? The first state to implement a public option plan directed government officials to contract with private health insurers, rather than opening up access to traditional public benefits. For the fall 2020 open enrollment period, Washington's health insurance exchange featured fifteen plans touted as public options, offered by five private carriers. Colorado's governor proposed a similar plan, pursuant to 2019 legislation directing state officials to create a privatized public option, but legislation to implement it was paused in 2020 due to the coronavirus pandemic. These developments raise important questions. Is it necessary to eliminate private insurance companies to serve the goals of progressive health reform? What makes public health care programs public*? Does privatized public health insurance have enough advantages over highly regulated privately financed insurance to be worth the trouble?*

This Article explores the role of privatized public health insurance in progressive efforts to expand public health care financing and administration. It is highly unlikely that any argument will persuade die-hard progressive reformers that they should prefer *to rely on private administration to any degree. Nonetheless, it is helpful to understand that privatization is not* inherently incompatible *with the ethos of solidarity*

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(interdependence among individuals and groups), mutual aid (reciprocity of support), and communitarianism (connectedness between individuals and their communities) that animates progressive reform proposals. State and federal lawmakers could use statutory provisions, regulations, and contract terms to secure the public's interest in universal coverage, fair distribution of the health benefits and financial burdens of public investments in health care, and public deliberation on plan design. By these normative criteria, which are derived from prior work developing a health justice *model for health law and policy, emphasize collective problem-solving in response to collective problems, privatized public health insurance may be nearly as* public *as our current Medicare and Medicaid programs.*

This Article's descriptive contribution furthers its normative argument. By laying out the questions legislatures and executive officials must answer in terms that are accessible to public-minded participants in civil society debates, it demonstrates how health reform proposals should be vetted through discourse that makes trade-offs explicit and fosters collective problem-solving in response to collective problems.

TABLE OF CONTENTS

> "In health, democracy is rooted in common love for and contestation of public things."[1]

INTRODUCTION

Preference for private market power over government intervention is the foundation of the US economy, a fixture of American law, and regarded by many progressives as an obstacle in the path of meaningful health reform.[2] Public financing to secure the goods and services

[1] Bonnie Honig, *The Politics of Public Things: Neoliberalism and the Routine of Privatization*, *in* 10 NO FOUNDATIONS 59, 60 (2013). Honig's use of "health" in this epigraph refers to the health of a *democracy*, not to governance of health care or the public's health. But the concept of public things, which Honig's work elucidates, has particular salience for the public-private divide in health governance. Honig's insistence that "contestation" of public things "betrays a common love, more than sentimental claims of devotion do," *id.* at 64, echoes Ed Sparer's exhortation that "the very struggle to reconstruct health care, organized along mutual aid lines which stress cooperative and caring relations, helps to provide a grace . . . and character to society and to each person who struggles for it." Ed Sparer, *Fundamental Human Rights, Legal Entitlements, and the Social Struggle: A Friendly Critique of the Critical Legal Studies Movement*, 36 STAN. L. REV. 509, 551 (1984); *see also* Lindsay F. Wiley, Elizabeth Y. McCuskey, Matthew B. Lawrence & Erin C. Fuse Brown, *Health Reform Reconstruction* (forthcoming 2021), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3760086 [https://perma.cc/TU3N-NWTG] (arguing for reconstruction of the conceptual foundations of health reform to center health justice, social solidarity, and mutual aid).

[2] MARTHA MINOW, PARTNERS, NOT RIVALS: PRIVATIZATION AND THE PUBLIC GOOD 140 (2002) ("Market ideas and privatization have affected medicine and law in ways that affect discussions of public duties, redistribution, public benefits, and service to those in need."); Honig, *supra* note 1, at 59 ("In recent years, neoliberals have sought to privatize public things in the name of efficiency, citing waste in public bureaucracy and the unreliability of civil servants unmotivated by private market incentives."); Jon D. Michaels, *Privatization's Pretenses*, 77 U. CHI. L. REV. 717, 717-18 (2010) ("The case for privatization . . . has centered on its technocratic promise of efficiency and cost savings."); Jeffrey W. Stempel, *Adam, Martin, and John: Iconography, Infrastructure, and America's Pathological Inconsistency About Medical Insurance*, 14 CONN. INS. L. J. 229, 237 (2008) ("Working in tandem with the rugged individualism ethos of 'freedom,' Smithian fidelity to private markets makes even Democrats flinch from advocating a single-payer, government administered medical insurance system . . . ."). In the 1990s and early 2000s, health reform itself was privatized, with private companies instituting managed care practices to achieve cost controls. M. Gregg Bloche, *Introduction*, *in* THE

essential for human well-being is typically viewed as an exception in need of justification, rather than the default. Thus, most Americans depend on private health insurance purchased on the market by individual households, usually with help from an employer and support from indirect public subsidies largely hidden from view.[3] Public health care coverage is eligibility-limited and means-tested.[4] Truly public

PRIVATIZATION OF HEALTH CARE REFORM: LEGAL AND REGULATORY PERSPECTIVES xiii (M. Gregg Bloche ed., 2003) ("The failure of President Clinton's health reform plan in 1994 set off a surge of entrepreneurship. With the prospect of comprehensive legislation gone, insurers, doctors and hospitals, and health care purchasers were free to act without high political and regulatory risk. Motivated by soaring medical costs, they did so aggressively. Health care payers and providers forged novel business arrangements and organizational forms, aimed at controlling costs while meeting consumers' expectations.").

[3] Employer-based health insurance, which covers 55% of Americans, is indirectly subsidized by favorable tax treatment of fringe health benefits. For people in households earning between 100% and 400% of the federal poverty level who are ineligible for public coverage and lack access to affordable employer-based insurance, the Affordable Care Act ("ACA") provides tax credits to subsidize the cost of private insurance purchased directly (rather than through an employer) on state-level health insurance exchanges. *See* EDWARD R. BERCHICK, JESSICA C. BARNETT & RACHEL D. UPTON, U.S. CENSUS BUREAU, P60-267(RV), HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2018, at 1-2 (2019), https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf [https://perma.cc/3GNX-A9P5] (noting that in 2018, 55.1% of Americans were covered by employer-based private health insurance, 10.8% by directly purchased private insurance, 17.8% by Medicare, and 17.9% by Medicaid); Jonathan Gruber, *The Tax Exclusion for Employer-Sponsored Health Insurance*, 64 NAT'L TAX J. 511, 511, 513 (2011) (analyzing the favorable tax treatment of employer-sponsored health insurance as a subsidy); Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C. L. REV. 1, 7 (2016) (arguing that hidden subsidies for private, employer-sponsored insurance support a false impression that individuals covered by it are self-sufficient).

[4] Medicare, a federal program, covers most people over sixty-five and those who have qualifying disabilities. Medicare requires enrollees to pay means-tested premiums, though premiums for the hospital insurance portion of traditional Medicare coverage are waived for enrollees who have paid Medicare taxes for at least thirty quarters. Medicaid, a program that is jointly financed and administered by the federal government and the states, covers most people in households earning up to 138% of the federal poverty level in states that have accepted the ACA eligibility expansion. In states that have not accepted the ACA expansion, Medicaid is limited to people with very low household income who satisfy additional criteria, such as being pregnant, a child, elderly, disabled, or a parent of a dependent child. The Children's Health Insurance Program ("CHIP") provides federal block grants, subject to periodic (and routinely precarious) renewal by Congress, for states to cover additional children and parents who are not eligible for Medicaid. Many states supplement these programs with their own funds to provide coverage to families whose income exceeds federal eligibility thresholds. *See* BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY STOLTSFUS JOST, ROBERT L. SCHWARTZ, BRIETTA R. CLARK, ERIN C. FUSE BROWN, ROBERT

systems are limited to special populations, including through the Veterans Administration and the Indian Health Service.

At the turn of the twenty-first century, lawmakers married expansion of eligibility and benefits under public health care programs with growing privatization within those programs.[5] Congress expanded Medicare benefits under the Medicare Modernization Act of 2003 ("MMA")[6] and Medicaid eligibility under the Affordable Care Act of 2010 ("ACA").[7] But in doing so, they relied on government contracts with privately administered health plans rather than expanding traditional public benefits.[8] Proposals to cover everyone through a government-run, single-payer health plan failed to gain traction in the build-up to passage of the ACA.[9] The ACA improved coverage and consumer protection within the basic structure of a largely privatized, decentralized hodge-podge, rather than replacing it with a unified system.[10] To secure the votes needed to overcome a filibuster, the ACA's framers abandoned even the relatively modest proposal to create a government-run "public option" that would compete for enrollment against private plans.[11]

In the decade following the ACA's passage, commitment to health care access as a public responsibility and (more esoterically) to health

GATTER, JAIME S. KING & ELIZABETH PENDO, HEALTH LAW: CASES, MATERIALS AND PROBLEMS 625-28 (8th ed. 2018).

[5] *See* Ronald A. Cass, *Privatization: Politics, Law, and Theory*, 71 MARQ. L. REV. 449, 451 (1988) (defining "privatization" as "signif[ying] a lessening of governmental involvement in some particular enterprise"); Eleanor Bhat Sorresso, *A Philosophy of Privatization: Rationing Health Care Through the Medicare Modernization Act of 2003*, 21 J.L. & HEALTH 29, 31 (2008) ("The trend in coping with . . . rising Medicare costs has been to increase the role that private insurance plays in providing coverage for Medicare recipients.").

[6] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066.

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

[8] *See* Robert I. Field & Richard G. Stefanacci, *Beyond Drug Coverage: The Cumulative Effect of Privatization Reforms in the Medicare Modernization Act*, 1 ST. LOUIS U. J. HEALTH L. & POL'Y 207, 207 (2007).

[9] *See, e.g.*, MINOW, *supra* note 2, at 127 ("Universal, state-subsidized health care is politically infeasible whether or not it is wise.").

[10] *See* Alice Noble & Mary Ann Chirba, *Individual and Group Coverage Under the ACA: More Patches to the Federal-State Crazy Quilt*, HEALTH AFF. BLOG (Jan. 17, 2013), http://healthaffairs.org/blog/2013/01/17/individual-and-group-coverage-under-the-aca-more-patches-to-the-federal-state-crazy-quilt/ [https://perma.cc/6GGS-P7LT].

[11] *See* Helen A. Halpin & Peter Harbage, *The Origins and Demise of the Public Option*, 29 HEALTH AFF. 1117, 1117 (2010).

care programs as *public things*,[12] has grown. Calls to open up Medicare and Medicaid programs to all (or more) Americans — to "publicize" American health care coverage, if you will — have gained support from the public and a growing number of federal and state lawmakers.[13] In the 2020 Democratic presidential primary, single-payer and public-option proposals under the "Medicare for All" banner took center stage.[14] As the Democratic nominee, Joe Biden promised to build on the ACA by providing "the choice to purchase a public health insurance option like Medicare" for Americans whose "insurance company isn't doing right by" them.[15]

The 2020 coronavirus pandemic has added new urgency to demands for bolder health reform.[16] Millions of Americans have lost health insurance coverage when many of them need it most — for their own benefit and for the benefit of others whom they might unwittingly expose to infection if they are unable to access testing and (eventually) vaccination.[17] At the same time, state budgets are being strained to the

[12] *See, e.g.*, Honig, *supra* note 1, at 60-63 (emphasizing the importance of "public things" in a). For more on public things, see BONNIE HONIG, PUBLIC THINGS: DEMOCRACY IN DISREPAIR (2017).

[13] *See, e.g.*, *Healthcare System*, GALLUP, https://news.gallup.com/poll/4708/healthcare-system.aspx (last visited Dec. 25, 2020) [https://perma.cc/5X93-DCEH] (documenting survey responses from 2010 to 2020 to the question, "Which of the following approaches for providing healthcare in the United States would you prefer: a government-run healthcare system or a system based mostly on private health insurance?" with the percentage of respondents saying they prefer a government-run system increasing from 34% in November 2010 to 47% in November 2017, then decreasing to 42% in November 2019).

[14] *See, e.g.*, Olga Khazan, *The Stunning Rise of Single-Payer Health Care: How a Socialist-Seeming Health-Care Policy Became a Rallying Cry in the Democratic Mainstream*, ATLANTIC (Nov. 21, 2019), https://www.theatlantic.com/health/archive/2019/11/why-people-support-medicare-all/602413/ [https://perma.cc/74QT-TPQR] ("Medicare for All — otherwise known as single-payer health care — has taken on an astonishing popularity among Democrats and independents in recent years, rising from a fringe, socialist hobbyhorse to a policy seriously and frequently considered during the Democratic primary debates. In 2016, it was the special quirk of Sanders's candidacy; now 11 candidates support some version of it."); *see also* Jonathan Oberlander, *Lessons from the Long and Winding Road to Medicare for All*, 109 AM. J. PUB. HEALTH 1497, 1497 (2019); Danielle Kurtzleben, Lexie Schapitl & Alyson Hurt, *Health Care: See Where the 2020 Democratic Candidates Stand*, NPR (Sept. 10, 2019, 5:00 AM EST), https://www.npr.org/2019/09/10/758172208/health-care-see-where-the-2020-democratic-candidates-stand [https://perma.cc/YC5Z-BFUS].

[15] *Health Care*, JOEBIDEN.COM, https://joebiden.com/healthcare (last visited Dec. 25, 2020) [https://perma.cc/EWJ7-L3RV].

[16] *See* Wiley et al., *supra* note 1 (manuscript at 1-6).

[17] *See* JOSH BIVENS & BEN ZIPPERER, ECON. POL'Y INST., HEALTH INSURANCE AND THE COVID-19 SHOCK: WHAT WE KNOW SO FAR ABOUT HEALTH INSURANCE LOSSES AND WHAT

breaking point by pandemic response expenses coupled with big hits to revenues.[18] The health care providers whose organized political opposition has stymied many progressive reforms[19] are also feeling the economic pain of reduced revenues from elective procedures that have been halted by executive order and voluntarily delayed by patients.[20] Many have been subsidized by stimulus payments comparable to those

IT MEANS FOR POLICY 2 (2020), https://files.epi.org/pdf/206003.pdf [https://perma.cc/2JDR-5ZGQ]; JESSICA BANTHIN, MICHAEL SIMPSON, MATTHEW BUETTGENS, LINDA J. BLUMBERG & ROBIN WANG, URBAN INSTITUTE, CHANGES IN HEALTH INSURANCE COVERAGE DUE TO THE COVID-19 RECESSION: PRELIMINARY ESTIMATES USING MICROSIMULATION 1-3 (July 2020), https://www.urban.org/sites/default/files/publication/102552/changes-in-health-insurance-coverage-due-to-the-covid-19-recession_4.pdf [https://perma.cc/RD3D-PWHD]; ANUJ GANGOPADHYAYA, MICHAEL KARPMAN, & JOSHUA AARONS, URBAN INSTITUTE, AS THE COVID-19 RECESSION EXTENDED INTO THE SUMMER OF 2020, MORE THAN 3 MILLION ADULTS LOST EMPLOYER-SPONSORED HEALTH INSURANCE COVERAGE AND 2 MILLION BECAME UNINSURED 1 (Sept. 2020), https://www.urban.org/sites/default/files/publication/102852/as-the-covid-19-recession-extended-into-the-summer-of-2020-more-than-3-million-adults-lost-employer-sponsored-health-insurance-coverage-and-2-million-became-uninsured.pdf [https://perma.cc/5K3G-DWFS]; Karyn Schwartz & Jennifer Tolbert, *Limitations of the Program for Uninsured COVID-19 Patients Raise Concerns*, KAISER FAM. FOUND. (Oct. 8, 2020), https://www.kff.org/policy-watch/limitations-of-the-program-for-uninsured-covid-19-patients-raise-concerns/ [https://perma.cc/R884-ENSU].

[18] *See Coronavirus (COVID-19): Revised State Revenue Projections*, NCSL (Dec. 10, 2020), https://www.ncsl.org/research/fiscal-policy/coronavirus-covid-19-state-budget-updates-and-revenue-projections637208306.aspx [https://perma.cc/GP3E-2TZR]. COVID relief bills have provided significant (but not sufficient) relief to states, including in the form of a 6.2 percent bump to their Federal Medical Assistance Percentage ("FMAP"), which determines the split between federal and state spending on Medicaid. Robin Rudowitz, Bradley Corallo & Rachel Garfield, *How Much Fiscal Relief Can States Expect from the Temporary Increase in the Medicaid FMAP?*, KFF (July 22, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/how-much-fiscal-relief-can-states-expect-from-the-temporary-increase-in-the-medicaid-fmap/ [https://perma.cc/6UVM-P387].

[19] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY 28 (1982) ("Private physicians have sought to keep government from competing with them, regulating their practice, or, worst of all, incorporating medical care into the state as a public service like education. Their struggle to limit the boundaries of public health, to confine public medical services to the poor, and to prevent the passage of compulsory health insurance all exemplify these concerns."); *id.* at 448 ("The profit-making hospitals clearly benefit from the structure of private health insurance and can be counted on to oppose any national health program that might threaten to end private reimbursement.").

[20] Bruce Stuart, *The Hospital Industry Is in a Financial Mess: We Have a Unique Opportunity to Fix It*, HEALTH AFF. Blog (Aug. 27, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200825.24660/full/ [https://perma.cc/F465-Y5KQ].

offered to airlines and other industries affected by the pandemic.[21] Post-2020 reform efforts may have to navigate competing demands for more meaningful access to health care and more economic stimulus for the businesses that provide it.

As if these developments were not enough to throw health reform debates into chaos, the death of Supreme Court Justice Ruth Bader Ginsberg put the future of the ACA in greater doubt.[22] In *California v. Texas* more than a dozen states, with support from the Trump administration, asked the Court to strike down the ACA in its entirety.[23] One week after the 2020 election, and two weeks after Justice Amy Coney Barrett was confirmed to fill Justice Ginsberg's seat, the Court heard oral arguments in the case. Shortly thereafter, President Biden was elected, and Democrats gained enough seats in the Senate to create a 50-50 split. The Biden administration can immediately signal its support for the ACA in court filings and adopt administrative measures to sustain it unless and until the Court strikes it down. Moreover, with Vice President Kamala Harris casting the deciding vote in the Senate, Congress could moot the Supreme Court case by increasing the tax penalty for violating the individual mandate using a budget reconciliation process requiring a bare majority.[24] But without a filibuster-proof Democratic majority in the Senate, legislation to build on the ACA by adding a public option will face an uphill battle.[25]

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[21] Rebecca Pifer, *Federal COVID-19 CASH Saved Most Hospitals from Bleakest Forecasts: MedPAC*, HEALTH CARE DIVE (Sept. 4, 2020), https://www.healthcaredive.com/news/federal-covid-19-cash-saved-most-hospitals-from-bleakest-forecasts-medpac/584689/ [https://perma.cc/R743-J6XW] (summarizing MedPAC presentation at a public meeting on Sept. 3); Rachel Burton & Molly Morein, Context for Medicare Payment Policy (Sept. 3, 2020), http://www.medpac.gov/docs/default-source/meeting-materials/medpac_context_sept_2020.pdf?sfvrsn=0 [https://perma.cc/VQ4F-DMU6] (MedPAC public meeting slide presentation).

[22] Katie Keith, *After Justice Ginsburg's Loss, What a New Court Could Mean for the ACA*, HEALTH AFF. BLOG (Sept. 20, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200920.954961/full/ [https://perma.cc/CVY3-U5EC].

[23] Texas v. United States, 945 F.3d 355 (5th Cir. 2019), *cert. granted sub. nom.* California v. Texas, 140 S. Ct. 1262 (Mar. 2, 2020) (No. 19-840).

[24] *See* Nicholas Bagley & Richard Primus, *To Save Obamacare, Repeal the Mandate*, ATLANTIC (Dec. 20, 2018), https://www.theatlantic.com/ideas/archive/2018/12/how-save-obamacare-texas-lawsuit/578683/ [https://perma.cc/F9QP-CJ68] ("Congress could make the mandate constitutional again by raising the penalty for not having insurance from zero dollars, where Congress set it in 2017, to one dollar.").

[25] *See* Katie Keith, *What Biden's Election Would Mean for the Affordable Care Act*, HEALTH AFF. BLOG (Nov. 5, 2020), https://www.healthaffairs.org/do/10.1377/hblog20201105.33952/full/ [https://perma.cc/Y9PJ-8GSY].

Progressive reformers are likely to continue their focus on state-level legislation for the foreseeable future.[26]

In the midst of this turmoil, states are pursuing public option reforms to allow residents to buy into public coverage similar to state Medicaid plans.[27] At the federal level, many reformers tout their public option plans as creating a "glide path" to single-payer health care.[28] At the state level, reformers typically focus on the benefits that public option plans offer in their own right.[29]

Proponents of single-payer and public-option plans have multiple, interconnected goals. First and foremost is ensuring the availability and affordability of health care services via universal coverage (*universal* in the sense that everyone would be covered, but not necessarily in the sense that they would be enrolled in uniform coverage).[30] Reformers

[26] There may be sufficient support, including from enough Republicans to overcome a filibuster, to pass federal legislation adding an administrative waiver provision to the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829, to permit greater flexibility for state experimentation. *See* Elizabeth Y. McCuskey, *ERISA Reform as Health Reform: The Case for an ERISA Preemption Waiver*, 48 J.L. MED. & ETHICS 450, 454 (2020) (proposing ERISA waiver legislation).

[27] *See* Lindsay F. Wiley, *Medicaid for All? State-Level Single-Payer Health Care*, 79 OHIO ST. L.J. 843, 847 (2018) [hereinafter *Medicaid for All?*].

[28] *E.g.*, *2020 Hopefuls Confirm: Public Option is 'Natural Glide Path' to Medicare for All*, PARTNERSHIP FOR AMERICA'S HEALTH CARE FUTURE (July 1, 2019), https://americashealthcarefuture.org/2020-hopefuls-confirm-public-option-is-natural-glide-path-to-medicare-for-all/ [https://perma.cc/K47S-76Q4] (describing Democratic presidential candidate Pete Buttigieg as emphasizing "that a 'buy-in' or 'public option' system 'will be a very natural glide path to the single payer environment'" and quoting Senator Kristin Gillebrand as saying, "The truth is, if you have a buy-in over a four or five year period, you move us to single payer more quickly").

[29] *See, e.g.*, *Inslee Announces Five Carriers Intend to Participate in Public Option*, WASH. GOVERNOR (July 7, 2020), https://www.governor.wa.gov/news-media/inslee-announces-five-carriers-intend-participate-public-option [https://perma.cc/BB2Y-X865] (quoting Washington state Senator David Frockt on the goals of the public option legislation he sponsored: "One of the key goals of this bill was to ensure predictable and reduced deductibles and co-pays for consumers . . . [t]he standardized plans accomplish this important goal while also bringing new entrants into our individual market. I believe this effort has also put downward pressure on premiums for [other individual] plans that will now be competing against [public option] plans – another goal of the legislation. As we deal with pandemic related loss of employer sponsored coverage, we must do everything we can to build on the successful implementation of the Affordable Care Act here in Washington state in order to bring health security to our people").

[30] *See, e.g.*, Jacob S. Hacker, *From the ACA to Medicare for All?*, *in* THE TRILLION DOLLAR REVOLUTION: HOW THE AFFORDABLE CARE ACT TRANSFORMED POLITICS, LAW, AND HEALTH CARE IN AMERICA 333, 334 (Ezekiel J. Emanuel & Abbe R. Gluck eds., 2020) (describing "affordable, high-quality health care for all" as "the goal [Medicare for All] embodies"); *see also Healthcare System*, *supra* note 13 (documenting that more than 50%

also promise to lower costs, making expanded access more feasible and sustainable.[31] Some also seek to eliminate or limit out-of-pocket payments by households — in the form of deductibles, copayments, and coinsurance — by providing greater financial protection for enrollees.[32] Part of the appeal of "Medicare for All" is its vagueness. It means different things to different people, including the candidates who pledge to support it and the voters and donors whose support they seek. But if single-payer or public-option health care is ever to become a reality in the US, lawmakers — and, if our recent experience with less radical health reform is any indication, the courts as well — must attend to the specifics.

One key issue is the role private insurers might play in single-payer or public-option reforms. For the most part, our national conversation about expanding access to publicly financed health insurance treats public health coverage as an alternative to private insurance.[33] But, as Matthew Diller has explained regarding public assistance programs generally, "[t]he reality is that the divide between the public and private sectors has never been a clean line."[34] Private companies are thoroughly

of survey respondents have reported that they personally worry a great deal about the availability and affordability of health care in annual surveys from 2001 to 2019).

[31] *See, e.g.*, Hacker, *supra* note 30, at 336 ("The idea of the public option [eventually cut from bills culminating in passage of the ACA] was to give people who were covered through the state-based marketplaces . . . a public plan that used Medicare's payment rates to hold down prices.").

[32] *See, e.g.*, *Health Care as a Human Right - Medicare for All*, BERNIESANDERS.COM [hereinafter *Health Care as a Human Right*], https://berniesanders.com/issues/medicare-for-all/ (last visited Dec. 25, 2020) [https://perma.cc/XTR6-BNBM] (describing Sen. Sanders's proposal as ensuring "[n]o networks, no premiums, no deductibles, no copays, no surprise bills").

[33] *See* Hacker, *supra* note 30, at 334 ("Democrats are beginning to see a path to universal health care that builds on Medicare rather than expanding private insurance."); *Healthcare System*, *supra* note 13 (documenting survey responses from 2010 to 2019 to the question, "Which of the following approaches for providing healthcare in the United States would you prefer: a government-run healthcare system or a system based mostly on private health insurance?"). For a more nuanced view, see William M. Sage & Timothy M. Westmoreland, *Following the Money: The ACA's Fiscal-Political Economy and Lessons for Future Health Care Reform*, 48 J. L. MED. & ETHICS 434, 434 (2020) ("Imagine replacing the ACA with a system in which most beneficiaries participate in private Medicare Advantage plans rather than fee-for-service Medicare (which seems plausible).").

[34] Matthew Diller, *Form and Substance in the Privatization of Poverty Programs*, 49 UCLA L. REV. 1739, 1743 (2002); *see also* Martha Albertson Fineman, *Introduction* to PRIVATIZATION, VULNERABILITY, AND SOCIAL RESPONSIBILITY: A COMPARATIVE PERSPECTIVE 1, 2 (Martha Albertson Fineman et al. eds., 2017) ("Using a vulnerability lens . . . adds another dimension to the privatization debates by questioning the coherence of conceptualizing a divide between the public and the private realms to begin with.");

entwined with public benefit programs, and "[f]ew would argue that all of [the social welfare] programs that have long incorporated elements of privatization should be administered directly by government. In this sense, the debate focuses on the extent and terms of privatization, not on privatization per se."[35]

Moving beyond simplistic assumptions that public insurance and private insurance are opposites also opens up debate over what individuals owe to one another in a society and over the truly crucial questions at stake in the new wave of progressive reforms in health care and other sectors. As Martha Albertson Fineman has argued with respect to privatization generally, "[w]hether or not the typical arguments for or against privatization are rooted in fiscal necessity, profit maximization, or the pursuit of public interest and the elusive notion of justice, what is at issue is ultimately the question of what is the appropriate balance of responsibility between the state, the market and other societal institutions, and the individual."[36] Acknowledging that the public-private divide lacks coherence "allows a more focused discussion on the nature and extent of state responsibility for societal and individual functioning, success, and prosperity."[37]

It is highly unlikely that any argument I make will persuade die-hard progressive reformers that they should *prefer* to rely on private administration to any degree. Nonetheless, it is helpful to understand that privatization is not *inherently incompatible* with the ethos of

Duncan Kennedy, *The Stages of the Decline of the Public/Private Distinction*, 130 U. PA. L. REV. 1349, 1351-52 (1982) ("An important and exciting moment in the history of a distinction [between public and private] arrives when troublemakers begin to argue that the distinction is incoherent because, no matter how you try to apply it, you end up in a situation of hopeless contradiction.").

[35] Diller, *supra* note 34, at 1743, at 1743; *see also* David A. Super, *Privatization, Policy Paralysis, and the Poor*, 96 CALIF. L. REV. 393, 398 (2008) ("Ethically, categorical opposition to private contracting in all of its forms is unjustified. Few seriously argue that only public employees should distribute the food that the Food Stamp Program provides or deliver all health care under Medicaid."). For a more ambitious vision, see JON. D. MICHAELS, CONSTITUTIONAL COUP: PRIVATIZATION'S THREAT TO THE AMERICAN REPUBLIC 206-218 (2017) (setting forth a plan for renationalization of work outsourced to private companies as part of a broader effort to reclaim comprehensive civil service). Envisioning a path to "renationalize" Medicaid is an ambitious exercise worth conducting (at least as a thought experiment) but one that I must postpone for a future project.

[36] Fineman, *supra* note 34, at 2.

[37] *Id.*; *see also* Jody Freeman, *The Private Role in Public Governance*, 75 N.Y.U. L. REV. 543, 548 (2000) ("There is no purely private realm and no purely public one. . . . [T]he entity on which we ought to focus administrative law's scholarly attention is neither public nor private but something else: the set of negotiated relationships between the public and the private.").

solidarity (interdependence among individuals and groups),[38] mutual aid (reciprocity of support),[39] and communitarianism (connectedness between individuals and their communities)[40] that animates progressive reform proposals.[41] For the more moderate reformers who will need to

[38] *See* Françoise Baylis, Nuala P. Kenny & Susan Sherwin, *A Relational Account of Public Health Ethics*, 1 PUB. HEALTH ETHICS 196, 198 (2008) ("[I]ssues of trust, neighborliness, reciprocity and solidarity must be made central [to public health ethics]."); Erin C. Fuse Brown, Matthew B. Lawrence, Elizabeth Y. McCuskey & Lindsay F. Wiley, *Social Solidarity in Health Care, American-Style*, 48 J. L. MED. & ETHICS 411, 411 (2020) ("[T]racing the philosophical evolution of health care law in the United States toward the ethic of social solidarity . . . .").

[39] *See* Bruce Jennings, *Relational Liberty Revisited: Membership, Solidarity and a Public Health Ethics of Place*, 8 PUB. HEALTH ETHICS 7, 7 (2015) ("[B]oth the practical success of public health policies and programs and their capacity to gain normative legitimacy and trust rely on the presence of a cultural sense of obligation and mutual aid in a world of common vulnerability.").

[40] *See* Dan E. Beauchamp, *Community: The Neglected Tradition of Public Health*, 15 HASTINGS CTR. REP. 28, 34 (1985) ("[T]he communitarian language of public health . . . [reinforces] . . . the sense in which health and safety are a signal commitment of the common life — a central practice by which the body-politic defines itself and affirms its values." (emphasis omitted)). In my prior work, I have frequently argued that the goals of public health (what we as a society do collectively to ensure the conditions for people to be healthy) and health *care* reform (efforts to improve systems for health care financing and delivery) should be more fully integrated within a communitarian ethic. *See, e.g.*, Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL'Y 47, 52 (2014) [hereinafter *Social Justice*] ("I describe social justice as a communitarian approach (in its emphasis on collective problems and collective problem-solving) to ensuring the essential conditions for human well-being, including redistribution of social and economic goods and recognition of all people as equal participants in social and political life. Rather than merely adopting social justice as the 'core value' of public health as Beauchamp and others have done, I argue that social justice is emerging as a core value of health law and policy *writ large*." (emphasis omitted)). I have previously noted that the health justice model shares a collectivist impulse with the market power model. Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public's Interest in Affordable, High-Quality Health Care*, 37 CARDOZO L. REV. 833, 839 (2016) [hereinafter *Health Justice*] ("[T]he health justice model asserts the role of collective oversight through democratic governance — much in the same way that the market power model champions the role of private payers and market dynamics — in managing resources and securing common goods."); *id.* at 850-51 ("The market power paradigm represents collectivist impulses to some extent. Market power adherents 'instruct[] courts and regulators to value medical services only insofar as they boost biological functioning and to decide controversies so as to maximize collective welfare.' They lament the 'pernicious influence' of 'the ideal of the trustworthy, independent physician delivering the best possible medical care for her or his individual patients.'") (first quoting M. Gregg Bloche, *The Invention of Health Law*, 91 CALIF. L. REV. 247, 253 (2003); and then quoting Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155, 156 (2004)).

[41] In other work, I have argued that privatization is one of four fixtures standing in the way of realizing health justice and solidarity through progressive health reforms.

be persuaded to join any successful effort to reconstruct how nearly one-fifth of our economy is paid for,[42] privatization may have advantages. Whether it is wise for progressive reformers to compromise on private administration to achieve a public option reform depends on the extent to which a privatized public option reform confronts other fixtures standing in the way of realizing health justice. As I have argued (with coauthors) elsewhere: if a privatized public option plan provides a path for "equalizing payment rates and unifying the inequitable two-tiered public-private health care system that pays more to providers for seeing privately insured patients than publicly insured," it may be worthwhile to concede to privatized administration of public benefits.[43]

Maximizing the potential benefits of privatized public coverage will require a delicate balance between public and private governance. Preserving a role for private administrators could be politically expedient (assuming progressives could be appeased), but I will leave that analysis to the pollsters. As a legal scholar, I am more interested in the extent to which private administrators, by conducting negotiations with and providing oversight of hospitals, doctors, and other health care providers,[44] may help constrain health care prices, though often in ways

Fuse Brown et al., *supra* note 38, at fig. 2 (identifying state-level, privately administered public option reforms as moderately confronting fiscal fragmentation, but not privatization, federalism, or individualism); Wiley et al., *supra* note 1 (manuscript at 4-5) (arguing that privatization is among the fixtures that progressive health reforms must confront, albeit incrementally, to serve the health justice ethos that should guide post-2020 reform efforts). In this Article, I argue that state-level, privately administered public option reforms also confront individualism in health care governance, by creating opportunities for collective deliberation on the questions public option designers must answer. In addition, by confronting the powerful influence of organized medicine and hospital systems and incorporating rate setting into privatized public option contracts, privatized public option reforms may also confront privatized health care delivery, even as they reinforce privatized administration of health benefits.

[42] RYAN NUNN, JANA PARSONS & JAY SHAMBAUGH, THE HAMILTON PROJECT, A DOZEN FACTS ABOUT THE ECONOMICS OF THE U.S. HEALTH-CARE SYSTEM 1 (2020), https://www.brookings.edu/wp-content/uploads/2020/03/HealthCare_Facts_WEB_FINAL.pdf [https://perma.cc/H9CS-Q5WC] (relying on data from the U.S. Centers for Medicare and Medicaid Services) ("Sixty years ago, health care was 5 percent of the U.S. economy . . . ; at 17.7 percent in 2018, it was more than three times that.").

[43] Wiley et al, *supra* note 1, at 62.

[44] *See infra* Parts II.B.2, II.C.4. Market power scholars have pointed out that traditional Medicare has tended to inflate, rather than constrain, reimbursement rates for providers. David A. Hyman & Charles Silver, *Medicare for All: Four Inconvenient Truths*, 20 HOUS. J. HEALTH L. & POL'Y 133, 153 (2020) ("Health care providers know that when they are bargaining with Medicare, they're playing a stare-down game with an opponent who always blinks.").

that individual consumers find troubling.[45] The practices private insurers use to control costs provoke deeply emotional opposition from critics who insist "notions of economic efficiency do not belong in discussions of the provision of health care."[46] As a legal scholar who adopts a communitarian public health perspective, however, I am cognizant that health care price controls aimed at equalizing rates between public and private coverage could make expanded access to health care not only more feasible, but also more equitable. A stronger government role in rate setting could also free up resources to address other social determinants of health, such as educational and

[45] Indeed, the managed care practices that triggered backlash "patient protection" reforms were supported by arguments that empowering private, third-party payers would serve the public interest by constraining the ability of hospitals, physicians, and other health care providers to charge usual and customary rates or incurred costs for whatever services they deemed appropriate. *See, e.g.*, ALAIN C. ENTHOVEN, HEALTH PLAN: THE PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE 81 (1980) (discussing the use of opaque and complicated terms by insurance companies to control the insurance market); Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFF. 24, 24 (1993) (discussing the concept of "managed competition" in the health care industry); Clark C. Havighurst, *Controlling Health Care Costs: Strengthening the Private Sector's Hand*, 1 J. HEALTH POL. POL'Y & L. 471, 475-82 (1977) (discussing the upward price spiral over which insureds have no control). Patient protection reforms that sought to blunt the worst abuses of managed care by imposing specific coverage mandates and procedural checks and balances on utilization management techniques also triggered criticism. *See, e.g.*, David A. Hyman, *Getting the Haves to Come Out Behind: Fixing the Distributive Injustices of American Health Care*, 69 LAW & CONTEMP. PROBS. 265 (2006); David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights*, 73 S. CAL. L. REV. 221 (2000); Russell Korobkin, *The Efficiency of Managed Care Patient Protection Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 87-88 (1999) ("[P]ublic backlash against the perceived excesses of managed care has made 'patient protection' or 'mandated benefits' legislation ubiquitous in the 1990s . . . . The economic argument for mandated benefits depends, of course, on the assumption that government actors can successfully identify which mandates will be efficiency enhancing and which will not. This determination would be difficult under the best of circumstances, but courts and legislatures face institutional impediments to successfully making such complicated determinations."). The ACA federalized these managed care reforms and applied them to privatized public health plans as well as directly-purchased plans, while preserving a role for private health insurers in provider oversight. *See infra* Part II.B.2.

[46] Korobkin, *supra* note 45, at 87. This argument, which Korobkin and others have critiqued from a market power perspective, is central to the patient rights model that dominated progressive health law scholarship in the 1990s and early 2000s. I have argued elsewhere that a health justice model grounded in public health ethics provides a much-needed alternative to the individualistic patient rights model and offers collective, community interests as an important counterbalance to the assertion of rights to particular health care services by disproportionately privileged consumers who already have access to high-cost, private health insurance. *See generally* Wiley, *Health Justice*, *supra* note 40.

employment opportunities, food and housing security, environmental protection, and more.[47]

Within the movement to increase the government's involvement in health care — to "publicize" health care, if you will — reformers must grapple with the extent to which existing public health care programs are privatized. Publicly financed health care programs rely heavily on private contractors to perform the basic functions of health coverage. In the federal Medicare program, which covers most elderly people and some people with disabilities, two-thirds of beneficiaries are enrolled in traditional coverage, but private contractors handle utilization management and claims processing for those enrollees.[48] About one-third of Medicare beneficiaries are enrolled in fully privatized Medicare Advantage ("MA") plans for which the government pays a capitated fee

[47] *See, e.g.*, COMM'N ON THE SOC. DETERMINANTS OF HEALTH, WORLD HEALTH ORG., A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 39-40 (2010) ("[D]ifferences in access to health care certainly do not fully account for the social patterning of health outcomes . . . . In a comprehensive model, the health system itself should be viewed as an intermediary determinant [of health]."); *see also* NANCY KRIEGER, EPIDEMIOLOGY AND THE PEOPLE'S HEALTH: THEORY AND CONTEXT 181 (2011) ("[The social determinants of health thesis] posit[s] that people's ability to live healthy lives is shaped by . . . the social and physical quality of their neighborhoods, schools, transportation, and workplaces and their access to affordable healthy food and affordable appropriate medical care."). Like other health law scholars who adopt a collectivist orientation, I am deeply wary of organized medicine's historical success in circumventing public oversight. *See* Starr, *supra* note 19, at 28. I am far from alone among health law scholars in my skepticism. Other health law scholars who adopt a similarly collectivist orientation express grave concerns about organized medicine as a fixture that progressive reforms must confront. *See, e.g.*, William M. Sage, Lecture, *Over Under or Through: Physicians, Law, and Health Care Reform*, 53 ST. LOUIS U. L.J. 1033, 1036 (2009) ("[L]aw accedes too readily to physicians' declared (and ethically defensible) allegiance to each individual patient, and does not demand greater service to society as a whole."); William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497, 500 (2008) ("[P]oliticians and policymakers apply the mental construct of the specific patient, and that patient's therapeutic relationship with a specific physician, to problems of collective costs and benefits for which such a starting point . . . is not appropriate.").

[48] *See* Field & Stefanacci, *supra* note 8, at 208 ("Even at its inception in 1965, Congress balanced public and private roles in the program's administration. Legislators compromised to grant overall responsibility to the federal government, originally through the Social Security Administration, but delegated considerable portions of the day-to-day administration to private insurance companies that administered claims and made many coverage determinations."). In other work, I have argued that organized medicine is a manifestation of individualism and privatization, which are two of four fixtures that progressive health reform must confront. Wiley et al., *supra* note 1, at n.65.

to a private insurer.[49] Private companies play an even bigger role in Medicaid, the jointly administered federal-state program that covers people living in low-income households. About 70% of all Medicaid beneficiaries (including virtually all families and children who are enrolled in Medicaid) are covered by Medicaid Managed Care ("MMC") plans,[50] the vast majority of which are private plans operating pursuant to contracts with the state.[51] The 30% who remain in traditional Medicaid are mostly complex patients (including "dual eligibles" covered by both Medicare and Medicaid and people with disabilities).

What does single-payer coverage or a public option look like in a country where nearly a third of Medicare beneficiaries and more than two-thirds of Medicaid beneficiaries are enrolled in privatized health plans? The first state to implement a public option plan is following the trend of the last two decades by directing state agencies to contract with

[49] *An Overview of Medicare*, KAISER FAM. FOUND. (Feb. 13, 2019), https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/ (last visited Dec. 25, 2020) [https://perma.cc/K2SB-DQJZ] (indicating that 34% of Medicare beneficiaries were enrolled in MA plans in 2018). *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., ANNOUNCEMENT OF CALENDAR YEAR (CY) 2020 MEDICARE ADVANTAGE CAPITATION RATES AND MEDICARE ADVANTAGE AND PART D PAYMENT POLICIES AND FINAL CALL LETTER (Apr. 1, 2019), https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf [https://perma.cc/3JM6-628Y] (describing 2020 capitation rates for MA plans).

[50] *2017 Share of Medicaid Enrollees in Managed Care*, DATA.MEDICAID.GOV, https://data.medicaid.gov/Enrollment/2017-Share-of-Medicaid-Enrollees-in-Managed-Care/ikdz-jh6q (last updated June 12, 2020) [https://perma.cc/ZA72-DVQ2].

[51] The data reported by CMS includes all Medicaid beneficiaries enrolled in managed care plans, including in Vermont, California, and other states where at least some beneficiaries are covered by publicly administered MMCs. *Id.* Green Mountain Care, the sole Medicaid Managed Care organization in Vermont, is state administered, not privatized. The state agency contracts directly with health care providers to manage Medicaid beneficiaries' care. *See* MEDICAID, MANAGED CARE IN VERMONT (2014), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/vermont-mcp.pdf [https://perma.cc/VV2P-2RT6]; *see also* Kristin Peterson, *State Medicaid Agencies as Single Payers: An Innovative Approach to Medicaid Expansion Obligations Under the Patient Protection and Affordable Care Act*, 21 ANNALS HEALTH L. ADVANCE DIRECTIVE 35, 45 (2011). Similarly, in California, many Medicaid beneficiaries are enrolled in County Organized System plans operated by county governments, sometimes, but not always, in partnership with private companies. *See* ABBI COURSOLLE WITH RACHEL LANDAUER, NAT'L HEALTH LAW PROGRAM, COUNTY ORGANIZED HEALTH SYSTEM MEDI-CAL PLANS 1-2 (2014), https://healthconsumer.org/wp/wp-content/uploads/2016/10/County-Organized-Health-System-Medi-Cal-Plans.pdf [https://perma.cc/2W78-XVEH]; MEDICAID, MANAGED CARE IN CALIFORNIA (2014), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/california-mcp.pdf [https://perma.cc/2K5N-FABH]. Thus, the data on enrollment in MMC plans does not precisely reflect the percentage of Medicaid beneficiaries who are in privately administered MMC plans.

private health insurers rather than opening up traditional public benefits to buy-in enrollees. During the fall 2020 open enrollment period, Washington's health insurance exchange featured fifteen plans touted as public options, offered by five private carriers.[52] Privatized public option plans could have been offered in Colorado as soon as the fall 2021 open enrollment period, but implementing legislation was shelved in the midst of the pandemic.[53] These developments raise important questions: Is privatized public health insurance "public" enough to serve reformers' goals? Does it have enough advantages over highly regulated, privately financed insurance to be worth the trouble?

This Article argues that privatized public coverage can serve at least some of the goals adopted by progressive health reformers and, with proper public oversight and accountability, can be consistent with the communitarian ethos that animates progressive reforms. I argue that what makes public health insurance *public* is a commitment to mutual aid (to health care financing built on reciprocity of support)[54] and to public deliberation on the key questions involved in plan design. Who will be covered? Will they have a choice of plans? What will be covered? Who will decide? How will public investments be defined and financed? Who will bear the financial risk that enrollees will require more care than anticipated? Will there be out-of-pocket costs for enrollees? Will access to providers be limited by networks? Will reimbursement rates for health care providers be sustainable and equitable? The health

[52] CHRISTINE GILBERT, WASH. HEALTH BENEFIT EXCH., ENVIRONMENTAL SCAN: CASCADE CARE 6 (2020), https://www.wahbexchange.org/wp-content/uploads/2020/07/HBE_EB_200715_Cascade_Care_Presentation.pdf [https://perma.cc/MYL9-YNR9].

[53] Kerry Donovan, Dylan Roberts & Chris Kennedy, Opinion, *Guest Commentary: Colorado Health Care Option Dropped for This Year but Effort Continues*, DENVER POST (May 4, 2020, 6:40 AM), https://www.denverpost.com/2020/05/04/colorado-health-care-option-dropped-coronavirus-opinion/ [https://perma.cc/M97L-4AYJ] (commentary authored by legislators who sponsored the public option bill explaining that pandemic disruptions prompted them to set the legislation aside); *see* COLO. DIV. OF INS. DEP'T OF REGULATORY AGENCIES, FINAL REPORT FOR COLORADO'S PUBLIC OPTION 3-4 (2019), https://www.colorado.gov/pacific/sites/default/files/Final%20Report%20for%20Colorados%20Public%20Option.pdf [https://perma.cc/W69E-N2BL] ("In accordance with HB19-1004, we recommend that Colorado establish a public option that is structured as a public-private partnership and initially sold in the individual market, both on and off the exchange, starting in the 2022 plan year.").

[54] *See* Rosenblatt, *supra* note 40, at 191 (describing "[t]he sense of a great fork in the road between hyper-individualism and unrestrained competition, on the one hand, and some way of reconstituting solidarity and associated social policies, on the other"); Sparer, *supra* note 1, at 551; Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL'Y & L. 287, 290 (1993) (describing "mutual aid" and "actuarial fairness" as competing principles for health care financing).

justice model I have developed in a series of prior publications[55] and in conversation with other health law scholars[56] reveals the criteria that progressive reformers should use to assess reforms that rely on public-private partnerships rather than rejecting all privatization in health care.[57] The health justice model dictates that health reforms should be

[55] *See* Lindsay F. Wiley, *Applying the Health Justice Framework to Diabetes as a Community-Managed Social Phenomenon*, 16 HOUSTON J. HEALTH L. & POL'Y 191 (2016); Wiley, *Health Justice*, *supra* note 40; Wiley, *Social Justice*, *supra* note 40; Lindsay F. Wiley, *Tobacco Denormalization, Anti-Healthism, and Health Justice*, 18 MARQUETTE BENEFITS & SOCIAL WELFARE L. REV. 203 (2017).

[56] *See, e.g.*, ELIZABETH TOBIN TYLER & JOEL B. TEITELBAUM, ESSENTIALS OF HEALTH JUSTICE: A PRIMER 15 (2018) (noting that the authors "settled on *health justice* [for their title] because it tends to be relatively more recognized and understood by a greater number of people [than health equity]" and "[f]urthermore, 'justice' is often linked in people's minds to the legal system," and defining health justice in terms of "laws, policies, systems, and behaviors that are evenhanded with regard to and display genuine respect for *everyone's* health and well-being"); Emily Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. U. L. REV. 275 (2015) (describing health justice as an emerging framework for eliminating health inequity and social injustice); Emily A. Benfer, Seema Mohapatra, Lindsay F. Wiley & Ruqaiijah Yearby, *Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities During and After COVID-19*, 19 YALE J. HEALTH POL'Y, L. & ETHICS 122 (2020); Yael Cannon, *Injustice is an Underlying Condition*, 6 U. Pa. J.L. & Pub. Aff. 201 (2020) (applying the health justice model to food and housing insecurity as underlying causes of COVID-19 disparities); Yael Cannon, *The Kids Are Not Alright: Leveraging Existing Health Law to Attack the Opioid Crisis Upstream*, 71 FLA. L. REV. 765 (2019) (applying the health justice model to assess public commitments to meet the needs of people with adverse childhood experiences across the life-course); Angela Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. Rev. 758, 758 (2020) (arguing that a civil rights of health initiative built on a health justice framework can help educate policymakers and the public about the health effects of subordination, create new legal tools for challenging subordination, and ultimately reduce or eliminate unjust health disparities"); Matt Lawrence, *Against the Safety Net*, 72 FLA. L. REV. 49 (2020) (applying the health justice framework to critique the safety net metaphor for public benefits); Medha D. Makhlouf, *Health Justice for Immigrants*, 4 U. PA. J. L. & PUB. AFF. 235 (2019) (applying the health justice model to assess public commitments to health care access for immigrants); Wiley et al., *supra* note 1 (adopting health justice as a model for health reform reconstruction in the aftermath of 2020).

[57] Although I do not aim to offer a grand theory of privatization in this Article, I draw on the contributions of those who have. I apply health-justice criteria to design of privatized public coverage with David Super's exhortation in mind: "A useful theory of privatization must provide a basis for defeating destructive proposals without cutting programs off from genuine gains from dealing with the private market." Super, *supra* note 35, at 398. My assessment of privatized public health coverage is grounded in a normative model for health law and policy (health justice), that shares much in common with the public-values priors on which many privatization critics rely. *See* Wiley, *Health Justice*, *supra* note 40, at 873 (advocating for the health justice model as "a new approach that expressly recognizes the public — alongside the patient, the

assessed based on the extent to which they foster collective deliberation and problem-solving and ensure just distribution of the health benefits and the financial burdens of public investments in health care.[58] In my prior work, I have set forth the normative and descriptive arguments justifying these criteria and distinguishing them from the criteria that hold sway under alternative models, including patient rights, market power, and professional autonomy. Here, I demonstrate the explanatory and persuasive power of my health justice model by applying it to a concrete controversy.

In Part I, I begin by describing the current role of government in subsidizing and regulating private health insurance, providing public health insurance, and contracting for privatized public health insurance. In Part II, I compare each type of coverage according to the normative criteria indicated by the health justice model. I evaluate them in terms of how legislatures and executive-branch officials at the federal and state level secure the public's interest in universal health care coverage, fair distribution of the health benefits and financial burdens of public investments in health care, and lower health care costs. I also propose strategies for addressing each of these areas of concern in contracts that open up access to privatized public health insurance for all or more Americans. In the Conclusion, I focus particularly on what I view as the most underappreciated criteria for realizing health justice: the extent to which plan-design processes and public-accountability mechanisms further collective problem-solving in response to collective problems. I conclude that much — but not all — of what could be

provider, and the payer — as an important stakeholder and active participant in decisions about treatment, coverage, and allocation of scarce resources.").

[58] Bloche, *supra* note 40, at 300 (stating that the aims of health law "should emerge, in a democracy, from our hopes and expectations for the health care system, both as individuals and as public-regarding citizens"); Nan D. Hunter, *Health Insurance Reform and Intimations of Citizenship*, 159 U. PA. L. REV. 1955, 1995-97 (2011) (suggesting that the process of implementation and the "citizenship practices" that are entailed in signing up for insurance and pooling risks has the potential "to instantiate a new reciprocal covenant of mutual security, and . . . to enhance participatory self-governance"); Bruce Jennings, *Relational Liberty Revisited: Membership, Solidarity and a Public Health Ethics of Place*, 8 PUB. HEALTH ETHICS 7, 7 (2015) ("[B]oth the practical success of public health policies and programs and their capacity to gain normative legitimacy and trust rely on the presence of a cultural sense of obligation and mutual aid in a world of common vulnerability."); Wiley, *Health Justice*, *supra* note 40, at 833 (arguing for "a new model that expressly recognizes the public — alongside the patient, the provider, and the payer — as an important stakeholder and active participant in decisions about medical treatment, health care coverage, and allocation of scarce resources"); Wiley, *Social Justice*, *supra* note 40 (arguing that the health justice model should "root ongoing efforts to ensure access to health care and healthy living conditions more firmly in community engagement and participatory parity").

achieved through universal access to traditional public health insurance could also be achieved through careful government contracting with privatized public health insurance plan sponsors.

The descriptive contributions I offer in this Article further my normative argument. By laying out the questions legislatures and executive officials must answer in terms that are accessible to public-minded participants in civil society debates, I demonstrate how health reform proposals should be vetted through discourse that makes trade-offs explicit and fosters collective problem-solving. If progressive reformers are attentive to these underlying goals of health justice, expanding access to privatized public health insurance may be an important path for increasing social solidarity in American health care.[59]

I. GOVERNMENT'S ROLE IN SECURING HEALTH CARE COVERAGE

In the late nineteenth and early twentieth centuries, when mounting health care costs became too much for all but the wealthiest households to bear, most industrialized countries responded by creating public health care financing and administration schemes. Three main approaches developed. First, the system exemplified by the National Health Service in England: taxing and spending to support a publicly administered national health care delivery system.[60] Second, the system exemplified by Canadian Medicare: publicly financed and administered *single-payer* coverage for goods and services delivered by private health care providers. Finally, the German approach: mandatory participation in a multi-payer system of public and private nonprofit insurers centrally coordinated via a government administered system of cross-subsidization (to spread financial risk across multiple funds) and *single pipe* claims processing (to ensure uniform reimbursements for private health care providers).[61]

In the United States, however, the private market has prevailed, supplemented by direct and indirect public subsidies and heavily regulated to secure the public's interest. The US population is covered by a patchwork of privately financed, highly regulated health insurance

[59] Wiley et al., *supra* note 1 (manuscript at 3).

[60] Timothy Stoltzfus Jost, *Why Can't We Do What They Do? National Health Reform Abroad*, 32 J.L. MED. & ETHICS 433, 434 (2004).

[61] *Id.*; WILLIAM C. HSIAO, STEVEN KAPPEL & JONATHAN GRUBER, ACT 128 HEALTH SYSTEM REFORM DESIGN: ACHIEVING AFFORDABLE UNIVERSAL HEALTH CARE IN VERMONT 35 (2011) (comparing single-payer systems to multi-payer systems that adopt a single pipe); *see also* STARR, *supra* note 19, at 236-38 (1982) (describing the adoption of compulsory insurance in European countries).

(with or without an employer's contribution and with varying degrees of direct and indirect public subsidies), traditional public insurance, and privatized public health insurance. Narrow eligibility criteria for public programs leave many lower-income families churning through subsidized private coverage, various forms of state and federal public coverage, and periods without coverage on a month-to-month basis.[62] Disruption, uncertainty, and financial insecurity are typical side effects of our fragmented, not-quite-universal health care system. Market-based rationing and hidden subsidies obscure government's primary responsibility for securing universal health care coverage and hamper collective problem-solving regarding the fair distribution of benefits and burdens.[63]

A. Private Health Insurance: Privately Financed, Publicly Subsidized, and Highly Regulated

In the early-to-mid-twentieth century, health care providers organized themselves into privately financed and administered prepaid Blue Cross (hospitals) and Blue Shield (physicians) plans purchased directly by individuals and families.[64] Employers also began to offer health coverage to workers via prepaid provider plans as well as newly formed insurance companies.[65] These private health benefits were indirectly subsidized for most enrollees as a result of tax laws that exempted health care benefits from payroll and income taxes.[66]

In addition, the Employee Retirement Income Security Act of 1974 ("ERISA"),[67] though intended primarily to secure employee pensions, had the effect of encouraging large private employers to offer health benefits by shielding them from some forms of state regulation.[68] Some

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[62] *See* FAMILIES USA, THE RETURN OF CHURN: STATE PAPERWORK BARRIERS CAUSED MORE THAN 1.5 MILLION LOW-INCOME PEOPLE TO LOSE THEIR MEDICAID COVERAGE IN 2018, at 1 (2019), https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf [https://perma.cc/2XGF-N47F] (describing the decreased enrollment in Medicaid and the Children's Health Insurance Program due to churn).

[63] *See* MINOW, *supra* note 2, at 126 ("Privatization and market-based pressures, combined with religiously based restrictions on the kinds of care provided charitably, can seriously impair access to preventive care, treatment, and palliative care and yet do so subtly, invisible to public scrutiny.").

[64] *See generally* STARR, *supra* note 19, at 240-42 (describing the failure of social insurance and rise of private commercial insurance in the U.S.).

[65] *See id.* at 310-15.

[66] *See* Gruber, *supra* note 3, at 511.

[67] Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829.

[68] *See* N.Y. Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657 (1995) ("The basic thrust of [ERISA's] pre-emption clause . . . was to

very large employers establish their own health plans (typically managed by private companies who act as third-party administrators) whereby the employer itself bears the financial risk. This approach, called *self-funding*, shelters plans from state regulation due to preemption by ERISA.[69] Most employees are covered by self-funded plans, which tend to be offered by larger employers.[70] Most employers, however, *fully insure*, meaning that an outside insurance company bears the financial risk in exchange for a *premium* paid jointly by the employer and the employee. States actively regulate fully insured plans, which are expressly exempted from much of the protection of ERISA preemption.

Individuals and families who lack access to employment-based coverage may purchase private insurance on the individual (also known as non-group) market. Historically, this was difficult and costly because individuals lacked the negotiating power and shared risk-pools available to large groups of employees.[71] Market failures, inadequate consumer information, and overrepresentation of less-healthy prospective insureds in the individual market drove up the cost and limited the quality of individual plans.[72] Additionally, people with higher expected health care costs due to pre-existing conditions, family history, or other factors (such as being a woman) could be charged premiums that were prohibitively expensive, offered terms of coverage that left them with significant financial exposure, or denied coverage altogether.[73]

avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.").

[69] FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990) ("We read the deemer clause to exempt self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the saving clause."); Wurtz v. Rawlings Co., 933 F. Supp. 2d 480, 507 (E.D.N.Y. 2013) (finding that the company's health insurance program was an employee benefit plan and thus plaintiff's claims were preempted under ERISA).

[70] *2019 Employer Health Benefits Survey*, KFF (Sept. 25, 2019), https://www.kff.org/report-section/ehbs-2019-section-10-plan-funding/ [https://perma.cc/NNZ8-VZNQ].

[71] *See* Wendy K. Mariner, *Health Insurance Is Dead; Long Live Health Insurance*, 40 AM. J.L. & MED. 195, 195-96 (2014).

[72] *See* Jon R. Gabel, Ryan Lore, Roland D. McDevitt, Jeremy D. Pickreign, Heidi Whitmore, Michael Slover & Ethan Levy-Forsythe, *More Than Half of Individual Health Plans Offer Coverage that Falls Short of What Can Be Sold Through Exchanges as of 2014*, 31 HEALTH AFF. 1339, 1345 (2012).

[73] Gary Claxton, Karen Pollitz & Larry Levitt, *What Do They Mean When They Talk About Pre-Existing Health Conditions?*, KAISER FAM. FOUND. (Oct. 19, 2012), http://kff.org/health-reform/perspective/what-do-they-mean-when-they-talk-about-pre-existing-health-conditions/ [https://perma.cc/SLU6-P7W2].

As health care prices continued to rise in the 1980s and 1990s, private insurers began to exert more control over the rates at which they reimbursed health care providers and the utilization of benefits by insureds.[74] The resulting practices — referred to collectively as *managed care* — blend the traditional functions of an insurance company with functions that were traditionally limited to health care providers.[75] They have become so prevalent that the term *managed care organization* is now essentially synonymous with private health insurance company. Insurers began to conduct *utilization management*, relying on in-house staff with medical and nursing knowledge to determine whether the goods and services a patient and her doctor were requesting were, in fact, medically necessary and non-experimental.[76] This control is typically exerted prior to the delivery of benefits, in a practice known as *pre-utilization authorization*. Insurers also began to restrict insureds to *limited networks* of health care providers who had entered into contracts with the insurance company, limiting or denying coverage for out-of-network services.[77] Many managed care organizations also use *shared risk arrangements*, a type of payment incentive included in the insurance company's contract with in-network providers, to shift some of the financial risk associated with patients needing more care than anticipated onto hospitals, doctors, and other providers who make decisions about utilization of covered benefits.[78] Through these payment incentives, managed care organizations effectively prompt providers to think twice about the goods and services they recommend to patients, enlisting them to incorporate utilization management

[74] *See* Sorresso, *supra* note 5, at 35 ("Throughout the 1980s and 1990s, rising health care costs prompted commercial insurers to offer managed care options alongside traditional fee-for-service plans, and gradually managed care plans became the dominant available form of commercial insurance."); *see also* ENTHOVEN, *supra* note 45, at 81; Enthoven, *supra* note 45, at 25-26; Havighurst, *supra* note 45, at 475-82.

[75] *See* Jacob S. Hacker & Theodore R. Marmor, *How Not to Think About "Managed Care*," 32 U. MICH. J.L. REFORM 661, 669 (1999) ("Perhaps the most defensible interpretation of 'managed care' is that it represents a fusion of two functions that once were regarded as largely separate: the financing of medical care and the delivery of medical services."); *id.* at 675-76 ("[Managed care health plans should be understood in terms of] three . . . essential features [that characterize the trilateral relationship among the patient, the medical provider, and third-party payers]: first, the degree of risk-sharing between providers and the primary bearer of risk (whether an insurer or a self-insured employer); second, the degree to which administrative oversight constrains clinical decisions; and third, the degree to which enrollees in a plan are required to receive their care from a specified roster of providers.").

[76] *See id.* at 674.

[77] *See id.*

[78] *See id.* at 671.

directly into their medical judgments. Managed care organizations also used *cost-sharing* (which had also been included in traditional insurance contracts) to discourage patients from utilizing their covered benefits by requiring them to pay for goods and services until they reach a specific threshold at which coverage kicks in (deductible), a set fee for a good or service (copayment), or a defined percentage of the cost (coinsurance).[79]

Many policymakers and commentators initially supported empowering insurance companies to lower health care costs through these practices, including under the federal Health Maintenance Organization ("HMO") Act of 1973.[80] By the mid-1990s, however, federal and state lawmakers became more critical of HMOs and other forms of managed care. State legislatures enacted regulations mandating coverage of specific benefits, adopting procedural protections for insureds whose claims are denied via utilization management, policing the adequacy of provider networks, and shielding health care providers from financial risks so excessive that they threatened the quality of care.[81] These state regulations applied to fully-insured employer coverage as well as private insurance purchased directly by consumers, but not to self-insured employer coverage, due to ERISA preemption.

The next major wave of health reform was at the federal level and aimed to secure more equitable access to affordable health coverage. Enacted in 2010, the ACA doubled down on private insurance as the default while seeking to curb its shortcomings. The ACA's framers recognized that private health insurance was unaffordable for many Americans.[82] But rather than extending Medicaid eligibility much higher than the poverty line, the ACA established new *premium assistance tax credits* to subsidize the purchase of private coverage on state-level health insurance exchanges for people earning up to 400% of the federal poverty level who lack access to public coverage or

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[79] *See generally* CHRISTOPHER T. ROBERTSON, EXPOSED: WHY OUR HEALTH INSURANCE IS INCOMPLETE AND WHAT CAN BE DONE ABOUT IT (2019) (discussing cost-sharing in managed care organizations).

[80] Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914. *See generally* LAWRENCE D. BROWN, POLITICS AND HEALTH CARE ORGANIZATION: HMOS AS FEDERAL POLICY (1983) (discussing the history of cost-shared legislation).

[81] *See* David Mechanic, *The Managed Care Backlash: Perceptions and Rhetoric in Health Care Policy and the Potential for Health Care Reform*, 79 MILBANK Q. 35, 37-38 (2001); Robert F. Rich & Christopher T. Erb, *The Two Faces of Managed Care Regulation & Policymaking*, 16 STAN. L. & POL'Y REV. 233, 234-35 (2005).

[82] *See* Timothy Stoltzfus Jost & John E. McDonough, *The Path to the Affordable Care Act*, *in* THE TRILLION DOLLAR REVOLUTION: HOW THE AFFORDABLE CARE ACT TRANSFORMED POLITICS, LAW, AND HEALTH CARE IN AMERICA, *supra* note 30, at 27, 28-29.

affordable employer-based private insurance.[83] In addition, the ACA's employer mandate[84] and restriction of premium assistance tax credits to households that lack access to affordable employer-based coverage[85] further strengthened the link between health insurance and employment.

Building on the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"),[86] the ACA also transformed private health insurance into one of the most heavily regulated industries in the country. The most well-known provisions of the ACA aim to ensure equitable access to coverage and a choice of plans. HIPAA had already prohibited many forms of risk-based underwriting in the employer-based group insurance market. The ACA extended these regulations into the individual, direct-purchase market. *Guaranteed availability and renewability* requirements effectively ban insurers from denying coverage to individuals based on health-status related factors.[87] *Community rating* requirements prohibit insurers from charging higher rates based on perceived risk (though they are permitted to charge more based on household size, geographic area, age (up to three times higher), and tobacco use (up to 50% higher).[88]

Less well known provisions of the ACA federalized managed care regulations that had previously been adopted in some form by most states, but were preempted by ERISA for self-insured plans.[89] Even among individuals and families with employment-based insurance, under-insurance (insufficient coverage and burdensome cost-sharing)

[83] 26 U.S.C. § 36B (2018). Subsidies are styled as tax credits, but they are transferred from the federal government to private health plans via the Exchanges, without passing through insured individuals, and they are not refundable.

[84] *Id.* § 4980H (2018).

[85] *Id.* § 36B(c).

[86] Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

[87] 42 U.S.C. § 300gg-1 (2018) (requiring guaranteed availability); *id.* § 300gg-2 (2018) (requiring guaranteed renewability); *id.* § 300gg-4 (2018) (prohibiting discrimination based on health status).

[88] *Id.* § 300gg (2018).

[89] The ACA also federalized health insurance regulation that had not previously been preempted by ERISA. *See* Sara Rosenbaum, *Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System*, 7 J. HEALTH & BIOMEDICAL L. 1, 28 (2011) ("The Affordable Care Act changes . . . federal-state dynamics to a considerable degree. In the private health insurance market, the federal presence is much more heavily felt. Although states maintain their primary regulatory function and can maintain both Exchange and non-Exchange markets, the Act fundamentally alters the federal-state relationship by creating a federal framework for the regulation of health insurance.").

presented a significant barrier to access. Many employer-based plans offered limited coverage and additional employers had begun cutting back on coverage in response to decades of rising health care costs.[90] To address these inadequacies while reinforcing the primacy of the private, employment-based system, the ACA applied a range of patient protection provisions to employer-based plans.[91] These regulations attempted to reign in some of the worst abuses of private insurers. The ACA mandated that most types of private health plans cover a comprehensive package of essential health benefits and imposed internal and external grievance requirements for coverage denials. To limit out-of-pocket costs, the ACA banned annual and lifetime caps on benefits, imposed an annual limit on cost-sharing expenditures that goes down with household income, and created a system of metal tiers to designate plans according to the financial protection they typically provide.[92] But the ACA did very little to lower the reimbursement rates paid by private insurance plans to hospitals and other service providers — rates about twice as high as the prices Medicare pays.[93]

[90] *See* GARY CLAXTON, MATTHEW RAE, NIRMITA PANCHAL, ANTHONY DAMICO, JANET LUNDY, NATHAN BOSTICK, KEVIN KENWARD & HEIDI WHITMORE, KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TR., EMPLOYER HEALTH BENEFITS: 2012 ANNUAL SURVEY 1 (2012), https://www.kff.org/wp-content/uploads/2013/04/8345.pdf [https://perma.cc/YCC6-WBKH].

[91] *See* Sara Rosenbaum, *Can This Marriage Be Saved? Federalism and the Future of U.S. Health Policy Under the Affordable Care Act*, 15 MINN. J.L. SCI. & TECH. 167, 168 (2014).

[92] 42 U.S.C. § 300gg-11 (2018) (prohibiting lifetime and annual limits on benefits); *id.* § 18022(c)(1) (2018) (establishing out-of-pocket limit); *id.* § 18022(d) (specifying minimum actuarial values for bronze, silver, gold, and platinum tiers); *id.* § 18071 (2018) (requiring reduced cost-sharing for individuals earning between 100% and 400% of the federal poverty level).

[93] Carrie H. Colla & Jonathan Skinner, *Has the ACA Made Health Care More Affordable? in* Emanuel & Gluck, *supra* note 22, at 250-263; Eric Lopez, Tricia Neuman Follow, Gretchen Jacobson & Larry Levitt, *How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature*, KFF (April 15, 2020), https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/ [https://perma.cc/C2T3-PWKF] ("Private insurers paid nearly double Medicare rates for all hospital services (199% of Medicare rates, on average), ranging from 141% to 259% of Medicare rates across the reviewed studies."). The American Hospital Association argues that Medicare rates are an inappropriate benchmark for sustainability. *See* American Hospital Association, Underpayment by Medicare and Medicaid Fact Sheet — January 2019 (January 2019), https://www.aha.org/factsheet/2019-01-02-underpayment-medicare-and-medicaid-fact-sheet-january-2019 [https://perma.cc/49HK-ZAJ3]. But empirical studies suggest that it is possible to provide high-quality care at Medicare rates and that the market power of hospitals is the primary determinant of whether they respond to shortfalls between Medicare rates and actual costs by increasing efficiency or raising the prices they charge

B. Traditional Public Health Insurance: Publicly Financed and (Mostly) Publicly Administered

Historically, three main groups were left out of the market-driven private insurance system in the US — retirees, people with disabilities, and people living in low-income households.[94] In 1965, the federal government created Medicare and Medicaid to fill these gaps.[95] Unlike the New Deal programs launched in the 1940s, whose history is "interwoven with the story of the administrative state,"[96] Medicare and Medicaid were created during a time when calls to privatize administration of public programs were beginning to take hold. Rather than creating a public health care delivery system, as England had in the post-WWII era, Medicare and Medicaid's architects designed them to function somewhat like "open-ended voucher programs" with "beneficiaries . . . generally able to choose which doctors and hospitals to use and . . . few overall limits . . . on spending" and "government set[ting] the basic terms of the subsidized insurance contract and regulat[ing] rates."[97]

In many ways, traditional Medicare resembles private health insurance from the 1960s. Benefits are outlined in broad strokes in a federal statute. Medicare covers only those items and services that are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member," subject to additional statutory authorizations.[98] The rigidity and stagnation of the legislative process means that expansions of benefits are few and far between. Coverage for preventive services — which do not diagnose or treat illness or injury — came to Medicare long after

to private insurers. *See, e.g.*, James Robinson, *Hospitals Respond to Medicare Payment Shortfalls by Both Shifting Costs and Cutting Them, Based on Market Concentration*, 30 HEALTH AFF. 1265 (2011).

[94] *Cf.* Hacker, *supra* note 30, at 335 ("By the time advocates of government insurance finally had another bite at the apple [following FDR's decision to omit health insurance from the Social Security Act] in 1964, they had strategically retreated to the goal of covering those left out of the employment-based system: the elderly and the poor.").

[95] *See* Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286. Medicare eligibility was extended to people with qualifying disabilities in 1972. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329.

[96] Diller, *supra* note 34, at 1740.

[97] Susan Rose-Ackerman, *Social Services and the Market*, 83 COLUM. L. REV. 1405, 1410 (1983).

[98] 42 U.S.C. § 1395y(a)(1)(A) (2018).

private insurance companies deemed it cost effective.[99] Prescription drug benefits were not added until 2003.[100] The managed care practices that came to dominate the private insurance market in the 1980s and 1990s have made only modest inroads in traditional Medicare. Value-based payment methods promoted by the ACA mimics some of the private-insurance provider reimbursement incentives that shift financial risk onto the institutions and professionals who steward health care resources. But networks are nearly unlimited — few hospitals or doctors can afford to forego participation in Medicare — and pre-utilization review of claims is virtually unheard of.

In addition to maintaining the largely private health care delivery system, from its inception in 1965, Medicare has relied on private companies, known as Medicare administrative contractors ("MACs") in their current incarnation.[101] Some benefit rules are determined at the national level by the Centers for Medicare and Medicaid Services ("CMS"), but most are handled regionally by private MACs. MACs bid on contracts to issue coverage determinations governing which goods and services are covered for which patients and to process claims for reimbursement — conducting post-utilization review — for all traditional Medicare beneficiaries within a specified geographic jurisdiction.[102] Beneficiaries and health care providers seeking to challenge coverage denials must exhaust a series of administrative appeals before they can file a claim in court.

Medicaid provides publicly financed coverage for people living in low-income households who meet additional eligibility requirements. Together with the Children's Health Insurance Program[103] (which provides additional federal funding to states with fewer strings

[99] Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, 122 Stat. 2494 (authorizing the HHS Secretary to expand Medicare coverage to additional preventive services rated as grade A or B by the United States Preventive Services Task Force).

[100] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066.

[101] *See* 42 U.S.C. § 1395h (2018) (defining the MACs' role in administering Part A); *id.* § 1395u (2018) (Part B); *id.* § 1395kk-1 (2018) (provisions regarding MAC contracts).

[102] Centers for Medicare and Medicaid Services, a federal government agency, issues national coverage determinations ("NCDs"), which take precedence over the local coverage determinations ("LCDs") and individual reimbursement decisions made by MACs. But the day-to-day tasks of administering benefits are largely in the hands of MACs who bid for jurisdictional contracts. *See* FURROW ET AL., *supra* note 4, at 638.

[103] Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, 129 Stat. 87; *see* Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (section 4901 establishes the State Children's Health Insurance Program).

attached), Medicaid currently covers over seventy-five million Americans, most of whom are children.[104] Unlike Medicare, which is fully federally financed and administered, Medicaid is jointly financed and administered by the states and the federal government.[105] State lawmakers and administrators make important choices about who is eligible, which goods and services are covered, and how providers are paid. States may pursue their health reform goals by taking advantage of statutory flexibility and administrative waivers.

Eligibility for Medicaid and the quality of Medicaid benefits are determined by a mix of categories that states must cover as a condition of participation in the program (mandatory categories) and additional categories that a state may cover with matching federal funds if it wishes to do so (optional categories). For example, states must cover pregnant women living in households with incomes at or below 133% of the federal poverty level ("FPL").[106] They have the option, however, to cover pregnant women up to 185% of FPL (or higher in some states, with supplementation from the Children's Health Insurance Program) with the help of matching federal funds.[107] States wishing to cover people or benefits outside of these statutory categories must do so

[104] *July 2020 Medicaid & CHIP Enrollment Data Highlights*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (last visited Dec. 27, 2020) [https://perma.cc/TX82-6VSA].

[105] For 2020, the federal share of Medicaid costs is about 50% overall, varying from about 72% in Kentucky to 50% in Virginia. Each state's FMAP is determined by the state's average income. It applies to most Medicaid spending. Certain benefits (e.g., family planning) and beneficiaries (e.g., Native Americans and ACA newly eligibles) are covered by higher match rates. *See Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, KAISER FAM. FOUND., https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/ (last visited Dec. 27, 2020) [https://perma.cc/JHK9-MGMX]. COVID relief legislation increased the FMAP by 6.2 percentage points. Rudoziwtz et. al., *supra* note 18.

[106] Social Security Act, 42 U.S.C. §§ 1396a(a)(10)(A)(i)(III)-(IV) (2018) (Westlaw through Pub. L. No. 115-196); *id.* § 1396a(l)(1)(A); *id.* § 1396d(n) (2018); *see also* 42 C.F.R. § 435.116 (2020). Some states have higher mandatory eligibility levels for infants and pregnant women, ranging from 150% to 185% FPL, due to the fact that they had already expanded to these levels when legislation (Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106) was enacted in 1989 to mandate coverage of pregnant women up to at least 133% FPL. States are required to maintain these higher preexisting thresholds.

[107] *See* 42 U.S.C. § 1396a(a)(10)(A)(ii)(I), (IV), (IX); *id.* § 1396a(l)(2); 42 C.F.R. § 435.116.

without federal assistance unless they receive a waiver from the Secretary of Health and Human Services ("HHS").[108]

Medicaid's status as a conditional federal spending program administered by the states has important implications for the rights of beneficiaries and the providers who serve them. Federal judges occasionally note that Medicaid and other spending programs function somewhat like a contractual agreement between the federal government (as funder) and the state (as co-funder and administrator).[109] The administrative penalty for noncompliance with federal conditions is revocation of the funds by federal officials — a blunt instrument rarely threatened and never deployed.[110]

Historically, private advocates seeking to enforce federal Medicaid guidelines on behalf of beneficiaries and health care providers have played an important role in securing the public interests Medicaid was designed to serve. But a series of federal court decisions have narrowed the path for private enforcement. For example, federal Medicaid law mandates that states must establish reimbursement rates for doctors and other health care providers that are adequate to ensure that Medicaid beneficiaries' access to health care is comparable to that of the general population. With regard to covered benefits, federal regulations also

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[108] Section 1115 of the Social Security Act gives the HHS Secretary authority to waive portions of the Medicaid statute on a case-by-case as part of an experimental, pilot or demonstration project. By statute, the Secretary must determine that the state's proposal "is likely to assist in promoting the objectives of [the Medicaid Act]." 42 U.S.C. § 1315 (2018). Pursuant to longstanding HHS policy, the state's plan should also be budget neutral, meaning that it should not increase federal costs above the level anticipated in the absence of a waiver. Laura D. Hermer, *On the Expansion of "Welfare" and "Health" Under Medicaid*, 9 ST. LOUIS U. J. HEALTH L. & POL'Y 235, 237 & n.11 (2016).

[109] *See, e.g.*, Armstrong v. Exceptional Child Ctr., 575 U.S. 320, 332 (2015) (characterizing Medicaid as "much in the nature of a contract" and reasoning that health care providers are not intended beneficiaries entitled to a private right of action to enforce federal Medicaid law (quoting Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 17 (1981))); Blessing v. Freestone, 520 U.S. 329, 349-50 (1997) (Scalia, J., concurring) (analogizing a spending program to a contract and characterizing beneficiaries of spending programs as third-party beneficiaries); Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 17 (1981) (stating that "legislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions"). *But see* Westside Mothers v. Haveman, 289 F.3d 852, 858 (6th Cir. 2002) (rejecting the district court's description of the Medicaid program as a contract between the state and the federal government).

[110] *See* FURROW ET AL., *supra* note 4, at 714 ("If a state Medicaid program ceases to be in substantial compliance with federal requirements, CMS may, after a hearing, terminate federal funding to the state. Because this remedy is so drastic, CMS has rarely convened a hearing and has never terminated a state program.").

specify that "[e]ach service must be sufficient in amount, duration, and scope to reasonably achieve its purpose."[111] States frequently disregard these requirements, but when patients and health care providers have sought to enforce these and other federal rules against states, the courts have been increasingly hostile to their claims.

Initially, advocates found that Section 1983 provided an avenue for litigation with attorneys' fees available. Over time, however, the Supreme Court has tightened the standards for when a private individual may bring a 1983 claim to enforce spending regulations.[112] In recent years, the judiciary has refused to permit private enforcement of a variety of Medicaid provisions, finding that Congress was insufficiently clear in conferring a federal right upon private parties.[113] Advocates have turned to the Supremacy Clause (which does not provide for attorneys' fees) as a basis for litigation, but that avenue may also be narrowing.[114]

C. Privatized Public Health Insurance: Publicly Financed, Privately Administered, and Highly Regulated

Private health insurance companies like UnitedHealth, Humana, and Blue Cross Blue Shield play an important role in public programs.[115] After more than two decades of smaller-scale experimentation with privatized managed care as an alternative to traditional Medicare

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111 42 C.F.R. § 440.230(b) (2020).

112 *See, e.g.*, Gonzaga Univ. v. Doe, 536 U.S. 273, 289 (2002) ("In sum, if Congress wishes to create new rights enforceable under § 1983, it must do so in clear and unambiguous terms — no less and no more than what is required for Congress to create new rights enforceable under an implied private right of action.").

113 *See* FURROW ET AL., *supra* note 4, at 721 ("[The Supreme Court's ruling in *Gonzaga*] led courts to examine the Medicaid statute section by section to determine enforceability. Thirty-seven federal appellate court cases decided [in the decade following *Gonzaga*] held thirteen provisions of the Medicaid statute enforceable under § 1983 and seven provisions unenforceable.").

114 *See, e.g.*, *Armstrong*, 575 U.S. at 320 (finding that the Supremacy Clause does not contain an implied private right of action).

115 *See, e.g.*, GRETCHEN JACOBSON, MEREDITH FREED, ANTHONY DAMICO & TRICIA NEUMAN, KAISER FAMILY FOUND., A DOZEN FACTS ABOUT MEDICARE ADVANTAGE IN 2019, at 4 fig.4 (2019), https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/ [https://perma.cc/Y2P7-EX9X]; *Medicaid MCO Enrollment by Plan and Parent Firm, September 2020*, KAISER FAM. FOUND., https://www.kff.org/medicaid/state-indicator/medicaid-mco-enrollment-by-plan-and-parent-firm-september-2020/?currentTimeframe=0&sortModel=%7B%22colId%22:%22State%22,%22sort%22:%22asc%22%7D (last visited Dec. 23, 2020) [https://perma.cc/NTY3-6V9X].

coverage,[116] the Balanced Budget Act ("BBA") of 1997 solidified the option for Medicare beneficiaries to enroll in one of many government-contracted, fully privatized health plans, originally called Medicare+Choice plans.[117] In the bill's preamble, Congress expressed its hope that enrollment in privatized Medicare plans would "eventually eclipse original fee-for-service Medicare as the predominant form of enrollment under the Medicare program."[118] Lawmakers specifically noted that private administration of public coverage, would "enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options."[119] When Congress expanded Medicare benefits to include prescription drugs in the Medicare Modernization Act of 2003, lawmakers dictated that these benefits could *only* be provided through fully privatized plans.[120] The MMA also overhauled Medicare+Choice. Traditional Medicare (Parts A and B)[121] now operates alongside a fully privatized drug benefit program (Part D)[122] and a private alternative to Parts A, B, and D now known as

[116] *See* Jennifer Jordan, *Is Medicare Advantage Entitled to Bring a Private Cause of Action Under the Medicare Secondary Payer Act?*, 41 WM. MITCHELL L. REV. 1408, 1412 (2015) ("Congress first introduced the Medicare HMO risk-sharing concept in 1972. The Secretary had been authorized to contract with federally qualified HMOs to provide Medicare services on the government's behalf for over four decades. However, initial participation was low because the 'risk sharing' was skewed in the government's favor. To increase participation, Congress in 1982 established capitated payments to balance the risk sharing. Congress also created competitive medical plans (CMPs) to allow HMOs that were not federally qualified to participate. By 1985, the program finally took off as a result of these earlier interventions but was ultimately replaced by Medicare+Choice in 1997.").

[117] Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 275-327; Ann Connelly, Kathleen Healy, Hale Melnick & James Roosevelt, Jr., *A New Look at Medicare Advantage: What Lawyers Need to Know to Advise or Contract with Medicare Advantage Plans Now*, 12 J. HEALTH & LIFE SCI. L. 1, 6 (2018).

[118] Connelly et al., *supra* note 117, at 6 (quoting H.R. REP. NO. 105-217, at 638 (1997)).

[119] Caroline Schiff & Michael P. Abate, *Medicare Advantage: Fading Misconceptions and Remaining Uncertainty*, 29 NO. 2 HEALTH LAW. 21, 22 (2016) (quoting H.R. REP. NO. 105-217, at 585 (1997) (Conf. Rep.)).

[120] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 101, 117 Stat. 2066, 2071-152.

[121] Part A (hospital insurance) and Part B (medical insurance) of the Medicare statute create and regulate traditional fee-for-service, government-administered Medicare. 42 U.S.C. §§ 1395c to 1395i–5, 1395j to 1395w–5 (2018).

[122] *Id.* §§ 1395w–101 to –154 (2018).

Medicare Advantage (Part C).[123] Currently, about one-third of Medicare beneficiaries are enrolled in private MA plans.[124]

MA plan sponsors enter into contracts with the Secretary of Health and Human Services in which they agree to provide enrollees with benefits covered by traditional Medicare Parts A and B and to comport with various Medicare regulations.[125] They must submit an annual explanation of coverage to be approved by CMS and shared with enrollees, which explains the terms and conditions of their coverage[126] — similar to the insurance policy enrollees receive on the private market.[127] This document resembles a typical insurance policy sold on the commercial market, but it is not. There is no insurance contract between the MA plan sponsor and the enrollees it serves.[128] The remedies typically available to people enrolled in private insurance — including contract claims arising out of coverage denials — are preempted by the administrative grievance process established for traditional Medicare beneficiaries. The design of MA plans is considerably more flexible than traditional Medicare benefits.[129] For example, to cover a new treatment under traditional Medicare may require a formal administrative process.[130] MA plans are permitted to

[123] *Id.* §§ 1395w–21 to –29 (2018). The Balanced Budget Act of 1997 originally referred to privatized Medicare as Medicare+Choice; the program was renamed Medicare Advantage in the Medicare Prescription Drug, Improvement, and Modernization Act.

[124] *See supra* note 49 and accompanying text.

[125] *See* 42 C.F.R. § 422.504 (2020); CTR. FOR MEDICARE & MEDICAID SERVS., PART C -MEDICARE ADVANTAGE AND 1876 COST PLAN EXPANSION APPLICATION 5 (2021), https://www.cms.gov/files/document/cy-2021-medicare-part-c-application.pdf [https://perma.cc/7XTW-C547].

[126] *See* 42 C.F.R. § 422.111 (2020).

[127] *See* Jordan, *supra* note 116, at 1414 n.25.

[128] Schiff & Abate, *supra* note 119, at 22 ("Because they have no 'insurance contracts' with their enrollees, [MA plan sponsors] 'do not pay benefits pursuant to a "policy" but rather under a statutory framework.' Moreover, Part C expressly preempts any state law inconsistent with standards established by Congress or the Secretary pursuant to her delegated rulemaking authority." (quoting E. Kuo, *Developments in Medicare Secondary Payer Law*, *in* HEALTH LAW HANDBOOK § 12.5 (Alice Gosfield ed., 2013))).

[129] Jordan, *supra* note 116, at 1414 ("While many of the benefits provided to enrollees in Medicare Advantage plans parallel those under traditional Medicare, MAOs have some more flexibility in how these services are provided.").

[130] *See* Eleanor D. Kinney, *Medicare Coverage Decision-Making and Appeal Procedures: Can Process Meet the Challenge of New Medical Technology?*, 60 WASH. & LEE L. REV. 1461, 1471-72 (2003) (describing the administrative process for issuing an NCD). MACs may approve coverage for a new treatment in the absence of an NCD. Indeed, interested parties "often attempt to get a number of contractors to cover a

cover benefits excluded from traditional Medicare coverage — including dental, vision, and hearing — and may add or drop benefits from year to year, subject to broadly defined categories mandated by federal law.[131]

Private health insurance companies play an even bigger role in Medicaid. The 1965 statute left Medicaid administration largely to the states, without specifying a role for private contractors. In short order, however, states began to experiment with privatization via administrative waivers under Section 1115.[132] The Deficit Reduction Act of 2005 gave states the option of offering what are now known as *alternative benefit plans* — all of which are subject to far more flexible federal oversight and most of which are privately administered — for specified groups of Medicaid beneficiaries.[133] When the ACA expanded Medicaid eligibility to nondisabled, childless adults living at 138% of the federal poverty level, it specified that this expansion population *must* be covered through alternative benefit plans.[134] Alternative benefit plans are exempt from many of the federal requirements that apply to traditional Medicaid benefits, giving states and the private insurance companies who administer most of the alternative plans considerable flexibility. Currently, states may enroll Medicaid beneficiaries in privatized plans through multiple statutory and administrative mechanisms.[135] As a result, more than 70% of all Medicaid beneficiaries

technology through LCDs before attempting to get an NCD." FURROW ET AL., *supra* note 4, at 638.

131 Connelly et al., *supra* note 117, at 3.

132 Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to waive specific provisions of federal Medicaid law as part of a demonstration project that meets statutory criteria. 42 U.S.C. § 1315(a) (2018). *See generally* Isaac D. Buck, *Managing Medicaid*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y 107, 107 (2017) (discussing the "difficulties in constructing and organizing the bidding and selection processes of the private companies"); Laura D. Hermer, *Medicaid, Low Income Pools, and the Goals of Privatization*, 17 GEO. J. POVERTY L. & POL'Y 405 (2010) (discussing the goals of privatization and the use of Section 1115 waivers for federal Medicaid requirements).

133 *See* Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6044, 120 Stat. 4, 88-92 (2006).

134 *See* Social Security Act of 1935, 42 U.S.C. § 1903(i)(26) (codified as amended at 42 U.S.C. § 1396(b)(i)(26) (2018)).

135 *See* Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27,498, 27,500 (May 6, 2016) (to be codified at 42 C.F.R. pts. 431, 433, 438, 440, 457, and 495) [hereinafter 2016 MMC Rule], https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaidand-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered [https://perma.cc/S8EV-7C2B] ("States may implement a Medicaid managed care delivery system under four types of federal authorities: (1) Section 1915(a) of the Act

are currently covered by Medicaid Managed Care plans, the vast majority of which are run by private insurance companies pursuant to government contracts.[136]

The government itself does not insure privatized MA or MMC enrollees, nor does it pay health care providers who care for privatized enrollees on a fee-for-service basis. Rather, the government pays a premium to private companies to insure enrollees, determined by a bidding process.[137] The bidding process and payment methodologies have been tweaked from time to time to incentivize more plans to enter the market or to better control costs.[138] In general, though, privatized plan sponsors submit estimated costs per enrollee to the government.

The capitated payments are risk-rated, that is, the per-person, per-month payment is adjusted to reflect various characteristics of the enrollee that are likely to determine how much care she needs over the course of the coverage period.[139] For example, the government pays a

permits states with a waiver to implement a voluntary managed care program by executing a contract with organizations that the state has procured using a competitive procurement process. (2) Through a state plan amendment that meets standards set forth in section 1932 of the Act, states can implement a mandatory managed care delivery system. This authority does not allow states to require beneficiaries who are dually eligible for Medicare and Medicaid (dually eligible), American Indians/Alaska Natives, or children with special health care needs to enroll in a managed care program. State plans, once approved, remain in effect until modified by the state. (3) CMS may grant a waiver under section 1915(b) of the Act, permitting a state to require all Medicaid beneficiaries to enroll in a managed care delivery system, including [the groups exempted from mandatory enrollment under section 1932]. (4) CMS may also authorize managed care programs as part of demonstration projects under section 1115(a) of the Act using waivers permitting the state to require all Medicaid beneficiaries to enroll in a managed care delivery system, including [the groups exempted from mandatory enrollment under section 1932].").

136 *See supra* notes 50–51 and accompanying text.

137 *See* 42 C.F.R. §§ 422.250-.272 (2020) (governing the MA bidding process); Buck, *supra* note 132, at 107 (describing the states' difficulties in organizing the MMC bidding process); Jordan, *supra* note 116, at 1413 (describing the MA bidding process).

138 *See* Patricia Neuman & Gretchen A. Jacobson, *Medicare Advantage Checkup*, 379 NEW ENG. J. MED. 2163, 2165 (2018); *see, e.g.*, *Medicare Advantage*, KAISER FAM. FOUND. (June 6, 2019), https://www.kff.org/medicare/fact-sheet/medicare-advantage/ [https://perma.cc/JU3W-D5YT] ("The Balanced Budget Act (BBA) of 1997 established a payment floor, applicable almost exclusively to rural counties. The Benefits Improvement and Protection Act (BIPA) of 2000 created payment floors for urban areas and increased the floor for rural areas. The Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 increased payments across all areas, and the Affordable Care Act (ACA) of 2010 reduced payments to plans.").

139 *See, e.g.*, United States *ex rel.* Silingo v. Wellpoint, Inc., 904 F.3d 667 (9th Cir. 2018) (describing the risk-adjustment process and holding that allegations that various MA organizations submitted false risk-adjustment data to CMS to receive higher capitated rates stated a cognizable claim for fraud under the federal False Claims Act);

higher premium for enrollees with chronic health conditions like diabetes or heart disease. But otherwise, the financial risk that enrollees will need more health care goods and services than anticipated is borne by the private health plan, not the government. For this reason, government-contracted privatized coverage is sometimes referred to as involving a *risk-sharing* arrangement, in contrast to traditional Medicare or Medicaid, which is referred to as *fee-for-service*. Capitation makes the government's costs far more predictable by shifting the risk to the private contractor.[140] If a plan sponsor's bid meets basic requirements specified by law, it is automatically accepted and the plan is offered to enrollees. If the plan sponsor's estimated costs are higher than a specified benchmark, the plan charges the excess to enrollees in the form of a premium. If any given enrollee ultimately uses more goods and services than the capitated payment anticipated, the privatized plan bears the cost. If, however, the enrollee uses fewer goods and services, the plan keeps the difference as profit.

Enrollees in MA and MMC plans are typically offered a choice of privatized public plans, with MA enrollees having far more options than MMC enrollees. The privatized plans are prohibited from imposing eligibility criteria and must take all comers,[141] but commentators note that privatized plans may seek to "skim the cream" of the public program risk pool by attracting healthier enrollees with enhanced convenience and wellness services and discouraging less healthy enrollees by imposing onerous requirements on those who use a lot of treatment services.[142]

see also Michael Geruso & Timothy Layton, *Upcoding: Evidence from Medicare on Squishy Risk Adjustment*, 128 J. POL. ECON. 984, 984 (2020).

[140] *See* Buck, *supra* note 132, at 110-11 ("[The] expansion [of Medicaid Managed Care] is no doubt owed to the promise of predictability and cost control of capitation that it provides to states' Medicaid programs.").

[141] 42 C.F.R. §§ 422.50, 422.110 (2020).

[142] *See, e.g.*, Janet Currie & John Fahr, *Medicaid Managed Care: Effects on Children's Medicaid Coverage and Utilization*, 89 J. PUB. ECON. 85, 89 (2005) ("Many previous investigations suggest that those who enroll in [Medicaid] MCOs are generally healthier and less likely to use services than those who do not. This may be due either to the personal preferences of the patients, or to the cream-skimming behavior of the MCOs."). In addition to selecting for healthier patients, MMC plans may offer incentives for providers to diagnose beneficiaries with chronic conditions that increase their risk score, and therefore the plan's capitated payment. *See, e.g.*, Anna Chorniy, Janet Currie & Lyudmyla Sonchak, *Exploding Asthma and ADHD Caseloads: The Role of Medicaid Managed Care*, 60 J. HEALTH ECON. 1, 1 (2018) (finding that "the transition from [traditional Medicaid] to MMC explains about a third of the rise in the number of Medicaid children being treated for ADHD and asthma, along with increases in

As private health insurance plans, MA and MMC plans all engage in some form or another of managed care. Their use of restrictive provider networks[143] — which allow them to incentivize hospitals, physicians, and other providers to control costs via reimbursement formulas — are a major reason why privatized plans are believed to be more cost-effective than traditional public coverage.[144] They may also engage in more searching utilization management than traditional Medicare and Medicaid, particularly by requiring pre-utilization authorization.[145] "While some of the surplus funds . . . find their way back to the beneficiaries in the form of benefits beyond those that Medicare provides, the rest [is] profit."[146] MA plan sponsors tout this as "a win-win situation for the government and [MA plans], as well as beneficiaries."[147] "In return for accepting the restrictions that [MA plans] impose, such as requiring prior authorization for expensive services and referrals for visits to specialists, beneficiaries received a more comprehensive set of benefits at lower premiums."[148]

A 2016 regulation harmonized federal requirements applicable to MMC plans with those applied to MA plans and the private plans consumers purchase directly on the state-level health insurance exchanges.[149] Thus, all three types of government-subsidized, privately administered health plans are currently subject to very similar regulations. However, many important details with respect to the quality of coverage, the scope of provider networks, utilization management, reimbursement, and cost-sharing are left to the discretion

treatment for many other conditions. These are likely to be due to the incentives created by the risk adjustment and quality control systems in MMC").

143 *See* Jordan, *supra* note 116, at 1414 ("Medicare Advantage HMOs may establish networks of accepted specialists and other providers that may be broader or narrower than the networks under traditional Medicare.").

144 *See id.* at 1412 ("Due to provider network arrangements and other efficiencies, private sector insurers could potentially provide care to their enrollees for less money than what the government paid.").

145 *See* DANIEL R. LEVINSON, U.S. DEP'T OF HEALTH & HUMAN SERVS. OFFICE OF INSPECTOR GENERAL, MEDICARE ADVANTAGE APPEAL OUTCOMES AND AUDIT FINDINGS RAISE CONCERNS ABOUT SERVICE AND PAYMENT DENIALS 1-2 (2018), https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf [https://perma.cc/Z92W-SSQ8].

146 Jordan, *supra* note 116, at 1412.

147 *Id.*

148 Field & Stefanacci, *supra* note 8, at 209.

149 *See* 2016 MMC Rule, *supra* note 135, at 27,498 ("The final rule aligns, where feasible, many of the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans."). In February 2020, CMS released proposed changes to these rules.

of plan sponsors.[150] In this respect, privatized public coverage resembles privately financed health insurance. But ultimately, privatized public coverage "is not private insurance, even if it is offered by private insurers."[151] It is governed by different statutes and regulations, and by the terms of government contracts.

II. SECURING THE GOALS OF PROGRESSIVE HEALTH REFORM

Although its achievements may have been incremental,[152] the ACA's surprising resilience in the face of legal and political challenges is monumental. The decade following the ACA's narrow evasion of a filibuster has been marked by legal challenges that have captured the nation's attention, repeal-and-replace proposals that have been at the top of voters' minds in every federal election, and mounting calls to take progressive reforms further. Political candidates at the state and federal level have proposed various approaches to open up public Medicare and Medicaid programs to all — or more — Americans. Some progressive reformers would create a universal — and uniform — publicly financed and administered health plan for all residents. Others would offer a publicly financed and administered plan as an alternative to private insurance for those who wished to buy into public coverage. Federal proposals have gotten the most attention, but state-level single-payer and public option reforms are also on the table.[153]

Universal coverage is the primary goal touted by most progressive health reformers. Other goals include improving access to care and lowering out-of-pocket costs for the underinsured, cutting through red tape, and securing a sense of solidarity — that we all rise or fall together when we are covered under a single health plan.[154] Making public

[150] *See* Jordan, *supra* note 116, at 1414 ("Each [MA organization] may charge different out-of-pocket costs and develop its own rules for how enrollees get their services.").

[151] Schiff & Abate, *supra* note 119, at 25.

[152] The ACA took an incremental approach by preserving a fragmentary mix of public and private health insurance coverage, rather than replacing it with a unified system. It also excluded undocumented immigrants and (thanks to the Supreme Court's decision in *NFIB v. Sebelius*, 567 U.S. 519 (2012)) many people living in states that have rejected federal financing to expand Medicaid eligibility remain uninsured. *See* Mariner, *supra* note 71, at 195-96; Noble & Chirba, *supra* note 10.

[153] *See generally* Wiley, *Medicaid for All?*, *supra* note 27 (discussing the "efforts of states to succeed where federal reformers have failed by adopting a state-level public option or single-payer health care system").

[154] *See generally* Erin C. Fuse Brown, Matthew B. Lawrence, Elizabeth Y. McCuskey & Lindsay F. Wiley, *Social Solidarity in Health Care, American Style*, 48 J.L. MED. &

expenditures more efficient is also a key talking point for single-payer supporters, who understand that sustainable health care prices are necessary to make universal access feasible. Beyond these big-picture commitments, the details of specific proposals touted as offering "Medicare for All" vary widely. One key point of distinction among proposals is what role, if any, private insurance companies will play in administering benefits.

Reformers seeking to open up access to publicly financed health care programs must carefully parse the public-private divide within the existing versions of those programs. Reforms built on the model of the Medicare Modernization Act, the Deficit Reduction Act, the Affordable Care Act, or the recently implemented Washington public option could continue the trend of opening up privatized public health insurance to more (or all) Americans. An approach that preserves a role for private insurers is likely to face less political opposition from insurers and health care providers (whose most powerful lobbies prefer competitive reimbursement contracts). But is the resulting coverage "public" enough to serve the goals of progressive health reformers? The answer depends on how public and private responsibilities are exercised with respect to several key functions of health coverage, including the distribution of financial risk, determinations regarding enrollee eligibility and choice, benefit design, contracted provider networks, utilization management, and reimbursement of providers.[155] Taken together, these functions determine how universal health care coverage will be, how the health benefits and financial burdens of public investments in health care coverage will be distributed, and whether health care costs will be sustainable and equitable. Lawmakers and government officials may exercise their primary responsibility for securing the public's interest in each of these functions while delegating significant administrative responsibilities to private contractors.[156] As

ETHICS 411 (2020) (discussing social solidarity in health care and the fixtures of American law that complicate the attainment of this goal).

[155] *Cf.* Fineman, *supra* note 34, at 2 ("Whether or not the typical arguments for or against privatization are rooted in fiscal necessity, profit maximization, or the pursuit of public interest and the elusive notion of justice, what is at issue is ultimately the question of what is the appropriate balance of responsibility between the state, the market and other societal institutions, and the individual for social and individual wellbeing.").

[156] *See* MINOW, *supra* note 2, at 142 ("It should not be controversial to insist that public values follow public dollars. When the government funds programs, the government should be able to set terms and conditions. Not only does this match the age-old idea that 'he who pays the piper calls the tune,' it also fulfills the particular trust granted to government to act on behalf of — and with the resources of — the

Martha Fineman has argued, "The fact that the state chooses some institutions, mechanisms, or actors conveniently labelled 'private' . . . in meeting its responsibilities should not substantially alter the substance of that responsibility even if it substitutes the means to ensure it."[157]

A. Universal Health Care Coverage

Widespread support for preserving the core protections of the ACA suggests universal coverage is a goal that reformers on both sides of the political divide claim to support. But the meaning of universality in health reform is contested.[158] For some progressive reformers, universal coverage means everyone has the *same* coverage.[159] But reformers who require only that everyone's care is publicly financed, and everyone has the same *options* may support an approach that incorporates privatized public health insurance. Reform that achieves a more universal menu of coverage options would be a major change from our current system, in which narrow eligibility criteria restrict access to public insurance programs and limit individual choice.

1. Who Will Be Covered?

In the US, public health insurance is treated as an exception in need of justification, rather than the default. Eligibility criteria for Medicare and Medicaid are limited based on the identity of the enrollee. In addition to being means-tested, Medicaid eligibility was historically tied to categories deemed deserving of government aid, including children, pregnant women, people with qualifying disabilities, and some parents of dependent children. These criteria still govern eligibility in states that have declined the ACA's Medicaid expansion, as the Supreme Court's opinion in *NFIB* permits.[160] Medicare eligibility, like social security, is

community. That trust must not falter when the government chooses [private entities] to carry out the work it funds.").

157 Fineman, *supra* note 34, at 2.

158 *See* Lindsay F. Wiley, Universality, Vulnerability, and the Goals of Twenty-First Century Health Reform, manuscript at 6 (Jan. 26, 2020) (unpublished manuscript) (on file with author).

159 *See, e.g.*, Khazan, *supra* note 14 (quoting a supporter of Democratic presidential candidate Bernie Sanders as saying that "the only way we're going to ever have health-care justice is if the guys writing the policies have to live by it" and concluding that "[t]hat would mean everyone would have the same health-insurance plan. Which would mean Medicare for All"); *see also* MINOW, supra note 2, at 3 (discussing tension between commonality and choice in privatization debates and questioning).

160 *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 586 (2012) (finding the ACA's requirement to expand Medicaid to be "unconstitutional when applied to

widely understood to be earned through one's own eligible work history or that of a spouse. Both programs are frequently under political threat, a consequence of the role rising health care costs play in mounting federal debt.[161]

Prior to federal regulation, private insurers operated on a common-law freedom of contract principle. The basic business model that allowed them to bear unpredictable financial risk for a set fee required that they engage in risk-based underwriting to decide to whom they would sell coverage and on what terms. If a person's health history, family history, or other factors indicated that their need for goods and services was likely to be high, private companies may have deemed her uninsurable. Alternatively, some may have offered her coverage at very high rates or with an exclusionary clause specifying that care for her preexisting conditions would not be covered. HIPAA and the ACA have fundamentally changed this model, preempting contractual freedom by imposing universal eligibility criteria and mandating that insurers take all comers on largely equal terms.[162] Propping up the private market under these conditions requires substantial public subsidies, which the ACA provides.

Reformers seeking to open up access to public health insurance must determine which enrollees will be eligible for which kinds of publicly financed coverage. Some proposals at the federal level would make access to publicly financed care truly universal for all US residents, regardless of immigration status or any other eligibility criteria.[163] More moderate proposals — like the reforms recently adopted in Washington and proposed in Colorado — would make one or more publicly financed plans available for purchase on the state level health insurance

withdraw existing Medicaid funds from States that decline to comply with the expansion").

[161] *See* Brian Riedl, *Health Care Will Bankrupt the Nation*, U.S. NEWS (July 14, 2017, 6:00 AM), https://www.usnews.com/opinion/articles/2017-07-14/health-care-will-bankrupt-the-nation-we-need-reform-now [https://perma.cc/3W5S-3XSW]; *see also How Medicare, Medicaid, and Social Security are Driving the National Debt — and How We Can Fix It*, CATALYST (2020), https://www.bushcenter.org/catalyst/federal-debt/macguineas-medicaid-medicare-social-security-national-debt.html [https://perma.cc/YUQ9-UYG4] (discussing the growing costs of federal health care programs and their negative impact on the federal budget).

[162] As noted above, rates may still vary based on household size, geographic area, age, and tobacco use.

[163] *See Where Democrats Stand: Do You Believe All Undocumented Immigrants Should Be Covered Under a Government-Run Health Plan?*, WASH. POST, https://www.washingtonpost.com/graphics/politics/policy-2020/medicare-for-all/undocumented-immigrant-health-care/ (last visited Feb. 17, 2021) [https://perma.cc/NN2L-J6SY].

exchanges. While buying coverage on the exchanges is technically an option for any resident other than undocumented immigrants, subsidies are only available for those who lack access to affordable employer-based coverage or traditional public coverage. Other proposals would incrementally broaden access to existing programs by lowering the age for Medicare eligibility or raising Medicaid income thresholds.[164]

2. Will They Have a Choice of Plans?

Reformers must also determine whether enrollees will have a choice of plans. When multiple options are available, law may also play a role in ensuring that adequate information about those options is available to potential enrollees. Proponents of private insurance point to enrollees' freedom to choose their coverage as a political argument against expanding public coverage.[165] Some progressive reformers strongly prefer that everyone have the same coverage, pitting themselves against others who value choice.

Traditional public coverage largely eliminates choice of plans. People who meet specified eligibility criteria are enrolled in a program whose contours are determined by statutes and regulations. Statutes and regulations may guarantee special coverage tailored to the needs of particular populations, such as the unique early-intervention benefits Medicaid provides for low-income children.[166] There is also variation from place to place as a consequence of federalism (in the case of Medicaid) or private contractors who administer benefits within specified geographic areas (in the case of Medicare). Otherwise,

164 *See* Hacker, *supra* note 30, at 334, 342-43.

165 *See, e.g.*, Wendell Potter, *How the Health Insurance Industry (and I) Invented the 'Choice' Talking Point*, N.Y. TIMES (Jan. 14, 2020), https://www.nytimes.com/2020/01/14/opinion/healthcare-choice-democratic-debate.html [https://perma.cc/5N7R-QSPQ] ("If the nation [expands public health care coverage] . . . it would restrict the ability of Americans to choose their plans or doctors or have a say in their care.").

166 Medicaid-eligible children up to age nineteen, even if they are enrolled in an MMC plan, are entitled to coverage for early periodic screening, diagnosis and testing services ("EPSDT") — a bedrock of traditional Medicaid coverage. *See* Medicaid Program; State Flexibility for Medicaid Benefit Packages, 75 Fed. Reg. 23,068, 23,071 (Apr. 30, 2010) (to be codified at 42 C.F.R. pt. 440); *see also* MARYBETH MUSUMECI & PRIYA CHIDAMBARAM, KAISER FAMILY FOUND., MEDICAID'S ROLE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS: A LOOK AT ELIGIBILITY, SERVICES, AND SPENDING 6 (2019), https://www.kff.org/medicaid/issue-brief/medicaids-role-for-children-with-special-health-care-needs-a-look-at-eligibility-services-and-spending/ [https://perma.cc/86AN-LVFC] ("Medicaid's Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit includes regular medical, vision, hearing, and dental screenings as well as the services necessary to 'correct or ameliorate' physical or mental health conditions.").

coverage is uniform, and eligibility is guaranteed (assuming the program's criteria are met).

With privatized public health insurance, assuming multiple contractors participate, enrollees may be offered a choice of plans. Regulations typically require contractors to disclose information about the various options to promote informed decisions by enrollees and government programs may provide assistance with weighing options.[167] Privatized public insurance may be offered alongside a publicly-administered option (as is the case in our existing Medicare program) or it could be offered without a traditional public alternative (as is currently the case for many Medicaid enrollees). Federal Medicaid law currently specifies which enrollees may be *offered* the option of a (typically privatized) MMC plan, which enrollees *may* be placed into an MMC plan without being offered the option of traditional Medicaid, and which enrollees *must* be placed into an MMC plan. For example, states are generally prohibited from placing enrollees who are dually eligible for Medicare and Medicaid, pregnant enrollees with income below 133% of the federal poverty level, enrollees qualifying for long-term care services, enrollees with qualifying medical needs, and other groups specified by statute without at least giving them the option of maintaining traditional Medicaid coverage.[168] Carving out groups who are expected to need a lot of health care goods and services protects them from profit-motivated denials and narrow contract-based provider networks while also indirectly subsidizing private contractors by removing them from the risk pool.

If privatized public coverage is maintained as part of an expanded public program, government officials may require contractors to take all comers on an equal basis, while paying them a variable fee, depending on health-related factors. In some cases, the government may enroll beneficiaries in a privatized plan selected for them by health officials, providing notification to the enrollees and permitting them to opt for different coverage within a specified timeframe if they choose to do so, but otherwise requiring no action on their part.[169]

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[167] *See* 2016 MMC Rule, *supra* note 135, at 27,617, 27,623 (requiring MMC plans to disclose up-to-date provider directories and prescription drug formularies to enrollees and requiring states to establish an independent beneficiary support system to offer information and counseling to Medicaid enrollees).

[168] 42 U.S.C. § 1396u-7(a)(2)(B) (2018).

[169] *See* 2016 MMC Rule, *supra* note 135, at 27,614 (requiring states that passively enroll beneficiaries to notify the beneficiaries and provide them a 90-day period to change plans, and, in cases where enrollment in MMC coverage is voluntary, giving them the option of enrolling in traditional, publicly administered Medicaid coverage).

Even if they mandate that privatized public plan sponsors must take all comers on an equal basis, reformers must pay careful attention to the problem of regulatory arbitrage by private contractors seeking to enroll healthier people while driving less healthy enrollees to alternative plans. There is evidence that MA and MMC plans engage in cream skimming, though the advent of competitive bidding and risk-adjusted capitation rates has mitigated the problem to some extent.[170] Nonetheless, regulating the process by which enrollees are matched with privatized public plans should be a high priority. Risk adjustment for enrollees in privatized public health insurance is governed by statute, regulation, and contract, with harsh penalties for those found to have committed fraud. Although enrollees themselves are seldom aware of fraudulent risk rating, internal whistleblowers may play an important role in privately enforcing federal fraud and abuse laws against MA and MMC plan sponsors.[171]

B. Fair Distribution of Health Benefits

Defining the terms of coverage will require reformers to grapple with difficult questions regarding the conditions that trigger a mutual aid response and mechanisms for ensuring that those conditions are met when enrollees and the providers who care for them submit requests for coverage. Utilization management — review of requests for coverage to determine whether the requested benefit is medically necessary, nonexperimental, and otherwise falls within the terms of coverage — is a key feature of managed care. Pioneered by the private insurance industry, it now permeates public coverage as well. Defining covered benefits and developing the standards and processes that govern claims by enrolled patients and the health care providers who serve them raise

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[170] *See* Michael Geruso & Timothy J. Layton, *Selection in Health Insurance Markets and Its Policy Remedies*, 31 J. ECON. PERSP. 23, 24 (2017) (discussing risk adjustment as a mechanism for mitigating cream skimming); Vilsa Curto, Liran Einav, Jonathan Levin & Jay Bhattacharya, Can Health Insurance Competition Work? Evidence from Medicare Advantage 1 (June 2020) (unpublished manuscript), http://web.stanford.edu/~leinav/wp/MA.pdf [https://perma.cc/YNX2-CJ2L] ("Historically, [MA plan] payments were set administratively and the program suffered from limited uptake and cream skimming. In the last decade, however, Medicare introduced two new ingredients touted by advocates of managed competition: competitive bidding to encourage plans to accept payments below a maximum benchmark rate, and risk adjustments that make payments a function of enrollee health status." (citations omitted)).

[171] *See, e.g.*, Elise Reuter, *Whistleblower Lawsuit Accuses Cigna of Medicare Advantage Fraud*, MEDCITY NEWS (Aug. 7, 2020, 6:00 AM), https://medcitynews.com/2020/08/whistleblower-lawsuit-accuses-cigna-of-medicare-advantage-fraud/ [https://perma.cc/4L2M-VA9M] (describing a whistleblower lawsuit alleging fraud against Cigna).

difficult questions. On the one hand, widespread narratives about wrongfully denied claims suggest that private insurers seek to protect their bottom line by inappropriately barring access to covered benefits. On the other hand, health care providers may act in their own self-interest, requesting payment for goods and services that are medically unnecessary, inappropriate, or whose benefit is unproven. Third party payers and administrators may provide a useful check on profit-motivated health care providers, protecting the public fisc and preserving resources for those who truly need them.[172]

1. What Will Be Covered?

In addition to deciding who will be covered, reformers must also determine what will be covered and how uniform coverage should be. Beyond basic services like inpatient hospital care and ambulatory medical care, the market alone may not provide adequate coverage for preventive services, prescription drugs, treatment for mental health and substance use disorders, and vision and dental care.

Private insurance benefits vary from plan to plan, though less so than prior to the ACA. The ACA requires directly purchased private insurance plans to offer a core package of essential health benefits ("EHB"), but does not require employer-based coverage to do the same.[173] ACA statute defined the EHB requirement in terms of ten broadly defined categories of benefits: emergency services; hospitalization; ambulatory patient services; preventive and wellness services and chronic disease management; rehabilitative and habilitative services and devices; treatment for mental health, behavioral health, and substance abuse disorders; maternity and newborn care; pediatric services, including oral and vision care for children; prescription drugs; and laboratory services.[174]

The benefits package for public coverage is defined differently. For traditional Medicare, a benefit must fall within a category recognized in the Medicare statute. Part A generally covers hospital, nursing home, home health, and hospice services.[175] Part B generally covers services provided in physician's offices and other outpatient settings.[176] To be

[172] *Cf.* Rosenblatt, *supra* note 50, at 156 (lamenting the "pernicious influence" of "the ideal of the trustworthy, independent physician delivering the best possible medical care for her or his individual patients").

[173] 42 U.S.C. § 18022 (2018).

[174] *Id.*

[175] *See id.* § 1395d(a) (2018).

[176] *See id.* 1395k(a) (2018).

covered, goods and services must also be deemed by CMS or the relevant Medicare administrative contractor to be "reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member."[177] In recent years, Congress has expanded Medicare coverage for preventive services, bringing Medicare benefits more into line with what private insurance had long offered.[178] Traditional Medicaid benefits are defined in the federal statute as either mandatory (meaning they must be covered by the state program) or optional (meaning the state may elect to cover them using matching federal funds).

The benefits provided by privatized public health insurance are regulated in much the same way as private plans offered for direct purchase on the health insurance exchanges. The same EHB package that the ACA mandates for plans sold on the exchanges also applies to privatized MA and MMC plans. State contracts with MMC sponsors typically outline covered benefits in some detail.[179] Some also specify which services may not be covered.[180]

2. Who Will Decide?

For private insurance, utilization management typically involves preauthorization. Barring an emergency, a health care provider must submit a request for coverage prior to delivering goods or services. For public coverage, utilization management varies. Utilization management for traditional Medicare is handled primarily by private

[177] *Id.* § 1395y(a)(1)(A) (2018).

[178] Susan Bartlett Foote & Lynn A. Blewett, *Politics of Prevention: Expanding Prevention Benefits in the Medicare Program*, 24 J. PUB. HEALTH POL'Y 26 (2003); Brett Lissenden & Nenglian "Aaron" Yao, *Affordable Care Act Changes to Medicare Led to Increased Diagnoses of Early-Stage Colorectal Cancer Among Seniors*, 36 HEALTH AFF. 101 (2017).

[179] *See, e.g.*, UTAH DEP'T OF HEALTH & UNIV. OF UTAH HEALTH PLANS, CONTRACT NO. 182700622: ACO – HEALTHY U MEDICAID, at attachments C-D (Jan. 1, 2018), https://medicaid.utah.gov/Documents/pdfs/managedcare/ACO%20-%20Healthy%20U%20Medicaid_Redacted%202018-01-01%20-%20182700622.pdf [https://perma.cc/2PF7-WQQQ] (detailing covered services, such as anything covered under the Medicaid State Plan); VA. DEP'T OF MED. ASSISTANCE SERVS., CONTRACT TO PROVIDE MANAGED CARE SERVICES FOR THE MEDICAID AND FAMILY ACCESS TO MEDICAL INSURANCE SECURITY (FAMIS) PROGRAM 335-66, 414-29 (July 1, 2020) (providing a chart detailing the many covered services, including medical benefits under the State Medicaid fee-for-service program).

[180] *See, e.g.*, COLO. DEP'T OF HEALTH CARE POLICY & FIN. & ROCKY MOUNTAIN HEALTH MAINT. ORG., CONTRACT NO. 19-107507A6: CONTRACT AMENDMENT #6, § 14.3 (Dec. 29, 2020), https://www.colorado.gov/pacific/sites/default/files/Region%201%20-%20Rocky%20Mountain%20Health%20Plan.pdf [https://perma.cc/5DCR-LG34] (noting list of exclusions to services).

Medicare administrative contractors. MACs issue local coverage determinations — policies that govern which benefits are covered under which circumstances — and review claims for reimbursement after goods and services have been delivered. Prior authorization is not typically required. Traditional Medicaid varies from state to state, but prior authorization often does play an important role.[181] For privatized public health insurance, utilization management is handled by the private plan. Privatized public insurance contracts typically include detailed provisions relating to utilization management. State contracts with MMCs typically require plan sponsors to provide documentation of their utilization management policies, including reviewer qualifications, procedures, and the sources of information to be consulted in determining whether the requested benefit is medically necessary and nonexperimental under the circumstances.[182] Some contracts are more specific, requiring, for example, "demonstrat[ion] that [enrollees] have equitable access to care across the network and that [utilization management] decisions are made in a fair, impartial, and consistent manner that serves the best interests of the members."[183]

Just as important as when and how coverage decisions are made is the process for appealing denials. Under the ACA, private insurance companies must follow internal and external grievance procedures.[184] For traditional Medicare, denied claims and the coverage-determination policies that influence them may be challenged via a multi-level administrative review process that enrollees and providers must exhaust prior to bringing suit for judicial review. For privatized MA plans, coverage denials are subject to the same administrative process that applies to traditional Medicare.[185] MMC plans must comply with similar

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[181] *See* MEDICAID & CHIP PAYMENT & ACCESS COMM'N, THE MEDICAID FEE-FOR-SERVICE PROVIDER PAYMENT PROCESS 1-2 (2018), https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid-fee-for-service-provider-payment-process.pdf [https://perma.cc/HXY4-9J56].

[182] *See, e.g.*, COLO. DEP'T OF HEALTH CARE POLICY & FIN. & ROCKY MOUNTAIN HEALTH MAINT. ORG., *supra* note 180, § 14.8 (providing that "the Contractor shall establish and maintain a documented Utilization Management Program and Procedures . . . that includes . . . the following: description of its utilization management program structure and assignment of responsibility for utilization management activities to appropriate individuals; identification of a designated licensed medical professional responsible for program implementation, oversight, and evaluation; evidence of behavioral health practitioner's involvement in program development and implementation").

[183] VA. DEP'T OF MED. ASSISTANCE SERVS., *supra* note 179, § 8.1.D.

[184] *See* 42 U.S.C. § 300gg-19 (2018).

[185] *See id.* § 1395w-22(g) (2018).

administrative appeal requirements and are protected by administrative exhaustion requirements.[186]

Enrollees and providers seeking coverage or payment have attempted to bring contract claims against MA plans, but most courts have held that these suits are preempted.[187] The 1997 BBA included relatively narrow preemption provisions that allowed state officials and MA enrollees to pursue many state law claims against MA plan sponsors.[188] The 2003 MMA overhaul was more generous in its protection of MA plan sponsors, however, including a broad preemption provision that bars most state contract, tort, and insurance regulation claims against MA plans.[189]

Although the regulations governing benefit design and utilization management (for public programs as well as private insurers) are now quite comprehensive, administrative enforcement may be inadequate, allowing rampant abuse by private insurers and government administrators to persist. Historically, private lawsuits by enrollees played an important role in securing the quality of private insurance and public health coverage alike. But avenues for bringing suit in court have narrowed considerably for both types of coverage — and for privatized public health insurance as well. Progressive reformers should pay close attention to options for reviving private enforcement of the commitments private insurers and public programs make to cover appropriate benefits in a timely and efficient manner.[190]

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[186] *See* 2016 MMC Rule, *supra* note 135, at 27,505-07 (aligning time frames for administrative appeals with those applicable to MA plans and private plans sold on the health insurance exchanges).

[187] *See, e.g.*, United Behavioral Health v. Maricopa Integrated Health Sys., 377 P.3d 315 (Ariz. 2016) (holding that coverage denials by a private MA plan sponsor were not arbitrable under the contract between the defendant MA sponsor and the plaintiff health care providers because they were subject to administrative review under the Medicare statute).

[188] *See* Peter Leininger, *Medicare Advantage Preemption Begins to Take Shape: Two Federal Appellate Courts Weigh In*, 21 HEALTH L. 36, 36 (2009) (noting the previous program, Medicare+Choice, contained a limited two-part preemption clause that was "relatively narrow" and "did not provide a broad defense for Medicare+Choice organizations" allowing state officials and MA beneficiaries to bring "a host of state law claims against Medicare+Choice organizations").

[189] *See id.* at 36-37 (noting Congress eliminated the relatively narrow two-part preemption clause in favor of a "presumption of preemption" in areas of "contracting relationships, tort law, labor law, civil rights law, and similar areas of law").

[190] *Cf.* MINOW, *supra* note 2, at 140 ("We cannot leave the needs of those who cannot pay to the vagaries of politics and to the preferences of those who can command legislative and judicial majorities.").

C. Fair Distribution of Financial Burdens

The primary function of health coverage is to distribute the financial burdens of health care. At the individual level, uncertainty about how much health care a person will need over the course of a month, a year, or a lifetime is unavoidable. This uncertainty can be understood as a financial risk — the risk that an individual will require costly health care goods. Some or all of this financial risk may be borne by individual patients and the families who take responsibility for their care. Some of it may be borne by doctors, hospitals, and others who may provide goods and services at the risk of their bills going unpaid. In exchange for a set fee, employers and private insurance companies may offer to bear some portion of this financial risk. The risk may be erratic at the individual level but becomes quite predictable when individuals are pooled into large groups, making insurance a potentially profitable enterprise. The government may also bear risk at the population level through taxation and spending.

In addition to deciding whether private insurers or the government will bear the lion's share of financial risks associated with health care, reformers must also make difficult choices regarding how much risk to redistribute to patients (in the form of premiums and cost-sharing) and providers (in the form of value-based payment incentives). Related to payment incentives is the question of whether access to specific providers will be limited by contracted networks and how reformers will ensure the sustainability of reimbursement rates. Widespread news coverage of cases where enrollees in private insurance, including privatized public health insurance, have been unable to access needed care or have been exposed to exorbitant medical bills when they do, suggest that existing strategies do not go far enough to protect enrollees.[191]

[191] *See, e.g.*, Helaine Olen, *Even the Insured Often Can't Afford Their Medical Bills*, ATLANTIC (June 18, 2017), https://www.theatlantic.com/business/archive/2017/06/medical-bills/530679/ [https://perma.cc/7KZ2-9AQ8] (detailing personal anecdotes of private enrollees suffering from high medical bills); Michael Sainato, *The Americans Dying Because They Can't Afford Medical Care*, GUARDIAN (Jan. 7, 2020, 4:00 AM EST), https://www.theguardian.com/us-news/2020/jan/07/americans-healthcare-medical-costs [https://perma.cc/6QSJ-7LYS] (citing personal stories and statistics on the number of Americans who struggle to afford health care); *Bill of the Month*, KAISER HEALTH NEWS, https://khn.org/news/tag/bill-of-the-month/ (last visited Dec. 29, 2020) [https://perma.cc/25KW-277T] (telling the stories of various patients who had to pay enormous amounts of money regardless of whether or not they were covered).

1. How Will Public Investments Be Defined and Financed?

Private insurance — which currently covers the majority of US residents — is, for the most part, privately financed. Access to it is among the rewards our economy provides for doing well financially.[192] Public investments in employer-based private insurance are indirect and largely obscured from public scrutiny. They come primarily in the form of forgone public revenues. It is difficult to convey to voters the trade-offs between favorable tax treatment of health insurance and the public investments that could be made if more revenue were collected from employers and employees. With private insurance that is directly purchased on the market, financial responsibilities are more clearly defined. ACA tax credits financed with general federal revenues subsidize premiums for people living in households with income between 100% and 400% of the federal poverty level to a defined percentage of income.[193] Otherwise, the purchase is privately financed.

Traditional public insurance programs are financed primarily with general revenues at the state and federal level. Medicare funding comes from federal general revenues (43%), federal payroll taxes (36%), and means-tested monthly premiums paid by enrollees (15%),[194] while Medicaid is jointly financed by the states and the federal government, with federal revenues making up a share of spending that varies from state to state.[195]

2. Who Will Bear the Financial Risk that Enrollees Will Require More Care than Anticipated?

With private insurance, a private company bears most of the financial risk that enrollees will need more care than anticipated over a specified coverage period. Insurers typically leave a smaller portion of financial risk to be borne by patients and their families, in the form of exposure

[192] *See* Sorresso, *supra* note 5, at 29 (describing "the traditional American ideals of individuality and personal autonomy . . . [as] support[ing] the idea that our accomplishments, including our ability to pay for our own health care, should reflect personal effort rather than the benefits of a charity state").

[193] 26 U.S.C. § 36B(b)(3)(A)(i) (2018).

[194] JULIETTE CUBANSKI, TRICIA NEUMAN & MEREDITH FREED, KAISER FAMILY FOUND., THE FACTS ON MEDICARE SPENDING AND FINANCING 7 fig.7 (2019), https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/ [https://perma.cc/PX2Q-VKJJ].

[195] ROBIN RUDOWITZ, KENDAL ORGERA & ELIZABETH HINTON, KAISER FAMILY FOUND., MEDICAID FINANCING: THE BASICS 1 (2019), https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/ [https://perma.cc/UZD7-8WKP].

to cost sharing (deductibles, copayments, and coinsurance).[196] Enrollment in high-deductible health plans has grown considerably over the last decade, with more than 45% of private insurance enrollees in a high-deductible plan.[197] Regulators impose an annual cap on out-of-pocket costs for covered benefits — about $7000 per year for individuals and about $14,000 for families — but the limit does not apply to out-of-network services.[198] Via managed care payment incentives, insurers also shift some portion of the risk to health care providers. By shifting some of the risk to others, the insurance company seeks to ensure that the patient and the provider both have "skin in the game" when making decisions about utilization of covered benefits.

With traditional public coverage, the government bears most of the risk over the course of the enrollee's eligibility. It promises to pay health care providers for the covered goods and services they provide to enrollees. If enrollees require more care over the course of the coverage period than government officials anticipated, the program pays more. Thanks to relatively recent reforms, providers are bearing some financial risk in public health coverage programs via value-based payment formulas modeled on private-insurance provider contracts. Cost-sharing is a feature of public coverage, as well. In fact, traditional Medicare imposes higher copayments and coinsurance than many private insurance plans — so much so that most traditional Medicare enrollees purchase private "Medigap" policies to make up the shortfall.[199] Medicaid has not traditionally imposed cost-sharing on enrollees, though recent reforms have piloted the imposition of small deductibles and copayments in an effort to influence enrollee behavior.

With privatized public health insurance, the government takes primary responsibility for financing health care goods and services for enrollees over the course of their eligibility, but it does so by paying a set fee to private insurance companies to bear most of the financial risk over a defined coverage period. The coverage is still paid for via taxation

196 *See generally* ROBERTSON, *supra* note 79 (describing cost-sharing in private and public insurance and posing the question: "To what degree should those costs be borne individually or shared collectively?").

197 NAT'L CTR. FOR HEALTH STATISTICS, NCHS HEALTH INSURANCE DATA 2 (2019), https://www.cdc.gov/nchs/data/factsheets/factsheet_health_insurance_data.pdf [https://perma.cc/2WQT-NJRA]. For 2020, the Internal Revenue Service defines a high deductible health plan as any plan with a deductible of at least $1,400 for an individual or $2,800 for a family.

198 *See* 42 U.S.C. § 300gg-11 (2018).

199 FURROW ET AL., *supra* note 4, at 638 ("To contain the significant out-of-pocket costs of traditional Medicare, most seniors purchase Medicare supplement policies (known as 'MedSupp' or 'Medigap' plans).").

and spending, but the costs to the government are predictable. If enrollees require more care than anticipated, the additional costs are borne by the private contractors. If they require less care than anticipated, or if care is delivered less expensively, the savings go to the contractors in the form of profits. Value-based payment incentives and patient cost-sharing may still be imposed in some form — as they currently are for public coverage. Regulators may police risk-shifting by contractors by imposing limits to ensure that it doesn't interfere with access to needed care.

Some progressive reformers would certainly object to privatized public health insurance on the basis that it fails to eliminate private profit from the health care system.[200] But for those willing to tolerate some degree of privatization, having private companies bear financial risks via government contracts may be an acceptable compromise. The rate paid to private contractors has been and will continue to be a crucial point for negotiation. In past reforms, advocates for contractors' interests have argued that generous rates are necessary to tempt companies to enter and remain in the privatized public health insurance market. But overly generous compensation for Medicare Advantage plans has arguably undercut the goal of controlling costs, making expanded access less sustainable. States, on the other hand, may be tempted to engage in a bidding race to the bottom with MMC contractors. The elephant in the room in these discussions is how much overhead (including administrative costs, executive compensation, and profit) is acceptable. The 2016 MMC Rule directed states to develop capitated rates for MMCs that allow them to sustain overhead costs of 15%.[201] Reformers interested in expanding access to privatized public health insurance could mandate minimum medical loss ratios ("MLR"), which correspond to the proportion of premium revenues that are ultimately spent on payment of claims and quality improvement

[200] *See* S. 1129, 116th Cong. (2019); Khazan, *supra* note 14 (quoting a Medicare for All activist as saying "[w]hat the ACA has failed to deal with is the profit motive . . . . The fact that a lot of people are becoming enormously rich off of our lives"); Bernie Sanders, *Bernie Sanders: Medicare for All's Time Has Come*, CNN (Aug. 16, 2018), https://www.cnn.com/2018/08/16/opinions/medicare-for-all-now-bernie-sanders/index.html [https://perma.cc/BZY7-AFBW].

[201] Overhead costs for health plans are typically described and regulated in terms of the medical loss ratio, a measure of the percentage of all revenues that is ultimately spent on medical losses and quality improvement activities versus other administrative costs, compensation, marketing, profit, etc. The 2016 MMC Rule imposes a minimum MLR on state MMC plans, requiring states to calculate capitated rates for MMC plans that allow them to achieve an MLR of 85%, allowing for 15% overhead. *See* 2016 MMC Rule, *supra* note 135, at 27,837-38.

activities — functionally capping overhead and profits — by statute, regulation, or contract. Minimum MLR, and thus maximum administrative costs and profits, could be adjusted as needed to ensure adequate access to a choice of plans for enrollees.

3. Will There Be Out-of-Pocket Costs for Enrollees?

Sanders and some other Medicare for All proponents have argued that care should be free at the point of service for all enrollees.[202] That would be a radical change from existing public programs, which impose significant out of pocket costs on enrollees.

Monthly premiums for traditional Medicare Part B started at three dollars per month in 1966.[203] Premiums are indexed to spending within the program, with means-tested adjustments introduced in 2007. In 2020, the standard monthly premium was $144.60.[204] For the nearly 7% of Medicare enrollees earning above a defined income threshold, an income-related monthly adjustment amount is added to the standard premium, with 2020 monthly premiums approaching $500 per month for those earning more than $163,000 (for those who file individual returns) or $326,000 (for those who file joint returns).[205] Monthly premiums are not a significant source of revenue for states, but several states have introduced them into their Medicaid programs in recent years.[206]

Traditional Medicare has always imposed significant out of pocket costs on enrollees, as well.[207] Today, the actuarial value of Medicare —

[202] *Health Care as a Human Right*, *supra* note 32 (advocating for "a Medicare for All, single-payer, national health insurance program to provide everyone in America with comprehensive health care coverage, free at the point of service").

[203] SOC. SEC. ADMIN. OFFICE OF RET. & DISABILITY POLICY, ANNUAL STATISTICAL SUPPLEMENT, 2011: PROGRAM PROVISIONS AND SSA ADMINISTRATIVE DATA (2011), https://www.ssa.gov/policy/docs/statcomps/supplement/2011/2b-2c.html [https://perma.cc/35EZ-DLJY].

[204] *2020 Medicare Parts A and B Premiums and Deductibles*, CENTERS FOR MEDICARE & MEDICAID SERVICES (Nov. 8, 2019), https://www.cms.gov/newsroom/fact-sheets/2020-medicare-parts-b-premiums-and-deductibles [https://perma.cc/UA5R-JUT9].

[205] *Id.*

[206] *See* TRICIA BROOKS, LAUREN ROYGARDNER & SAMANTHA ARTIGA, KAISER FAMILY FOUND., MEDICAID AND CHIP ELIGIBILITY, ENROLLMENT, AND COST SHARING POLICIES AS OF JANUARY 2019: FINDINGS FROM A 50-STATE SURVEY 73-75 (2019), https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2019-findings-from-a-50-state-survey/ [https://perma.cc/F6Z2-5T9X].

[207] *See 2020 Medicare Parts A and B Premiums and Deductibles*, *supra* note 204 ("The standard monthly premium for Medicare Part B enrollees will be $144.60 for 2020, an increase of $9.10 from $135.50 in 2019.").

a figure that combines the deductible, copayments, and coinsurance requirements of a plan into a single number that can be compared with those of other plans — is somewhat lower than for private insurance plans. As with monthly premiums, some states have begun imposing cost-sharing on Medicaid enrollees in recent years as well.[208]

Premiums and cost-sharing vary widely for privatized public health insurance. Currently, some MA and MMC enrollees pay monthly premiums and others do not. As explained above, for MA plans whose bid exceeds the threshold, the difference is charged to enrollees in the form of monthly premiums. Some MMC plans charge a nominal monthly premium pursuant to the administrative waiver that also governs the state's traditional Medicaid coverage. MA plans are given wide latitude to impose cost-sharing on enrollees, though MA copayments and coinsurance rates often compare favorably to the high out of pocket costs imposed on traditional Medicare enrollees. MMC plans are generally subject to the same limits on cost-sharing that apply to traditional Medicaid, with a strong presumption against it, subject to exceptions permitted for nominal user fees pursuant to pilot programs.[209] States have imposed cost-sharing requirements in their CHIP programs, generally on a means-tested basis, similar to the sliding scale the ACA mandated for private plans purchased on the state-level exchanges.[210]

Premiums and cost-sharing for expanded privatized public coverage could be governed by the bidding process (as currently is the case for Medicare Advantage), or by statute and regulation. The current, bid-based system for determining premiums for Medicare Advantage plans stands in contrast to the sliding scale that the ACA introduced for people living in households earning between 100% and 400% of the

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208 BROOKS ET AL., *supra* note 206, at 22.

209 For example, Illinois's model contract states that the MMC "Contractor may charge copayments to Enrollees, but in no instance may the copayment for a type of service exceed the Department's [traditional fee-for-service Medicaid] copayment policy then in effect." ILL. DEP'T OF HEALTHCARE & FAMILY SERVS., STATE OF ILLINOIS CONTRACT BETWEEN THE DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES AND [MODEL CONTRACT] FOR FURNISHING HEALTH SERVICES BY A MANAGED CARE ORGANIZATION § 7.8 (Jan. 24, 2018), https://www.illinois.gov/hfs/SiteCollectionDocuments/2018MODELCONTRACTadministrationcopy.pdf [https://perma.cc/DU9Z-6JK2].

210 For example, Virginia's model contract states that cost sharing in its CHIP program is "limited to 2.5% of gross income for families with incomes below 150% of the federal poverty level (FPL), and to 5% of income for families with incomes between 150% and 200% of the FPL. Families below 150% of the FPL are responsible for co-payments, which are currently capped at $180 per family per calendar year. Families with incomes between 150% and 200% of the FPL co-payments are capped at $350 per family per year." VA. DEP'T OF MED. ASSISTANCE SERVS., *supra* note 179, § 8.1.A.

federal poverty level who purchase coverage directly on the state-level exchanges. Reformers could seek to introduce more uniformity and equity with regard to out-of-pocket costs — both for premiums and for cost-sharing in the form of deductibles, copayments, and coinsurance.

4. Will Access to Providers Be Limited by Networks?

Coverage does not necessarily guarantee access to the health care providers patients need or prefer to see. Hospitals, physicians, and other providers are generally free to choose not to accept payment from particular payers, whether private insurers or public programs. The adequacy of participating provider networks is thus an important priority for health reformers.

Enrollees in private insurance plans may have difficulty navigating the restrictive networks of providers covered by their plans. This can result in a lack of access to care or surprise medical bills after enrollees inadvertently receive care from out-of-network providers. In-network providers enter into contracts with private health plan sponsors in which they agree to provide care pursuant to pre-determined payment formulas. Coverage for out-of-network services is typically quite limited or nonexistent barring an exception allowed by the private insurer.

Public programs vary in the extent of their provider networks, which are determined by the choice of providers to participate in the program. Medicare participation among physicians, hospitals, and other providers is nearly universal. In contrast, Medicaid enrollees are more likely to have difficulty identifying providers — especially specialists — who are willing to take new patients.[211] The contrast between Medicare and Medicaid is largely driven by the lower reimbursement rates for physicians under Medicaid, though other factors may also play a role.

For privatized public health insurance, MA and MMC plan sponsors create provider networks through contracts, just as they do on the private market. As for private insurance plans, network adequacy is subject to public regulations. The 2016 MMC Rule requires states to establish network adequacy requirements for MMC plans based on time and distance required for a specified threshold of enrollees to access

[211] *See* NAT'L CTR. FOR HEALTH STATISTICS, NCHS HEALTH INSURANCE DATA 2 (2018), https://www.cdc.gov/nchs/data/factsheets/factsheet_health_insurance_and_access_to_care.pdf [https://perma.cc/7KGM-NSHR] ("The majority of physicians reported that they accepted new patients with private insurance (89%), compared with 69% who accepted new patients with Medicaid. . . . [H]igher state Medicaid-to-Medicare fee ratios were correlated with greater acceptance of new Medicaid patients.").

providers.[212] Changes proposed in 2020 would codify the longstanding application of similar time-and-distance standards to MA plans.[213]

Network adequacy provisions in state MMC contracts have varied widely. Some hold MMC plan sponsors to a general standard, promising, for example, to "maintain and monitor a network" of providers "sufficient to provide adequate access" to covered services.[214] In others, plan sponsors agree to secure specific ratios of primary care providers to enrollees.[215] Some impose specific time and distance standards requiring, for example, that the sponsor must ensure that there are at least two in-network providers within a thirty-mile radius or a thirty-minute drive from each enrollee's home, with wider ranges permitted for enrollees living in rural areas.[216] The 2016 rule requires states to satisfy time and distance standards for specific types of providers in their MMC plans.[217]

Reformers who open up privatized public health insurance to all — or more — Americans could govern network adequacy via statute, regulation, or contract. On one hand, guaranteeing enrollees free choice of provider and few limits on benefits may come with diminished opportunities to control costs.[218] On the other hand, exerting the

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[212] 2016 MMC Rule, *supra* note 135, at 27,567.

[213] *See* Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 85 Fed. Reg. 9002, 9006 (Feb. 18, 2020) (to be codified at 42 C.F.R. pt. 417).

[214] VA. DEP'T OF MED. ASSISTANCE SERVS., *supra* note 179, § 5.1.1.

[215] *See, e.g.*, VA. DEP'T OF MED. ASSISTANCE SERVS., *supra* note 179, § 4.6.F ("[A]s a means of measuring accessibility, the Contractor must have at least one (1) full-time equivalent (FTE) PCP, regardless of specialty type, for every 1,500 Medicaid members, at least one (1) full-time equivalent (FTE) pediatric PCP, for every 1,500 FAMIS members, and there must be one (1) FTE PCP with pediatric training and/or experience for every 1,500 members under the age of eighteen (18).").

[216] ILL. DEP'T OF HEALTHCARE & FAMILY SERVS., *supra* note 209, § 5.8.1.1 ("Contractor shall ensure an Enrollee has access to at least two (2) primary care Providers within a thirty (30)-mile radius of or thirty (30)-minute drive from the Enrollee's residence.").

[217] 2016 MMC Rule, *supra* note 135, at 27,658 ("[S]tates must establish time and distance standards for the following network provider types: Primary care (adult and pediatric); OB/GYN; behavioral health; specialist (adult and pediatric); hospital; pharmacy; pediatric dental.").

[218] *Cf.* Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 LAW & CONTEMP. PROBS. 7, 9-10 (2006) (noting "a seemingly well-meant but essentially destructive policy bias — assiduously cultivated by the health care industry and shared by many commentators and policy analysts — in favor of more and better health care for all with only nominal regard for how much it costs or who bears the burden. Because unwillingness to view health care as an economic good accords so

negotiating power of a single-payer to lower prices for health care goods and services could diminish access to high-quality care. Some associations of heath care providers have repeatedly warned that moving to a single-payer system will put hospitals out of business and prompt doctors to opt out of participating in the public program if rates are too low.

5. Will Reimbursement Rates for Health Care Providers Be Sustainable and Equitable?

Progressive health reformers frequently point to the potential for single-payer programs to lower health care costs. One mechanism is the elimination of private insurer profits. But the far more important driver of health care inflation is the prices health care providers demand for goods and services. In a single-payer system, the government could lower prices, or at least control their growth, by exerting its negotiating power. This already happens in public programs. Medicare for hospitals are, on average, about half as much as the rates paid by private insurers pay.[219] Whether it will be possible in a single-payer program built on the Medicare platform remains to be seen, however.[220]

From a health justice perspective, lowering costs is important, but so is equalizing the prices paid by public and private programs. All-payer reimbursement, whereby hospitals are paid uniform rates by Medicare, Medicaid, and private insurers, have been pioneered in Maryland and have equalized costs — and contained them to some degree.[221] Moreover, strategies that approach the single-pipe reimbursement model used in Germany and other countries confront one of the worst impacts of a hands-off approach to privatization. Uniform — or at least more uniform — reimbursement rates result in a more equitable distribution of the benefits of public investments in health care. Dramatically higher reimbursement rates paid by (publicly subsidized,

well with illusions about health care in the public mind, it has been easy for industry and other interests to manipulate people's thinking about health care issues, both as consumers and as voters").

219 Lopez et al, *supra* note 92.

220 Hyman & Silver, supra note 44, at 146 ("Medicare pays substantially less than private payers. But it is one thing to observe that fact and entirely another to suggest that M4A will be able to force lower prices down the throats of providers once it becomes a monopsony purchaser for the entire population.").

221 *See* Nelson Sabatini, Joseph R. Antos, Howard Haft & Donna Kinzer, *Maryland's All-Payer Model — Achievements, Challenges, and Next Steps*, HEALTH AFF. BLOG (Jan. 31, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170131.058550/full/ [https://perma.cc/5KWX-QC9K].

but privately purchased) private insurers relative to traditional (and privatized) public coverage stand in the way of realizing health justice.[222]

Government contracting with privatized public health insurance plans offers a third avenue for government control over reimbursement. Privatized public plans generally offer lower rates than private insurance plans. There is some evidence that this may be because the private companies that offer MA and MMC plans argue convincingly to providers that they simply cannot pay the high rates available under fully private plans because the capitated payments they receive from CMS and state agencies make them infeasible for privatized public plans.[223]

Washington is taking rate control a big step further in its privatized public option program, known as Cascade Care.[224] Legislation signed into law in 2019 directs the Washington State Health Care Authority ("WSHCA") to contract with private health insurance carriers to offer plans that meet criteria specified by statute.[225] Most of these criteria are applicable to all qualified health plans offered on the state's health insurance exchange. The statute adds new criteria applicable only to public option plans, however, including a cap on reimbursement rates for health-care providers and facilities. The initial version of the bill would have taken a hard line, directing the Washington State Health Care Authority to ensure that the privatized public option plans' reimbursement rates may not exceed the rates paid by Medicare.[226] Eventually, this provision was revised to allow for a cap of 160% of

[222] *See* Wiley et al., *supra* note 1 (discussing fiscal fragmentation as a fixture that progressive reforms must confront); Fuse Brown et al., *supra* note 38, at fig. 2 (designating privately administered public option and single-payer reforms as moderately confronting fiscal fragmentation).

[223] *See, e.g.*, Robert A. Berenson, Jonathan H. Sunshine, David Helms, & Emily Lawton, *Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Price*s, 34 HEALTH AFF. 1289 (2016).

[224] *See Cascade Care*, WASH. ST. HEALTH CARE AUTHORITY, https://www.hca.wa.gov/about-hca/cascade-care (last visited Dec. 30, 2020) [https://perma.cc/2U8V-SW46].

[225] Engrossed Substitute S.B. 5526, 66th Leg., 2019 Reg. Sess. (Wash. 2019), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5526-S.SL.pdf [https://perma.cc/2DTE-6BTC].

[226] S.B. 5526, 66th Leg., 2019 Reg. Sess. § 3(1)(d) (Wash. 2019) ("[F]ee-for-service rates for providers and facilities may not exceed the [M]edicare rates for the same or similar covered services in the same or similar geographic area. For reimbursement methodologies other than fee-for-service, the aggregate amount the qualified health plan pays to providers and facilities may not exceed the equivalent of the aggregate amount the qualified health plan would have reimbursed providers and facilities using fee-for-service [M]edicare rates.").

Medicare reimbursement rates[227] — higher than Medicare and Medicaid rates, but substantially lower than the rates typically paid by privately purchased insurance.[228] In Colorado, the Department of Health Care Policy and Financing and Department of Regulatory Agencies submitted a proposal to the state legislature that would have required a base reimbursement rate for public option plans of 155% of Medicare rates, subject to significant increases for independent and critical access hospitals,[229] as well as those that treat a high share of Medicaid and Medicare patients and for efforts to manage underlying costs of care.[230]

The WSHCA solicited public comment on the procurement criteria for Cascade Care, including criteria relating to reimbursement and the statutory cap that ties rates to Medicare reimbursement rates.[231] The resulting Request for Applications soliciting applications from private health insurance carriers interested in providing public option plans specified that plans must "address affordability" through the 160% reimbursement ceiling for providers and facilities.[232] But it also included floors on reimbursement to critical access hospitals and sole community hospitals (of no less than 101% of Medicare's allowable costs) and for primary care services (of no less than 135% of Medicare rates).[233] These

[227] Wash. Engrossed Substitute S.B. 5526 § 3(2)(g)(i) ("The total amount the qualified health plan reimburses providers and facilities for all covered benefits in the statewide aggregate, excluding pharmacy benefits, may not exceed one hundred sixty percent of the total amount [M]edicare would have reimburse[d] providers and facilities for the same or similar services in the statewide aggregate.").

[228] *See* Lopez, *supra* note 92.

[229] "Critical access hospital" is a designation conferred on eligible rural hospitals by the Centers for Medicare and Medicaid Services, pursuant to a Medicare reform provision enacted in response to rural hospital closures. *Critical Access Hospitals (CAHs)*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/topics/critical-access-hospitals (last visited Dec. 30, 2020) [https://perma.cc/3UCG-JY47].

[230] COLO. DEP'T OF HEALTH CARE POLICY & FIN., HOSPITAL REIMBURSEMENT UNDER THE COLORADO HEALTH INSURANCE OPTION RECOMMENDATION (2020), https://www.colorado.gov/pacific/sites/default/files/Colorado%27s%20Health%20Insurance%20Option%20Hospital%20Reimbursement%20One%20Pager.pdf [https://perma.cc/Z78Q-W8DM]; *see* COLO. DEP'T OF HEALTH CARE POLICY & FIN., EXPECTED HOSPITAL-SPECIFIC REIMBURSEMENT RATES UNDER COLORADO AFFORDABLE HEALTH CARE OPTION (2020), https://drive.google.com/file/d/1reV18qe6KQo0WrJ--nZ2cgaqqIVE2JDP/view [https://perma.cc/P7QA-6Y3W].

[231] *See* MILLIMAN, CASCADE CARE MEDICAID PRICING METHODOLOGY – DRAFT, at 1 (2019), https://www.hca.wa.gov/assets/program/draft-medicare-methodology-report-20191212.pdf [https://perma.cc/52UZ-YJQL].

[232] WASH. STATE HEALTH CARE AUTH., REQUEST FOR APPLICATIONS RFA NO. 2020HCA1, at 18, https://www.hca.wa.gov/assets/program/RFA%202020HCA1-Cascade%20Care%20Public%20Option%20Plans_0.pdf (last visited Jan. 5, 2021) [https://perma.cc/LX9E-57B6].

[233] *Id.*

provisions appear to be intended to ensure network adequacy, while taking a big step toward equalizing rates between public and private coverage. Acknowledging the concern that imposing rate controls on provider reimbursements may result in inadequate networks of participating providers, the drafters of the public option legislation contemplated *mandating* participation in privatized public insurance networks,[234] presumably as a condition of state licensure. Ultimately, they left this intervention on the table for consideration at a later date.

CONCLUSION: FOSTERING COLLECTIVE PROBLEM-SOLVING FOR COLLECTIVE PROBLEMS

This Article argues that progressive health reform does not necessarily require elimination of private insurers. Lawmakers and government officials may exercise their primary responsibility for securing the public's interest in universal health care coverage and fair distribution of the benefits and burdens of public investments in health care while delegating significant administrative responsibilities to private contractors.

What makes public health insurance programs *public* is not the day-to-day administration of benefits by government employees — even traditional Medicare benefits are largely administered by private contractors. What makes public health insurance programs public is the sense of solidarity built through collective determinations regarding the basic questions of how benefits and burdens will be fairly distributed in a mutual aid program. Growing regulation of private health insurance has raised awareness of the trade-offs and values-choices involved in health care financing. Government contracts with public-option plans — and perhaps eventually a single-payer system whereby all Americans are offered a choice of publicly-financed, but privately-administered health plans — may be a productive path for building on the growing commitment to solidarity in American health care financing.

Reliance on private markets to determine the distribution of health care goods and services has allowed American voters to side-step public deliberations on difficult decisions regarding which people and which

234 Sarah Kliff, *The Lessons of Washington State's Watered Down "Public Option,"* N.Y. TIMES (June 27, 2019), https://www.nytimes.com/2019/06/27/upshot/washington-state-weakened-public-option-.html [https://perma.cc/4KNR-YXXH] ("Hospitals and doctors will also get to decide whether to participate in the new plan, which pays lower prices than private competitors. The state decided to make participation voluntary, although state officials say they will consider revisiting that if they're unable to build a strong network of health care providers.").

conditions trigger collective responsibility for health and wellbeing.[235] As efforts in Washington and Colorado to implement an innovative public option demonstrate, the process of government contracting to create privatized public health insurance plans may promote more collective deliberation on matters of plan design, including the critical question of reimbursement rates for health care providers. Rather than "marginaliz[ing] public participation in the administrative process," and "sidelin[ing] . . . civil society," as privatization efforts often do,[236] the Washington and Colorado public option reforms have created new opportunities for civil servants and the general public to debate the critical choices — about what health care coverage should do and how it should do it — laid out in this Article.

Unsustainable health care costs are a matter of public concern — a collective problem that warrants collective problem-solving. Traditional public programs have historically accommodated the demands of health care providers for ever-higher reimbursement rates.[237] Recent reforms incorporating managed care practices into traditional programs show promise for controlling costs. Progressive reformers should hesitate before abandoning these gains. Moreover, government contracting may afford health officials more leverage to cap reimbursement rates than regulation of private health insurance, as illustrated by Washington's experiment with a cap on reimbursement rates in its privatized public option plans. Direct regulation of health care prices has been notoriously difficult in the United States. In this sense, the Washington public option is a true breakthrough. Although capping rates at more than 1.5 times Medicare rates still falls well short of implementing single-pipe reimbursement, privatized public coverage could be a key stepping stone toward equalizing reimbursement rates between private insurance and public coverage. This may be a rare instance in which the "workaround" afforded by privatization allows the legislature, in cooperation with the executive branch, "means of achieving distinct public policy goals that — but for the pretext of technocratic outsourcing — would be impossible or much more difficult to attain in the ordinary course of nonprivatized public administration."[238]

Arguing that private health insurance companies, the longstanding villains of progressive health reforms, may have a legitimate role to play

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[235] *Cf.* Bloche, *supra* note 40, at 302 ("Health law should take a dim view of contractual efforts to submerge hard substantive choices in euphemism.").

[236] MICHAELS, *supra* note 35, at 131, 219.

[237] *See* STARR, *supra* note 19, at 375 (describing "the politics of accommodation" in the development of traditional fee-for-service Medicare).

[238] Michaels, *supra* note 2, at 719.

in public-option and single-payer programs is a very tough sell. The key is open and deliberative public administration of the *design* of public option plans according to the principles set forth in this Article. First, reforms must promote universal health care coverage — at least in the sense of everyone being covered, if not in the sense that their coverage must be uniform. Second, reforms should ensure a more just distribution of the burdens and benefits of public investments in health care. By agreeing to public, rather than private contracts, health insurance companies may "increasingly commit themselves to traditionally public goals as the price of access to lucrative opportunities to deliver goods and services that might otherwise be provided directly by the state."[239] Indeed, private insurer participation in the Medicare Advantage and Medicaid Managed Care markets has exploded in recent years, even as the obligations imposed on those plans by legislatures and regulators have expanded.[240] The desire of private companies to continue to play a role in public-option and single-payer programs that appear to be on the legislative horizon (at the state level if not yet at the federal level) is undoubtedly a strategic reason for their increasing participation in these markets.

Contracting with private health plans also gives health officials greater flexibility than traditional public health insurance, on the one hand, or government regulation of private insurance, on the other. The flexibility offered by government contracting has advantages and disadvantages. It allows officials to experiment with new approaches and respond more swiftly to regulatory arbitrage by health care providers and changes in the health care marketplace, most notably by increasing vertical and horizontal integration. But it also allows executive-branch officials to scale back coverage in response to economic strain or political disfavor, to the detriment of enrollees who lack the legal entitlements that come with traditional coverage.

With this concern in mind, legislators seeking to expand access to privatized public health insurance as an alternative to universal public insurance can and should guarantee the rights of enrollees to enforce the obligations undertaken by both private insurers and the government — via contract as third party beneficiaries or pursuant to an administrative process. Private enforcement of contractual agreements between the state and private insurers has considerable potential to

[239] Jody Freeman, *Extending Public Law Norms through Privatization*, 116 HARV. L. REV. 1285, 1285 (2003).

[240] Shelby Livingston, *Health Insurers Migrating to Medicare, Medicaid*, MODERN HEALTHCARE (March 30, 2019), https://www.modernhealthcare.com/insurance/health-insurers-migrating-medicare-medicaid [https://perma.cc/3T8Z-75MP].

increase public accountability and collective engagement in ensuring that privatized public coverage truly reflects a mutual aid approach to health care financing. In addition to securing "accountability as redress,"[241] litigation by private parties and adjudication of their claims by courts are among the "procedures . . . that allow [communities] to work out personal decisions and public policies in the face of conflicting values."[242] One "way to work out the balance between autonomy and the common good as it applies to specific matters [including health care financing reform] is to leave these issues to courts . . . ."[243]

In closing, it is essential to comment on the likely impact of the events of 2020 on the coming decade of health reforms. The coronavirus pandemic has already affected implementation of state-level public option reforms. In Washington, average premiums for the fifteen public option plans offered during the fall 2020 open enrollment period were higher than average premiums for ordinary exchange plans offered the previous year.[244] The CEO of one public option plan sponsor, Community Health Network of Washington, noted that the plans her company offered featured lower premiums than comparable plans in seven counties, in part because it was able to leverage a primary care network based on lower-cost community health centers.[245] She noted the difficulty, however, of negotiating for lower rates with hospitals in the midst of a pandemic in which their revenues have been hard hit by restrictions on and reduced demand for elective services.[246] Meanwhile, Colorado lawmakers set aside legislation to implement their public option plan.[247] The legislation, which would have empowered the state insurance commissioner to develop the requirements applicable to public option plans while also requiring health insurance companies to

241 Laura Dickinson, Privatization and *Accountability*, 7 ANN. REV. L. & SOC. SCI. 101, 102 (2011).

242 AMITAI ETZIONI, *Communitarian Bioethics*, *in* HAPPINESS IS THE WRONG METRIC: A LIBERAL COMMUNITARIAN RESPONSE TO POPULISM 297 (2018).

243 *Id.*

244 Sara Hansard, *Public Option Experiment Hits Speed Bump as Premiums Don't Fall*, BLOOMBERG L. (Aug. 10, 2020, 2:30 AM), https://news.bloomberglaw.com/health-law-and-business/public-option-experiment-hits-speed-bump-as-premiums-dont-fall [https://perma.cc/X9QC-ZC3A].

245 *Id.* (quoting Leanne Berge, CEO of Community Health Network of Washington).

246 *Id.*

247 Donovan et al., *supra* note 53 (explaining that pandemic disruptions prompted legislators to set the legislation aside); *see also* Kelsey Waddill, *CO Public Option Bill Paused, Unemployment Rises Due to COVID-19*, HEALTH PAYER INTELLIGENCE (May 6, 2020), https://healthpayerintelligence.com/news/co-public-option-bill-paused-unemployment-rises-due-to-covid-19 [https://perma.cc/7NU2-YS9V].

offer a public option plan alongside their ordinary exchange plans, was strongly opposed by private insurers in the state.[248] In the midst of the pandemic, they argued their ability to negotiate with providers and facilities for Medicare-based rates was further compromised.[249] The bill's sponsors also noted that the pandemic disrupted their ability to ensure public hearings and engagement on implementation questions.[250]

In addition, growing awareness among non-Black people of the impact that anti-Black racism has had on American law, society, and health care is increasing the urgency of demands for progressive reforms that confront the core fixtures of federalism, individualism, fiscal fragmentation, and privatization.[251] These fixtures are rooted in, and they perpetuate, structural racism. Indeed, "[r]acism is a key historical reason the U.S. has a predominantly private health care system rather than a national, universal health system."[252] These fixtures must be confronted, but incremental confrontation is a more realistic path forward than ripping them out by the roots.[253] Privatized public coverage, particularly when pioneered at the state level, may confront individualism (by promoting the design of an insurance plan as a task in which public-minded citizens should have a hand) and fiscal fragmentation (by equalizing private-insurer and public-program reimbursement rates) to some extent, but it leaves federalism and privatization intact.

The long-term impacts of the pandemic, *California v. Texas*, increasing attention to racial justice, and the 2020 election on increasingly dynamic health reform debates at the state and federal levels remain to be seen. On the one hand, the failures of our high-cost, fragmented, heavily privatized, and structurally racist health care system have been cast in a stark light by the failure to ensure widespread and equitable access to testing, vaccination, and treatment for COVID-19. On the other hand, health care providers are struggling to cope with the financial fallout of disruptions to elective care and state budgets

248 *See* Waddill, *supra* note 247 ("The Colorado Association of Health Plans consistently decried the bill.").

249 *See id.* ("Amanda Massey, executive director of the Colorado Association of Health Plans, said . . . the bill gives the commissioner too much authority.").

250 *See id.*

251 Wiley et al., *supra* note 1 (manuscript at 3-7); *see also* W. MICHAEL BYRD & LINDA A. CLAYTON, AN AMERICAN HEALTH DILEMMA: RACE, MEDICINE, AND HEALTH CARE IN THE UNITED STATES 1900-2000, at 9-18 (2002); DAVID BARTON SMITH, HEALTH CARE DIVIDED — RACE AND HEALING A NATION 9-18 (1999).

252 Wiley, et al., *supra* note 1, manuscript at 49.

253 *Id.*

have also taken a hard hit. Privatized public option proposals may offer an appealing compromise if expanding traditional coverage is seen as less feasible from a fiscal standpoint. But even these modest proposals, and the modest extent to which they would deliver on progressive reformer's bolder goals for twenty-first century reform, face an uphill political battle. Compromising on privatized public coverage that takes a hands-off approach to public oversight[254] and hides deliberation of complex trade-offs from public view could be tempting. Clear articulation of communitarian criteria for assessing public-private partnerships — (1) mechanisms that foster collective deliberation and problem-solving to ensure (2) just distribution of the health benefits and (3) the financial burdens of public investments in health care — will provide much-needed clarity about what is at stake in the debates that lie ahead.

[254] *See* Dickinson, *supra* note 229, at 102 (discussing "accountability as managerial oversight" as "a measure of . . . respect for public values").