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PRIVATE HEALTH INSURANCE IN THE UNITED STATES: A PROPOSAL FOR A MORE FUNCTIONAL SYSTEM

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I. INTRODUCTION

The American health care system may appear at first glance as though it provides health care to most U.S. residents. Our primary means of accessing health care, through private, employment-based health insurance, covers over 60% of the population.¹ We have public health insurance for categories of individuals who are less likely to have access to private health insurance: the indigent, low-income children, the disabled, and the elderly, among others. We also provide health care to our soldiers and veterans, and their families. The presence of a robust regulatory system suggests that health care providers and institutions are held to high standards of care in both treating patients and dealing with financial matters. Additionally, the technology and expertise available through the U.S. health care system is the envy of the world. It would seem that such a system could do a reasonable and efficient job covering most, if not all, U.S. residents, and providing them with good care.

The system does work relatively well for some groups. Those Americans with generous private health coverage and stable jobs have been, for the most part, content with the status quo. Additionally, certain sectors of the health care economy are extraordinarily lucrative. In 2002, for example, the top ten pharmaceutical companies posted profits of 17%, as compared to 3.1% for other Fortune 500 companies that year.² One recent study found that the top fifty health maintenance organizations (HMOs) saw their profits rise by 88% between 2000 and 2003.³

In a system in which people were paramount, rather than profits or the pure pursuit of science and technology, access to both coverage and decent health care would be universal. In our system, however, they are not. Medicine in the United States largely does not attend to the health of everyone, but rather only to those who have the means to present themselves for treatment.⁴ Population health is contingent on many factors: individual wealth, environmental health, access to clean water and adequate sewage disposal, universally adequate education, and universal access to adequate

¹ See *infra* note 25 and accompanying text.

² See, e.g., Arnold S. Relman & Marcia Angell, *A Prescription for Controlling Drug Costs; Drug Spending Is Rising at More than Four Times the Rate of Inflation*, NEWSWEEK, Dec. 6, 2004, at 74.

³ *Id.* at 79.

⁴ The United States is one of the few developed Western nations that fails to provide health insurance to most, if not all, of its residents. For further discussion, see *infra* notes 393–394 and accompanying text.

health care.⁵ Because of the diversity of factors involved, we cannot solve the nation's health care problems merely by improving access to health care. However, extension of universal access can indeed improve population health, in particular by providing primary and preventive care, so that medical issues are spotted and treated early or headed off before they have a chance to start.⁶

In 2004, the U.S. Census Bureau estimated that 45.8 million Americans, or 15.7% of the population, lacked health insurance coverage.⁷ Almost double that amount—almost one third of the U.S. population—lacked health insurance coverage for some period of time between 2001 and 2002.⁸ These numbers do not include the millions more who have limited and inadequate access to health care, due to issues involving coverage type, ability to pay, and limited access to providers due to geographical issues or problems with mobility. Note the distinction here between “access to care” and “access to coverage.” Access to care concerns one's ability to obtain various necessary health care services. Access to coverage concerns one's source, or lack thereof, for third-party reimbursement of costs for health care services. Without access to coverage, one's access to health care in this country is usually significantly limited.⁹ In this article, I will focus primarily on the narrower issue of access to coverage.

A system in which nearly one-third of the population lacked health coverage for at least one month over a year's period¹⁰ is not functioning properly. This would not be so problematic if lacking coverage statistically had little effect on one's health. But, alas, those who lack coverage, even for limited periods of time, tend to be in

⁵ See, e.g., S. V. Subramanian & Ichiro Kawachi, *Whose Health Is Affected by Income Inequality? A Multilevel Interaction Analysis of Contemporaneous and Lagged Effects of State Income Inequality on Individual Self-Rated Health in the United States*, 12 HEALTH PLACE 141, 154 (2006).

⁶ Universal access correlates, at least, with better national performance on a variety of measures of population health. See *infra* Section VI.C.1.

⁷ CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE IN THE UNITED STATES: 2004, 16 (2005), available at <http://www.census.gov/prod/2005pubs/p60-229.pdf> (last visited Feb. 9, 2006).

⁸ KATHLEEN STOLL ET AL., FAMILIES USA, GOING WITHOUT HEALTH INSURANCE: NEARLY ONE IN THREE NON-ELDERLY AMERICANS 12 (Mar. 2003), available at http://www.familiesusa.org/assets/pdfs/Going_without_report3b26.pdf (last visited Feb. 28, 2006).

⁹ While a number of public programs exist, most contain stringent eligibility requirements, usually based on income and assets, as well as age, family and/or disability status, along with residency. The Medicaid program is one such example. Some of the baseline individual eligibility requirements for Medicaid can be found at 42 U.S.C.A. § 1396a(a)(10)(A)(i) (West 2005).

¹⁰ See STOLL ET AL., *supra* note 8, at 12.

worse health and have worse care than those whose coverage is continuous.¹¹ Lack of insurance also adversely affects our population health and economic productivity.¹² Finally, it suggests that our society, whatever lofty ideals we might hold, may possess a limited sense of genuine community and cohesiveness.¹³

The Bush administration has proposed solutions to the problems of high numbers of uninsured and rising health care costs.¹⁴ If the administration is successful in its goals, then in the not-so-distant future, public health programs that currently provide for certain low-income groups may be scaled back significantly.¹⁵ In their place would be a refundable tax credit or fixed sum of money, to provide funds for low to low/middle-income groups in order to pay for private health insurance.¹⁶ Meanwhile, an increasing number of Americans would no longer access their private health insurance coverage through their employment. Rather, they would pay for their individual, high-deductible health insurance policies out of pocket.¹⁷ For those who can save, a tax-advantaged health savings account would help pay for uncovered medical expenses.¹⁸

Is the Bush administration's plan likely to succeed in expanding coverage while reining in costs? While there are ways by which private coverage could be expanded, it appears unlikely that private market reforms alone can solve the problems of lack of insurance and rising health care costs. Even if federal law mandated all U.S. residents to obtain and maintain health insurance or otherwise pay on their own for their own health costs under the present system (in conjunction, perhaps, with some public expansions),

¹¹ See *infra* notes 419–424 and accompanying text; INST. OF MED., COVERAGE MATTERS: INSURANCE AND HEALTH CARE (2001), available at <http://darwin.nap.edu/books/0309076099/html/> (last visited Jan. 31, 2006) [hereinafter COVERAGE MATTERS].

¹² JACK HADLEY, HENRY J. KAISER FAM. FOUND., SICKER AND POORER: THE CONSEQUENCES OF BEING UNINSURED 82–86 (2002); COVERAGE MATTERS, *supra* note 11. The United States trails most other developed nations in leading population health indicators such as neonatal mortality and average lifespan. See *infra* Section VI.C.1.

¹³ Daniel Callahan, *It's the Culture, Stupid—Lack of Solidarity Is Responsible for U.S. Failure to Provide Universal Health Care*, COMMONWEAL, Feb. 11, 2000, available at http://findarticles.com/p/articles/mi_m1252/15_2000_Feb_11/ai_59948865/prmt (last visited Jan. 31, 2006).

¹⁴ See, e.g., *infra* notes 300–305, 331–333, and accompanying text.

¹⁵ For one example of a framework—here, a defined contribution plan—praised by some in the administration, see Robert Pear, *U.S. Gives Florida a Sweeping Right to Curb Medicaid*, N.Y. TIMES, Oct. 20, 2005, at A1.

¹⁶ See *infra* notes 331–333 and accompanying text.

¹⁷ See *infra* notes 300–305, 356, and accompanying text.

¹⁸ See *infra* notes 300–305 and accompanying text.

studies indicate that health costs would remain inadequately controlled, and significant inefficiencies would remain.¹⁹ On the contrary, in order to both contain costs and expand coverage with the end of improving the overall health of our population, some degree of universal, public coverage will be necessary.

This article contains three parts. The first provides a history and overview of the private health care system in the United States, through which most Americans obtain their coverage. The second discusses who provides and obtains private health insurance in the United States, the types of private coverage most commonly available and the benefits provided, the legal framework within which private health insurance functions at the federal level, and analyzes legal and policy-related problems with private health insurance coverage and proposals put forth by the Bush administration and others for change. The third part offers suggestions for revising our health care system to provide greater, more consistent, more cost effective coverage for everyone through the institution of universal primary care coverage, and select public expansions to cover catastrophic and specialist care.

II. THE DEVELOPMENT OF EMPLOYMENT-BASED COVERAGE

Private health insurance obtained through one's employer may seem an inexorable fact of life in the United States today. Yet private health insurance came into being in this country only in the last century.²⁰ Moreover, health insurance costs can be covered in many ways other than employer-sponsored private health insurance. Insurance can be provided through the government, whether publicly through a single-payer system (i.e., where a public body provides the sole means of health care reimbursement), or through other means such as government-sponsored health insurance purchasing cooperatives. It can also be provided privately in other forms, such

¹⁹ See, e.g., William C. Hsiao, *Medical Savings Accounts: Lessons from Singapore*, HEALTH AFF., Summer 1995, at 260, 264–65 (discussing the failure of the private market to hold down costs where Singapore mandated that all residents save and pay directly for their own health care); see also JONATHAN GRUBER, NAT'L BUREAU ECON. RES., TAX POLICY FOR HEALTH INSURANCE 4 (Dec. 2004) (discussing the differences in efficiencies and efficacy of a public health insurance expansion versus expansion via the private market through forms of tax credits); Steffie Woolhandler et al., *Costs of Health Care Administration in the United States and Canada*, 349 NEW ENG. J. MED. 768 (2003) (finding that health care administration costs accounted for 31.0% of health care expenses in the United States, as compared to 16.7% in Canada, where Canada has a single payer system).

²⁰ See Thomas Bodenheimer & Kevin Grumbach, *Paying for Health Care*, 272 JAMA 634, 635–36 (1994).

as through private consumer cooperatives. Each of these possibilities, and others, have been considered or adopted, whether in whole or in part, in this country during the twentieth century.²¹ Some have survived and even flourished, such as employment-based private health insurance.²² Others, such as small consumer cooperatives, failed and have largely disappeared.²³ In both of these examples, the system's success or failure had more to do with political exigencies than with technical viability or relative success in delivering reasonable health care,²⁴ as a brief look at the history of private health insurance in this country shows.

A. The Genesis of Health Insurance

In 2004, nearly 174.2 million U.S. workers and their families, or approximately 60% of the U.S. population, received their health insurance through employment.²⁵ Although employment-based health insurance may seem as if it has been ever-present in this country, it came widely into being only about sixty years ago.²⁶ Moreover, less than 100 years ago, health insurance of any kind generally did not exist.²⁷ There was arguably little need for it then. In the 19th century, medicine had just started to evolve into a scientific discipline, and its practitioners earned little and often could do little to help their patients.²⁸ According to at least one account, it was only by 1912 that, for the first time in history, "a random patient with a random disease consulting a doctor chosen at random [stood] a better than 50/50 chance of benefiting from the encounter."²⁹ As physicians began to perform an increasing number of surgeries for a correspondingly increasing number of causes, the prestige of physicians and the hospitals in which the procedures

²¹ See generally PAUL STARR, SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 290-334 (1982).

²² See, e.g., *infra* note 25 and accompanying text.

²³ See, e.g., STARR, *supra* note 21, at 302-05.

²⁴ See generally STARR, *supra* note 21; ALAN DERICKSON, HEALTH SECURITY FOR ALL (2005) (providing a history of the various attempts at implementing universal health care in the United States).

²⁵ PAUL FRONSTIN, EMP. BENEFIT RES. INST., UNINSURED UNCHANGED IN 2004, BUT EMPLOYMENT-BASED HEALTH COVERAGE DECLINED 2 (2005), available at http://www.ebri.org/pdf/EBRI_Notes_10-2005.pdf (last visited Jan. 31, 2006).

²⁶ See *infra* Section I.C.

²⁷ STARR, *supra* note 21, at 241.

²⁸ See *id.* at 54-56, 84.

²⁹ Kenneth R. Wing et al., THE LAW AND AMERICAN HEALTH CARE 4 (1998) (quoting Professor L. Henderson).

were performed increased³⁰—as did the cost of medical care.³¹ With rising costs and rising health care utilization, health insurance began to become a viable commodity.

Several means of financing and/or accessing health care began to develop, though many were short-lived or occurred only on a small scale. For example, in the late nineteenth century, some employers in a number of industries began offering medical care to their employees through a physician hired specifically by the business for the task.³² A company physician usually treated workers who had been injured on the job.³³ He might also treat other, usually minor, ailments.³⁴ This benefit, which was quite common through the 1920s, largely died out in many regions of the country during the Great Depression.³⁵ In other areas, as a precursor to the modern-day HMO, some physicians offered general medical care to members of benevolent or fraternal organizations at a capitated rate (for example, \$2 per person per year).³⁶ While this system of providing access to health care became more widespread in certain employment contexts starting in the 1930s on the West Coast (e.g., with respect to the Kaiser system³⁷), it remained a relatively limited phenomenon until the past few decades, for reasons further discussed below.³⁸

In 1929, the first hospital-based health insurance program began, in which a Dallas hospital offered up to twenty-one days of hospital care (in its facility alone) to 1500 Dallas schoolteachers in exchange for a premium (or “prepayment”) of \$6 per year.³⁹ With the advent of the Great Depression, which caused a severe decline in hospital income, similar plans increased in number, because they guaranteed both a revenue stream and business to the hospital offering the insurance plan.⁴⁰ It was during this time that the Ameri-

³⁰ See, e.g., STARR, *supra* note 21, at 156–57.

³¹ From 1960–1965, health care costs rose 8.2% per year, yet from 1965–1975 rose an average of 12.9% per year. See NAT’L CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2005 WITH CHARTBOOK ON TRENDS IN THE HEALTH OF AMERICANS 362 (2005).

³² See, e.g., STARR, *supra* note 21, at 200–01.

³³ See *id.* at 203.

³⁴ *Id.*

³⁵ See *id.* at 203–04.

³⁶ *Id.* at 206–07.

³⁷ STARR, *supra* note 21, at 321.

³⁸ See *id.* at 302.

³⁹ See Bodenheimer & Grumbach, *supra* note 20, at 635.

⁴⁰ See *id.* at 635–36.

can Hospital Association established the Blue Cross system.⁴¹ Under this health insurance plan, an insured individual, in exchange for a premium, could choose from among any participating hospital for care.⁴² The Blue Shield plans, initiated by physician's associations to cover physician and other non-hospital-related medical expenses, followed several years thereafter.⁴³

B. The Theory Behind Health Insurance

Before continuing, a brief note about how health insurance works is in order. Health insurance such as Blue Cross functions by spreading risk across a wide range of individuals, some of whom need care in any given year and some of whom do not. While the risk that any one individual will need substantial health care in any given year may be fairly small⁴⁴, the financial consequences in the event that health care is necessary can be great. Even the healthiest individual can have an accident, or be unexpectedly diagnosed with an illness that is expensive to treat. Thus, even an individual who normally would require little if any care could be caught having to pay tens or even hundreds of thousands of dollars if the unexpected occurs.⁴⁵ This being said, the odds favor the prospect that a healthy person who has previously needed little health care and has no new risk factors (other than his inexorably increasing age) will continue to be relatively healthy.⁴⁶

An insurer banks on those sorts of odds. By offering insurance to a large number of individuals, it can take advantage of the likelihood that many insured individuals will pay more in health insurance premiums than they will require in health care costs.⁴⁷ The insurer then applies some of the excess to cover the health care costs of individuals whose costs exceed the amount of their insurance premiums.

But what if those odds don't pan out? What if the insurer insures a group of individuals who are more unhealthy than not? If

⁴¹ See *id.* at 635.

⁴² See *id.*

⁴³ See *id.* at 635–36.

⁴⁴ See, e.g., DAVID M. CUTLER & RICHARD J. ZECKHAUSER, NAT'L BUREAU ECON. RES., THE ANATOMY OF HEALTH INSURANCE 9 (1999), available at www.nber.org/papers/w7176 (last visited Jan. 31, 2006).

⁴⁵ See, e.g., *id.*

⁴⁶ This is the principle behind risk adjustment, in which insurers charge different amounts to customers based on their medical history. See, e.g., *id.* at 61–62.

⁴⁷ See *id.* at 65.

the insurer significantly misjudges the medical needs of its policyholders, it may find itself out of money or even out of business. Thus, prior to offering insurance, it looks at the relative health risks each individual faces based on her medical history and present risk factors (such as age, tobacco use, family medical history, etc.).⁴⁸ Using this information, it adjusts the price of the health care policy it offers to the individual, or the group with which she is associated, to account for the relative risk involved.⁴⁹ If the insured individual falls into a relatively risk-free group, her premium will likely be lower than if she were in a higher-risk group.⁵⁰

There are different ways of assigning subscribers to risk groups. The Blue plans, as non-profit entities, were required to use “community rating” in assigning their subscribers to a risk pool.⁵¹ The “community rating” system uses the locality in which subscribers live as a risk pool.⁵² Under a community rating system, all health insurance subscribers in a given area pay the same premium, regardless of their health status.⁵³ Thus, a young, healthy individual in Anytown pays the same premium to a health insurer using community rating as does an elderly individual in the same locality with liver cancer and poorly-controlled diabetes.

A relatively young and healthy individual in a plan using community rating may pay more for her health care premium than would the same individual in a plan using “experience rating.”⁵⁴ Experience rating is the other major form of risk pool assignment. It ties one’s premium to the health care experience, or use, of either oneself (in the case of individual coverage) or of one’s group (in the case of group coverage). If one or one’s group has had little need to use health care in the past, then one’s premiums are correspondingly lower.⁵⁵ Under an experience rating system, if the members of Risk Group A are all young and healthy and rarely use health care, then Risk Group A’s premiums will be less than those of Risk

⁴⁸ *Id.* at 60.

⁴⁹ Of course, an insurer may also simply refuse to insure an individual, if it deems the individual to pose too high a risk. Both state and recent federal legislation prohibit insurers from denying coverage to certain individuals. See *infra* notes 252–254 and accompanying text.

⁵⁰ CUTLER & ZECKHAUSER, *supra* note 44, at 61.

⁵¹ See, e.g., STARR, *supra* note 21, at 329.

⁵² Bodenheimer & Grumbach, *supra* note 20, at 636.

⁵³ *Id.*

⁵⁴ STARR, *supra* note 21, at 329–30.

⁵⁵ *Id.*

Group B, which has a number of older members and members with health problems.

C. Employment and Health Insurance Become Linked

When the Blues came into existence, most coverage was individual-based rather than group- or employment-based.⁵⁶ The present state of affairs, in which most private health coverage is provided through employment, is largely a historical accident.⁵⁷ Generally speaking, prior to the 1940s, only a handful of employers offered their employees health insurance or other health benefits as a term of employment.⁵⁸ During World War II, the government enacted wage controls to prevent escalation during the tight labor market.⁵⁹ As a result, competing firms, who could not offer higher wages to attract employees, began more widely providing benefit packages, including the newly minted Blue Cross/Blue Shield-style health insurance, to entice workers.⁶⁰ The practice quickly caught on and became widespread.⁶¹ It was further supported by the American Medical Association (AMA), which had decided that private health insurance was better than the alternative being debated at the time, national public health insurance.⁶²

This accidental result of wartime wage controls was codified in 1954, when the federal government changed the tax code to allow an employer's contributions to an employee's health insurance coverage to be excluded from the employee's taxable income.⁶³ Such benefits were untaxed to either the employer or employee and also were legally a proper subject of collective bargaining which promoted health benefits' ties with employment and led to a boom in employment-based health insurance.⁶⁴ While only approximately

⁵⁶ *Id.* at 240–43.

⁵⁷ See, e.g., Bodenheimer & Grumbach, *supra* note 20, at 636; STARR, *supra* note 21, at 311.

⁵⁸ STARR, *supra* note 21, at 311.

⁵⁹ Bodenheimer & Grumbach, *supra* note 20, at 636.

⁶⁰ STARR, *supra* note 21, at 311.

⁶¹ Bodenheimer & Grumbach, *supra* note 20, at 636.

⁶² See generally STARR, *supra* note 21, at 280–89.

⁶³ See John G. Day, *Managed Care and the Medical Profession: Old Issues and Old Tensions—The Building Blocks of Tomorrow's Health Care Delivery and Financing System*, 3 CONN. INS. L.J. 1, 15 n. 50 (1996–97).

⁶⁴ *Id.*; see *Inland Steel Co. v. NLRB*, 170 F.2d 247 (7th Cir. 1948), *cert. denied*, 336 U.S. 960 (1949); Bodenheimer & Grumbach, *supra* note 20, at 636–38. The federal government's subsidization of this system is enormous, totaling an estimated \$188.5 billion in 2004. See *infra* note 116 and accompanying text. It is also highly regressive: the entire premium cost is exempt from one's taxable income, and thus, as the cost of the premium declines or as one's in-

12 million people were enrolled in group hospital insurance plans in 1940, that number had increased to 101 million by 1955.⁶⁵

With the rise in employer-based coverage in the 1950s came a surge in the numbers of companies offering health insurance.⁶⁶ Because these for-profit companies used experience rating in their underwriting, they were able to snap up healthier groups by offering lower premiums to those groups than could the Blues, which used community rating.⁶⁷ This left less-healthy individuals to the Blues, whose premiums increased accordingly in order to keep the companies solvent, given the greater health care needs of their subscribers.⁶⁸ Ultimately, most of the Blues had to abandon their non-profit status and adopt experience rating in order to remain competitive.⁶⁹ This phenomenon—adverse selection—is a frequent problem, and today threatens other areas of the health insurance market.⁷⁰

This change left those in poor health with decreasing options for health insurance coverage.⁷¹ Presently, in those few states in which Blue Cross/Blue Shield plans remain not-for-profit and use community rating, the Blues are required to offer health insurance to all comers, regardless of their health status.⁷² In most other states, insurers are required to contribute to a “high risk pool” which must accept all comers at premiums that may not exceed 150% of market rate.⁷³ These options, however, are very expensive, putting them

come is taxed at lower rates, the value of the benefit correspondingly declines in relation to wealthier individuals. See, e.g., John Sheils & Randall Haught, *Cost of Tax-Exempt Health Benefits in 2004*, HEALTH AFF. — WEB EXCLUSIVE, Feb. 25, 2004, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.106v1/DC1> (last visited Jan. 31, 2006); Mark Pauly et al., *Individual Versus Job-Based Health Insurance: Weighing the Pros and Cons*, HEALTH AFF., Nov.–Dec. 1999, at 28, 32.

⁶⁵ Bodenheimer & Grumbach, *supra* note 20, at 636.

⁶⁶ *Id.*

⁶⁷ STARR, *supra* note 21, at 327–28.

⁶⁸ See Bodenheimer & Grumbach, *supra* note 20, at 636–37.

⁶⁹ See STARR, *supra* note 21, at 330. See also John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 316–17 (1997).

⁷⁰ Health savings accounts used in conjunction with high deductible health plans are one such area. See *infra* section IV.

⁷¹ Bodenheimer & Grumbach, *supra* note 20, at 637.

⁷² See Randall R. Bovbjerg & William G. Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857, 890 (1986).

⁷³ See, e.g., NAT'L ASS'N OF HEALTH UNDERWRITERS, CONSUMER GUIDE TO HIGH RISK INSURANCE POOLS, <http://www.nahu.org/consumer/HRPGuide.htm> (last visited Jan. 31, 2006) (noting that “State laws generally cap risk pool rates between 125–150% of the base individual market rate.”).

out of the reach of most individuals, particularly many of those whom the high-risk pools are intended to cover.⁷⁴

The switch from community rating to experience rating can also cause significant problems for those individuals who are not offered health insurance through their employer. "Experience rating," as discussed earlier, entails that one's premiums are based on the experience of the group and the risk that the group is thought to bear.⁷⁵ Where the "group" comprises only one individual, the risk is much greater than it would be if spread over a large number of people, even if the individual in question is presently in perfect health.⁷⁶ This significantly increases the premiums paid by those in the individual, as compared to the (larger) group, market.⁷⁷

Individuals seeking health insurance outside an employment context face further obstacles. Traditionally, insurers refused coverage for "preexisting conditions," or health conditions that existed when coverage began, in order to reduce their liability for claims.⁷⁸ Under a relatively recent change in federal law, discussed below, many of those in-group health insurance plans, such as those offered through employment, are largely protected from this type of exclusion.⁷⁹ The Health Insurance Portability and Accessibility Act (HIPAA) bans outright refusal of coverage to those seeking coverage in a group plan and significantly curtails the use of preexisting condition restrictions.⁸⁰ However, the federal law does not apply to most people potentially purchasing health insurance on the individual market.⁸¹ Thus, for many people seeking health insurance coverage on the individual market, an insurer may decline coverage altogether or impose preexisting condition exclusions. The same insurer may not deny coverage to the same individuals if they instead

⁷⁴ See Bovbjerg & Kopit, *supra* note 72, at 891.

⁷⁵ See, e.g., CUTLER & ZECKHAUSER, *supra* note 44, at 59-60.

⁷⁶ *Id.* at 65.

⁷⁷ See, e.g., Alain C. Enthoven & Sara J. Singer, *Market-Based Reform: What to Regulate and By Whom*, HEALTH AFF., Spring 1995, at 105, 109. Below a certain size (approximately 50 people), small groups do not provide sufficient dilution of the risk and diminished administrative burdens to substantially lower costs. *Id.*

⁷⁸ See, e.g., James P. Baker, *Equal Benefits for Equal Work? The Law of Domestic Partner Benefits*, 14 LAB. LAW 23, 45 (1998).

⁷⁹ See *infra* Section IV.

⁸⁰ 42 U.S.C.A. § 300gg-41(a)(1) (West 2005). See *infra* Section IV for further discussion.

⁸¹ A variety of conditions must be met first for HIPAA's portability provisions to apply to individual coverage; for example, the individual's previous health insurance must have been through a group health plan, and she must have held it for at least 18 months prior to dropping it. See 42 U.S.C.A. §300gg-41(a)(b) (West 2005). See also *infra* Section IV.

seek to obtain health insurance through their employment.⁸² These changes in the law further cement the role of the employer (among other sources of group coverage) as the primary means through which Americans obtain health insurance, and provide obstacles to those without a source for group coverage.

D. The Battle for Cost Containment

As insurers controlled largely by providers, the Blue Cross/Blue Shield plans had little incentive for cost containment. Both Blue Cross and Blue Shield were “fee for service” plans, and were controlled, respectively, by hospital and physician groups.⁸³ As such, they financed health care without significantly sacrificing the revenues of health care providers.⁸⁴ They, along with commercial insurers at the time, also had few built-in mechanisms to help reduce excessive health care utilization.⁸⁵ Subscribers had a free choice of providers, and could decide for themselves which type of physician or other health care provider they needed to see for any given problem.⁸⁶ Physicians and other care providers had largely unfettered discretion to provide any services and tests they wished to order.⁸⁷ The only cost containment measure in question was provided by the insured, who had to pay out of pocket for all expenses up through the deductible amount and, usually, pay some percentage of all costs thereafter.⁸⁸

In 1965, the federal government enacted Medicare and Medicaid to provide health insurance for the elderly, disabled and certain impoverished people—groups that had disproportionately diminished access to employment-based health coverage.⁸⁹ Both plans,

⁸² *Id.*

⁸³ See STARR, *supra* note 21, at 309.

⁸⁴ *Id.*

⁸⁵ While Blue Cross functioned more like a prepayment plan, and thus encouraged hospitals to be more judicious in their provision of health care, both commercial insurers and, to a certain extent, Blue Shield functioned more like indemnity insurers in the 1940s and 1950s, which did not seek to control costs other than by placing some of the burden of paying the fee on the patient. See *id.* at 308–09.

⁸⁶ See, e.g., Diana Joseph Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 BAYLOR L. REV. 285, 290 (1995).

⁸⁷ *Id.*; see also STARR, *supra* note 21, at 385.

⁸⁸ For an example of what a traditional indemnity plan covers and what copayments and deductibles are charged, see, e.g., Blue Cross of Northeastern Pennsylvania and Highmark Blue Shield BlueCare Traditional (Benefit Summary), http://www.bcnepa.com/ohpTraditional_Benefits.aspx (last visited Jan. 31, 2006).

⁸⁹ See Social Security Act Amendments, Pub. L. No. 89-97, 79 Stat. 286 (July 30, 1965).

when enacted, were based on the traditional fee-for-service model established by the Blues.⁹⁰ As health insurance coverage increased through the enactment of these plans and through continuing employment-based insurance, health care costs escalated dramatically.⁹¹ Significant advances in medical technology were made during this time.⁹² Unrestricted reimbursement by third-party payors led to increased charges and performance of diagnostic tests and procedures by health care providers, which in turn led to increased reimbursement.⁹³ The spiraling costs were enormous. “Between 1950 and 1970, national health care expenditures increased 586% (from \$12.7 billion to \$74.4 billion), while the gross national product increased by only 347% (\$288 billion to nearly \$1 trillion)[during the same period].”⁹⁴

By the early 1970s, health care costs were escalating rapidly.⁹⁵ Whereas the average cost of a single day in the hospital was \$16 in 1950, it had risen to \$45 by 1965 and by 1974 cost \$128.⁹⁶ For most of the next two decades, health care costs rose faster than the GDP.⁹⁷ This happened despite Congress’ 1982 enactment of a prospective payment system, in an attempt to slow the growth of health care costs within Medicare.⁹⁸ Further, it occurred despite the federal

⁹⁰ See, e.g., 42 U.S.C.A. §§ 1395 & 1395a (West 2005).

⁹¹ See, e.g., DERICKSON, *supra* note 24, at 147; STARR, *supra* note 21, at 384.

⁹² Nonetheless, some scholars such as Starr discount the role that rapid advancements in medical technology had on cost increases. See STARR, *supra* note 21, at 384.

⁹³ See, e.g., Nina J. Crimm, *Evolutionary Forces: Changes in For-Profit and Not-for-Profit Health Care Delivery Structures; A Regeneration of Tax Exemption Standards*, 37 B.C. L. REV. 1, 17–18 (1995).

⁹⁴ See Day, *supra* note 63, at 16 (citing HIAA (Health Insurance Association of America), SOURCE BOOK OF HEALTH INSURANCE DATA 97 (1995) (based on data from the U.S. Department of Health and Human Services, HealthCare Financing Administration, and the U.S. Department of Commerce)).

⁹⁵ Between 1970 and 1975, prices for medical care were rising at an average annual rate of 12.3 percent, whereas the consumer price index was rising at an annual rate of 6.6 percent. See NAT’L CTR. FOR HEALTH STATISTICS, *supra* note 31, at 362; DEP’T OF LABOR, CONSUMER PRICE INDEX: ALL URBAN CONSUMERS (OLD SERIES), <http://data.bls.gov/PDQ/servlet/SurveyOutputServlet> (last visited Feb. 9, 2006).

⁹⁶ *Id.*

⁹⁷ Sheila Smith et al., *National Health Projections Through 2008*, 21 HEALTH CARE FINANCING REV. 211, 221 (1999).

⁹⁸ Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248 (codified in relevant part at 42 U.S.C.A. 1395ww (West 2005)).

government's attempt to support alternate forms of insurance that promised stronger cost-control measures, such as HMOs.⁹⁹

The growth in health care costs started to slow by 1994, as managed care plans began to dominate the market.¹⁰⁰ Throughout the remainder of the 1990's, costs generally kept pace with domestic economic growth, resulting in a relatively stable health-spending share of the gross domestic product.¹⁰¹ This slowdown in the inflation of health care costs, however, was relatively short-lived. Even as early as 1998, the federal Center for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) forecasted that health care costs would rise again, anticipating that they would average 1.8% more than the growth in the GDP through 2008.¹⁰² These forecasts will likely have been too conservative.¹⁰³

What led to the plateau in health care costs in the 1990s, and why are costs again on the rise? CMS believes that the impact of the rise of managed care plans on the health care system in the late 1980s and early 1990s, in conjunction with the country's significant economic growth during the Clinton years, largely led to restraint in the growth of health care costs in relation to general economic growth.¹⁰⁴ CMS hypothesized—accurately, as it turns out—that this trend would be reversed over the next decade due in part to slower growth in managed care enrollment; a movement towards less restrictive forms of managed care; and increased state and federal regulation of health plans restricting various cost-containment measures used by managed care organizations (MCOs) and mandating certain benefits.¹⁰⁵

Health insurance premiums have largely mirrored these trends. While premiums for employer-sponsored insurance rose at a rate of 12 % in 1988, that inflation slowed to 8.5 % in 1993 and, by

⁹⁹ See generally, e.g., The Health Maintenance Organization Act of 1973, P.L. 93-222 (Dec. 29, 1973) (authorizing HMOs and, up until the early 1980s, providing federal funding for the creation of HMOs).

¹⁰⁰ Katharine R. Levit et al., *National Health Spending Trends in 1996*, HEALTH AFF., Jan.–Feb. 1998, at 35, 36.

¹⁰¹ See PRESS RELEASE, HEALTH CARE FINANCING ADMIN. (HCFA), HEALTH CARE SPENDING GROWTH RATES STAY LOW IN 1998, PRIVATE SPENDING OUTPACES PUBLIC (Jan. 10, 2000).

¹⁰² Smith et al., *supra* note 97.

¹⁰³ See *infra* note 108 and accompanying text.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

1996, dropped all the way down to 0.8 %.¹⁰⁶ Interestingly, those savings were realized in the nadir year of 1996 not only by HMO plans (whose premium costs *dropped*, on average, by 0.2 %), but also by preferred provider organizations (PPOs) (whose premiums rose by approximately 1%) and even by conventional indemnity insurance plans (whose premiums rose only 1.9%, on average).¹⁰⁷ However, as we saw above, managed care premium costs have accelerated in recent years, and are presently several times greater than the general rate of inflation, having risen at double-digit rates between 2001 and 2004.¹⁰⁸ These cost increases are often passed on to employees in the form of reductions to or even the cessation of health care benefits: for example, while 68% of small employers (those with 3 to 199 employees) offered health insurance to their employees in 2001, that percentage had dropped to 63% in 2004.¹⁰⁹

III. ISSUES WITH EMPLOYMENT-BASED HEALTH INSURANCE

A. Who Has Employment-Based Health Insurance?

Whatever the problems of the U.S. health care system, those with employer-sponsored private health insurance are fortunate to have it. Some may think it is largely the unemployed who are uninsured. This is not true. A sizeable minority of all full-time jobs do not offer health insurance benefits.¹¹⁰ Moreover, among those jobs that do offer health benefits, some require employees to pay half or more of the premium for either their own coverage or, more frequently, for coverage for their dependents, often making it unaffordable.¹¹¹

For the majority of the working population in the United States, employer-sponsored health insurance is a valuable benefit of employment.¹¹² Typically, employers pay the lion's share of the cost

¹⁰⁶ THE HENRY J. KAISER FAM. FOUND. & RESEARCH AND EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2003 ANNUAL SURVEY 21 (2003), available at <http://www.kff.org/insurance/ehbs2003-abstract.cfm> (last visited Jan. 31, 2006) [hereinafter KAISER 2003 ANNUAL SURVEY].

¹⁰⁷ *Id.* at 20.

¹⁰⁸ *See id.* (showing general inflation to have remained between 2.9% and 5.1% during the same time period).

¹⁰⁹ *See* Jon Gabel et al., *Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take Their Toll on Coverage*, HEALTH AFF., Sept.–Oct. 2004, at 200.

¹¹⁰ *See infra* notes 118–119 and accompanying text.

¹¹¹ *See infra* notes 136–137 and accompanying text.

¹¹² In 2003, employment-based health insurance covered 63% of the non-elderly adult population. Public health insurance such as Medicaid and Tricare, in comparison, covered only

of individual coverage for their employees.¹¹³ Because employer-sponsored health insurance is not taxed to the beneficiaries,¹¹⁴ and because employers may deduct the sum they spend on health insurance for employees and their dependents from their federal income tax bill, the federal government significantly subsidizes this otherwise private system of providing health insurance.¹¹⁵ In 2004, the cost of this subsidy to the federal government was estimated to be \$188.5 billion¹¹⁶—over \$15 billion more than the federal government is projected to spend on the Medicaid program the same year.¹¹⁷

Not all employers take advantage of this subsidy, however. In 2002, only 43% of workers in firms with fewer than twenty-five employees were offered health benefits, as compared to 81% of workers in firms with 100 or more employees.¹¹⁸ In 2003, 34% of all employers did not offer health benefits to their employees.¹¹⁹ This helps explain how 83% of the 44.7 million Americans who lacked health insurance in 2003 could live in a family with at least one worker.¹²⁰ Sixty-three percent of uninsured workers in 2003 were employed by small firms, firms with fewer than 100 workers.¹²¹ Overwhelmingly, the most significant reason cited by employers with fewer than 200 employees for not offering health insurance benefits was cost.¹²²

16.8% of the non-elderly population. PAUL FRONSTIN, EMP. BENEFITS RES. INST., SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED: ANALYSIS OF THE MARCH 2004 CURRENT POPULATION SURVEY 276 (2004).

¹¹³ This is not true, however, with respect to the premiums of employees' dependents. See *infra* note 137 and accompanying text.

¹¹⁴ Note that the tax-free nature of this benefit is highly regressive, as those in higher tax brackets save more than those in lower brackets. Whereas a worker in a 15% bracket with a health insurance premium costing \$100 per month would owe the federal government \$15 per month for the premium if it were taxed, a worker in the 28% bracket with the same premium would owe \$28 per month.

¹¹⁵ The self-employed are an exception to this rule, as they may deduct only a percentage of their health insurance premiums from their federal taxes.

¹¹⁶ Sheils & Haught, *supra* note 64.

¹¹⁷ CTRS. FOR MEDICARE AND MEDICAID SERVS. (CMS), NATIONAL HEALTH EXPENDITURES BY TYPE OF SERVICE AND SOURCE OF FUNDS: CALENDAR YEARS 1965–2013 (2004) (projecting that the federal government will spend \$171.9 billion on the Medicaid program in 2004), available at <http://www.cms.hhs.gov/statistics/nhe/> (last visited Jan. 31, 2006).

¹¹⁸ FRONSTIN, *supra* note 112, at 11.

¹¹⁹ See KAISER 2003 ANNUAL SURVEY, *supra* note 106, at 40.

¹²⁰ FRONSTIN, *supra* note 112, at 10–11.

¹²¹ *Id.* at 11.

¹²² KAISER 2003 ANNUAL SURVEY, *supra* note 106, at 43.

Employees who are not offered health benefits are more likely to be low-income, part-time, minority, female, and/or under the age of thirty.¹²³ In 2003, 30% of workers earning less than \$20,000 were uninsured, as compared to 5.8% of workers earning \$50,000 or more.¹²⁴ Employers who do not offer health benefits are also significantly more likely to have fewer full-time employees than those employers who do offer such benefits, and to have more workers who are female, minority and/or under age thirty.¹²⁵ Workers who are better-off, white, male, over the age of thirty, and who work for a firm with more than fifty employees, are more likely than the rest of the working population to have employment-based health insurance.¹²⁶

According to one study, the employee take-up rate at those firms offering health insurance benefits was 83% in 2003.¹²⁷ There are several reasons that a small but significant number of employees fail to take up employer-sponsored health insurance. Some are not eligible because they work part-time, are temporary employees, or have not worked at the firm for a sufficient length of time. In 2000, for example, 17% of employees in firms employing fewer than 200 employees were not eligible for health insurance benefits, and an even greater percentage (22%) of employees at larger firms were ineligible.¹²⁸ Others obtain their coverage from another source, frequently through a spouse who has better or cheaper coverage through his or her employer.¹²⁹ According to one study, 66% of employees who declined coverage in 2001 declined because they could not afford the premium.¹³⁰ Twenty-eight percent did not know why they declined coverage, and 6% had coverage elsewhere or otherwise did not need coverage.¹³¹

Is there a large group of relatively young and healthy employees who can afford the health insurance their employers offer, but who instead choose to gamble with their health and resources and save the money they would have otherwise spent on their share of

¹²³ See, e.g., FRONSTIN, *supra* note 112, at 14–15.

¹²⁴ *Id.* at 14.

¹²⁵ *Id.* at 14–15.

¹²⁶ *Id.* Employment type also matters; for example, while 67% of managers or professionals had health insurance in their own name, only 34.8% of service workers did. *Id.* at 8, 10.

¹²⁷ KAISER 2003 ANNUAL SURVEY, *supra* note 106, at 53.

¹²⁸ *Id.* at 58.

¹²⁹ See FRONSTIN, *supra* note 112, at 13.

¹³⁰ *Id.* at 17.

¹³¹ *Id.*

the premiums? It appears unlikely, but there is little data specific to the issue. In an older study using data from 1996–1997, approximately 5% of employees who failed to take up employment-based health insurance did not have insurance through another source, such as a spouse’s employer or a government program such as Medicaid.¹³² Such employees account for only approximately 3% of the adult population, or about 7.3 million people.¹³³

The existing data shows that cost can be a significant factor in the failure to take up employment-based health insurance. It is uncertain how many individuals fail to take up employer-sponsored insurance because they cannot afford the premium cost and still have enough money on which to subsist, as compared to those who technically could afford to pay the premium but instead choose to spend the money on nonessentials. Nevertheless, there does appear to be a positive correlation between income and health insurance take-up rates. According to one study, 19% of workers making less than the federal poverty level who are offered employment-based health insurance decline it.¹³⁴ This figure decreases steadily as income rises, however, dropping to only a 2% failure-to-take-up rate when income reaches 300% of the federal poverty level.¹³⁵ This is not surprising when we note not only that a low-income employee’s premium share forms a higher percentage of his income, but also that employers paying low wages are also more likely to cover a smaller percentage of their employees’ health insurance premiums than employers with higher-wage employees.¹³⁶

What about an employee’s dependents? Although an employee himself may be covered, he may sometimes not obtain coverage for his dependents, even if such coverage is available through his employer. Employers are far less likely to cover a significant portion of dependents’ insurance premiums than they are to cover a

¹³² Peter J. Cunningham et al., *Who Declines Employer-Sponsored Health Insurance and Is Uninsured?* (Oct. 1999), <http://www.hschange.org/CONTENT/46/?topic=topic03> (last visited Jan. 31, 2006).

¹³³ *Id.*

¹³⁴ See Cunningham, *supra* note 132. For another discussion of the correlation between income and health insurance take-up rates, see PAUL FRONSTIN, EMP. BENEFIT RES. INST., EMPLOYMENT-BASED HEALTH BENEFITS: TRENDS IN ACCESS AND COVERAGE 14 (Aug. 2005), http://www.ebri.org/pdf/briefspdf/EBRI_IB_08-20051.pdf (last visited Jan. 31, 2006).

¹³⁵ *Id.*

¹³⁶ See, e.g., *id.*; KAISER FAM. FOUND., EMPLOYER HEALTH BENEFITS: 2005 ANNUAL SURVEY 68 (2005), available at <http://www.kff.org/insurance/7315/upload/7315.pdf> (last visited Feb. 28, 2006) [hereinafter KAISER 2005 ANNUAL SURVEY].

significant portion of their own employees' premiums.¹³⁷ Thus, an employee's share of the cost of his dependents' health insurance premiums is often far greater than the share he pays of his own premium. One study revealed that, in 2005, while only 6% of employers offering health insurance paid less than 50% of the premium price for their employees, 35% of employers with fewer than 200 employees covered less than 50% of the premium for dependent coverage.¹³⁸ In a different and earlier study, 35% of employees declined coverage for their dependents because they could not afford it.¹³⁹

For those employees who obtain coverage through their employment, how much autonomy do they have in choosing the type of coverage they want? Generally the employer, not the employee, has the primary responsibility for choice of plans. In 2003, one study showed that 68% of all firms that offered health insurance offered only one choice of plan, on a take-it-or-leave-it basis.¹⁴⁰ Whether an employee has a choice of plans depends significantly on the size of the firm for which she works. Sixty-nine percent of firms with fewer than 200 employees offered only one health insurance plan, as compared with 20% of firms with 5,000 or more employees.¹⁴¹

Cost is the single largest determinant of which plan or plans an employer chooses to offer. Eighty percent of all firms surveyed in one study cited it as "very important" in determining which plan(s) to offer to their employees.¹⁴² The range of benefits offered and choice of providers permitted also play significant roles in employers' choice of plans.¹⁴³ On the other hand, measurable employee satisfaction with the plan ranks significantly lower on the list of employers' concerns. Only 45% of firms questioned in one survey cited employee satisfaction with the plan "very important" in determining which plan(s) to offer.¹⁴⁴

¹³⁷ See, e.g., FRONSTIN, *supra* note 112, at 14.

¹³⁸ KAISER 2005 ANNUAL SURVEY, *supra* note 136, at 66–67.

¹³⁹ BLUECROSS BLUESHIELD ASS'N ANALYSIS, 2002 SMALL EMPLOYER HEALTH BENEFITS SURVEY: SUMMARY OF FINDINGS 3 (Jan. 2003), <http://bcbshealthissues.com/relatives/20384.pdf> (last visited Jan. 31, 2006).

¹⁴⁰ KAISER 2003 ANNUAL SURVEY, *supra* note 106, at 64. The firms offering more than one plan tended to be the largest, with only a minority of firms with 1,000 or more employees offering a choice between three or more plans. *See id.*

¹⁴¹ *Id.*

¹⁴² *Id.* at 44.

¹⁴³ *Id.*

¹⁴⁴ *Id.*

Despite the fact that cost appears to be the single most important factor employers consider in determining which health insurance plan or plans to offer, and that employee satisfaction ranks lower on the list of factors which employers consider in choosing a health plan, studies suggest that employees are more confident with their employer's choice of health plans than with any choice the employee might individually make herself.¹⁴⁵ One study showed that 73% of employees believe their employers do a "good job" of selecting quality health care plans.¹⁴⁶ This percentage varied somewhat based on various demographic factors, but did not vary based on income.¹⁴⁷

If coverage remains in the hands of employers, this means employees often have little, if any, responsibility for choosing a plan on their own. Yet interestingly, it also appears that a majority of employees may prefer this state of affairs, given the figures cited above. Choosing from the myriad of private health insurance plans presently on offer is a daunting proposition, and one with which few individuals, given the nature of our health care delivery system, have had significant experience. Moreover, employees appear to value not only their employer's ability to handle the administrative burden associated with managing a health plan, but also the added clout their employer might have in advocating for an employee in any dispute that might arise with the insurance company.¹⁴⁸ Apart from the rising cost of health care premiums, to which we will return below, it appears there is little impetus from employees, at least, to change the existing passive system to one that requires more input from them in choosing plans and benefits.

B. Traditional Indemnity Insurance and Managed Care Plans

Traditional indemnity health insurance has largely died out.¹⁴⁹ Under traditional indemnity health insurance, an individual could choose any health care provider (usually a physician or hospital),

¹⁴⁵ See, e.g., EMP. BENEFIT RES. INST., HEALTH CONFIDENCE SURVEY, HEALTH INSURANCE: EMPLOYER INVOLVEMENT AND DEFINED CONTRIBUTIONS (Oct. 2001), available at <http://www.ebri.org/pdf/surveys/hcs/2001/dchlfs.pdf> (last visited Jan. 31, 2006); LISA DUCHON ET AL., HENRY J. KAISER FAM. FOUND., LISTENING TO WORKERS 9 (2000).

¹⁴⁶ DUCHON, *supra* note 145, at 9.

¹⁴⁷ *Id.*

¹⁴⁸ See Sally Trude & Paul B. Ginsburg, *Are Defined Contributions a New Direction for Employer-Sponsored Coverage?* (Oct. 2000), <http://www.hschange.org/CONTENT/273/?topic=topic03> (last visited Jan. 31, 2006).

¹⁴⁹ See *infra* note 159 and accompanying text.

and the insurer would cover the majority (usually 80 percent) of whatever fee the provider charged, with the insured making up the difference out-of-pocket. There were no physician panels or provider organizations, no primary care providers through whom services had to be managed, and no prospective utilization reviews or preauthorization requirements. The latter are unique to the managed care era.

Managed care appears to have played a significant role in the 1990s in slowing the rise in health insurance premium costs. Managed care plans have been a household term for some time. Yet at least one 2001 study found that, although about 90% of workers who obtained health care coverage through employment were enrolled in a managed care plan, 58% of those surveyed believed they have never been in a managed care plan, and 47% of those actually enrolled in a managed care plan reported never being in one.¹⁵⁰ In accordance with those figures, 52% of respondents said they were “not very familiar” or “not at all familiar” with managed care plans.¹⁵¹ Given the general confusion and lack of knowledge about managed care plans, a brief look at what managed care plans are and the different forms they can take is in order.

We saw above that fee-for-service plans separate the delivery of health care from the payment for health care, and that they traditionally have limited cost controls. On the other hand, managed care organizations (MCOs), broadly speaking, integrate the care delivery function with the care reimbursement function, in an effort to control both costs and health care utilization. Rather than permitting unfettered access to any health care provider, managed care organizations generally cover only those services rendered by a particular group or network of providers. Moreover, reimbursement for services provided is not determined by the fee which the health care provider wishes to charge, but rather by a scheme devised by the MCO and agreed to by the provider, designed to encourage cost-effective care.¹⁵² The goal of network integration is twofold: first, it is meant to provide high quality care while avoiding or minimizing the fee-for-service incentive to “over-utilize” medical services.¹⁵³ Second, network integration is intended to opti-

¹⁵⁰ EMP. BENEFIT RES. INST., HEALTH CONFIDENCE SURVEY, MANAGED CARE CONFUSION (Oct. 2001) <http://www.ebri.org/pdf/surveys/hcs/2001/mncr-fs.pdf> (last visited Jan. 31, 2006).

¹⁵¹ *Id.*

¹⁵² See Day, *supra* note 63, at 7.

¹⁵³ *Id.* at 8.

mize marketplace forces, such as volume and discounting arrangements, with providers and hospitals.¹⁵⁴

The managed care phenomenon took off in the late 1980s, although managed care plans had already been in existence for decades. As noted earlier, the first managed care plans appeared in the early 20th century, when large employers provided health care to employees through staff physicians and doctors' groups who treated employees at capitated rates.¹⁵⁵ Capitation is one way to control costs. For example, say a physician receives \$10,000 to provide health services to 100 people for one year. The physician then has a strong incentive to make sure he provides less than \$10,000 worth of services (including overhead, etc.) to that group of people, whether they need more services or not. Correspondingly, if an MCO receives \$10,000 to cover the costs of health services for a group of 100 individuals for one year, it has a strong incentive to control health care utilization by the group (i.e., by managing the group's care) so that, again, less than \$10,000 worth of services (plus overhead, etc.) is ultimately provided, whether or not more services are actually prescribed or needed.

As we saw earlier, physicians have bitterly opposed most attempts to interfere in the way they practice medicine and how they run their businesses. Thus, physicians lobbied hard—and, for many decades, successfully—for legal obstacles at the state level to the creation of MCOs. These obstacles prevented managed care organizations from becoming a major force until the waning decades of the 20th century.¹⁵⁶ Faced with spiraling health costs, the federal government enacted legislation in 1973 intended to encourage the formation of HMOs.¹⁵⁷ Among other things, the federal legislation preempted state laws that discouraged or prohibited HMO formation.¹⁵⁸ This lifted a significant impediment to the development of MCOs.

Since the managed care boom, the percentage of employees enrolled in traditional fee-for-service plans has become almost nonexistent: while 73% of employees receiving health care through employment were enrolled in a fee-for-service plan as recently as 1988, that number dropped to 27% in 1996, and plummeted even

¹⁵⁴ *Id.*

¹⁵⁵ *Id.* at 11.

¹⁵⁶ See STARR, *supra* note 21, at 325–27, 398.

¹⁵⁷ *Id.* at 21.

¹⁵⁸ See Day, *supra* note 63, at 21.

further to 5% in 2003.¹⁵⁹ At the same time, the percentage of those in managed care plans has jumped to 95 percent.¹⁶⁰ The majority in 2005 subscribed in preferred provider organizations (PPOs), at 61 percent, with the remainder split between HMOs (21 percent) and point-of-service (POS) plans (15 percent).¹⁶¹

There are several different types of MCOs. HMOs are perhaps the most familiar form, even though they are no longer the most widely subscribed form of MCO.¹⁶² An HMO is, broadly, an organized prepaid health care system that delivers health care solely through a network of health care providers in exchange for a monthly premium or other predetermined payments. It is important to understand that not all HMOs are the same; they take different forms. The differences have to do with the business and contractual relations between the HMO itself and the physicians and other health care providers with whom the HMO contracts. These relations can affect the way that care is delivered to the HMO members.

Generally in an HMO system, subscribers choose a primary care physician who acts as a “gatekeeper” for further services. If an HMO subscriber wants the HMO to cover a visit to a specialist, she must seek a referral to the specialist from her primary care physician. The specialist cannot be just any specialist, rather, she must be a member of the HMO’s physician panel or otherwise be approved for reimbursement by the HMO. Out-of-network care is generally not covered. If any procedures, surgeries or hospitalizations are required, HMOs require preauthorization in order for them to be eligible for reimbursement.

More specifically, HMOs come in several different varieties. Two of the most important forms of HMO are the network model and the independent physician association (IPA) model.¹⁶³ In the network model, the HMO bargains with individual doctors, hospitals, physicians’ associations and other caregivers to provide services to its members.¹⁶⁴ The doctors and other providers are not

¹⁵⁹ KAISER 2005 ANNUAL SURVEY, *supra* note 136, at 57.

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ See, e.g., Vickie Lawrence MacDougall, *The “Shared Risk” of Potential Tort Liability of Health Maintenance Organizations and the Defense of ERISA Preemption*, 32 VAL. U.L. REV. 855, 866 (1998).

¹⁶⁴ *Id.*

HMO employees.¹⁶⁵ Instead, they usually work on a fee-for-service basis, where they are paid according to a fixed fee schedule.¹⁶⁶ The providers also contract with other insurers. The IPA model is similar to the network model; however, in the IPA model, physicians and groups join together to form an IPA, which then contracts with the HMO.¹⁶⁷ One may also find HMOs with a staff or group model structure.¹⁶⁸ Here, the HMO either employs its physicians directly (in the staff model), or pays physician groups, who see only the HMO's subscribers, a capitated rate.¹⁶⁹ Some HMOs combine different elements of these structures.¹⁷⁰

In the 1980s, another form of MCO got a legal boost: preferred provider organizations (PPOs).¹⁷¹ PPOs, generally speaking, are networks of health care providers who agree to reduce their usual fee-for-service rate in exchange for incentives offered by the insurer to patients to utilize in-network care.¹⁷² PPO subscribers thus receive discounted care, as long as they see a physician within the network.¹⁷³ They may, however, need to pay more for in-network services than an HMO subscriber would, due to most PPOs' reliance on copayments and deductibles.¹⁷⁴ PPOs further differ from HMOs in that they usually do not require a primary care physician referral for specialist visits (though they do usually require preauthorization for hospitalizations and other matters).¹⁷⁵ PPOs are usually organized by a third-party payer.¹⁷⁶ Because they provide greater flexibility in physician choice and less oversight of healthcare utilization, some consumers find them preferable to HMOs, despite the fact that they may have more out-of-pocket ex-

¹⁶⁵ *Id.*

¹⁶⁶ *Id.* at 867.

¹⁶⁷ *Id.* at 866–67.

¹⁶⁸ MacDougall, *supra* note 163, at 865.

¹⁶⁹ *Id.* at 864.

¹⁷⁰ *Id.*

¹⁷¹ In the 1980s, a majority of states enacted legislation facilitating the formation of PPOs. *See, e.g.,* Cathy L. Burgess, *Preferred Provider Organizations: Balancing Quality Assurance and Utilization Review*, 4 J. CONTEMP. HEALTH L. & POL. 275, 280 (1988).

¹⁷² *See, e.g.,* Lori A. Tobias, *Cost v. Quality in the Regulation of Preferred Provider Arrangements: A 'Green Light to the Gold Rush'?*, 41 Sw. L.J. 1155, 1160–61 (1988).

¹⁷³ *Id.*

¹⁷⁴ *Id.*

¹⁷⁵ *See, e.g.,* Gail A. Jensen et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, HEALTH AFF., Jan.–Feb. 1997, at 125, 126–27.

¹⁷⁶ Burgess, *supra* note 171, at 276–77.

penses than an HMO subscriber would.¹⁷⁷ Although their status was somewhat nebulous at first, model legislation adopted in 1986 clarified the status of PPOs and encouraged the enactment of state laws recognizing and regulating this form of MCO.¹⁷⁸ They are now the most widely subscribed form of MCO.¹⁷⁹

A third type of managed care plan is a point of service (POS) plan. A POS plan permits a subscriber to see physicians within the managed care provider network, in which case the POS plan functions and pays largely like an HMO.¹⁸⁰ An out-of-network option is also provided.¹⁸¹ However, if subscriber goes outside of the network, he may owe significantly higher out-of-pocket expenses in connection with his care than he would if he stayed within the provider network.¹⁸²

MCOs, with their cost-containment and health care utilization strategies, appeared to provide a solution to the rapid escalation of health care costs and insurance premiums experienced in the 1970s and 1980s.¹⁸³ As a result, their membership began to soar as employers, eager to contain their health insurance expenditures, began switching their employees over to MCO plans exclusively or offering an MCO plan as one choice of health insurance from which their employees could choose.¹⁸⁴ For example, while only three million people received care through an HMO in 1970, that number increased to nine million in 1980, and jumped to 34 million in 1990.¹⁸⁵ Throughout the 1990s, during managed care's heyday, enrollment exploded. By 2003, approximately 165.3 million U.S. residents were enrolled in some form of managed care plan, whether an HMO or other form of MCO.¹⁸⁶

¹⁷⁷ See Day, *supra* note 63, at 22–23.

¹⁷⁸ *Id.*

¹⁷⁹ See *supra* note 160 and accompanying text.

¹⁸⁰ See, e.g., Christy A. Aumer, *The National Initiative to Reduce Medical Error: Should Managed Care Organizations Play a Part?*, 28 J. CORP. L. 455, 460 (2003).

¹⁸¹ *Id.*

¹⁸² See, e.g., Wendy K. Mariner, *Problems with Theory and Practice in Health Insurance Contracts*, 69 BROOK. L. REV. 485, 489 n.9 (2004).

¹⁸³ See, e.g., Jensen, *supra* note 175, at 134.

¹⁸⁴ *Id.*

¹⁸⁵ Day, *supra* note 63, at 7.

¹⁸⁶ This assumes that the population covered by employment-based health insurance equaled 174.0 million in 2003, and that 95% of that number was enrolled in some form of MCO. See, e.g., DeNavas-Walt, *supra* note 7, at 14; KAISER 2003 ANNUAL SURVEY, *supra* note 106, at 71.

C. The Scope of Benefits, and Restrictions on Them

Generally, when we talk about having health insurance, we usually mean insurance providing “comprehensive coverage.” Whether one has an expensive, traditional indemnity insurance or a comparatively less expensive HMO, such coverage usually includes most “medically necessary” physician, hospital and diagnostic services.¹⁸⁷ It may also include other items, such as prescription drug costs and certain medical supplies.¹⁸⁸ If it includes services such as home health care, psychological or psychiatric counseling, physical therapy and nursing home care, it usually only provides for a short course of treatment or therapy.¹⁸⁹ For non-hospital long-term care and other services that frequently do not have the endpoint of returning a worker to functional health, one usually must obtain supplemental insurance or pay out of pocket.¹⁹⁰

Note the term “medically necessary,” some form of which appears in most, if not all, health insurance policies.¹⁹¹ The purpose of this term is to limit to the type of care that an insurer will cover.¹⁹² For example, the “medical necessity” clause should enable an insurer to successfully avoid having to cover charges for a breast augmentation ostensibly performed to treat a subscriber’s irritable bowel syndrome. However, in most circumstances, it is far more difficult to determine whether or not a treatment or other intervention is truly medically necessary. For example, should a man who had severe abdominal pain two hours ago and an abdominal CT showing a potentially enlarged appendix, but who now feels all right, be held in the hospital overnight for observation of possible appendicitis—as his physician recommends—or should he be re-

¹⁸⁷ For example, for a study of the benefits provided by individual insurance products, which should be even less comprehensive than those generally provided in group plans, see Melinda Beeuwkes Buntin et al., *Trends and Variability in Individual Insurance Products in California*, HEALTH AFF. — WEB EXCLUSIVE, Sept. 24, 2003, http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.449v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=buntin&andorexactfulltext=and&searchid=1141476877707_244&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff (last visited Jan. 31, 2006).

¹⁸⁸ See, e.g., *id.*

¹⁸⁹ See, e.g., Howard F. Angione, *When the Baby Boom Boomerangs*, 77 AUG. N.Y. ST. BAR J. 28, 29–31 (2005); GEN. ACCT. OFFICE, MENTAL HEALTH PARITY ACT: DESPITE NEW FEDERAL STANDARDS, MENTAL HEALTH BENEFITS REMAIN LIMITED 6 (May 2000).

¹⁹⁰ As it has been gaining more attention in recent years, this is certainly the case with respect to nursing home care. See, e.g., Angione, *supra* note 189, at 31.

¹⁹¹ See, e.g., Timothy P. Blanchard, “Medical Necessity” Determinations—A Continuing Health-care Policy Problem, 37 J. HEALTH L. 599, 600 (2004).

¹⁹² *Id.*

leased, as his HMO does not believe observation is medically necessary? In such a case, it is not obvious who is right: the physician (who may be overcautious or perhaps seeking increased patient revenues) or the insurer (who may walk a narrow line between fulfilling its obligations to its subscribers and protecting its bottom line). Thus arise disputes between insurers, who rarely wish to pay for expensive care when a cheaper alternative might work just as well, and patients, who usually want to follow their physicians' recommendations (and have the resulting care paid for by the insurer). The nature of one's health insurance plan can make the difference between obtaining potentially life- or health-saving but expensive medical care, or receiving less expensive treatment or no treatment at all.

The other type of dispute occurs when the subscriber attempts to obtain benefits from the plan, only to find, usually to his surprise and dismay, that the plan expressly does not cover the type of benefits he seeks. Usually, a simple reading of one's health insurance policy uncovers this information, but the way one interprets a given provision can sometimes mean the difference between coverage and lack thereof. In most cases, the subscriber has little recourse where a particular service is expressly not covered by his insurance, and must pay out of pocket if he wishes to receive the care or treatment in question.¹⁹³ The legion of problems which HMO subscribers, in particular, have faced concerning denial of benefits by insurers has led to the proposal of legislation intended to help prevent some of the worst problems, both perceived and real.¹⁹⁴

The type of benefits one receives from one's policy is contingent on the type of health insurance one has. As noted above, the vast majority of Americans with private health insurance are covered by a managed care plan, usually a PPO or HMO.¹⁹⁵ Such plans, particularly HMOs, frequently provide health maintenance benefits, such as coverage for a yearly physical examination and, for women, gynecological services.¹⁹⁶ Managed care organizations are traditionally supposed to assist their subscribers in maintaining good health, on the theory that it costs less to keep a healthy beneficiary healthy

¹⁹³ Using basic contractual principles, the HMO (or other contracting party) is not bound to provide a service which it never agreed to provide in the first place.

¹⁹⁴ See *infra* note 272 and accompanying text.

¹⁹⁵ See KAISER 2005 ANNUAL SURVEY, *supra* note 136, at 57.

¹⁹⁶ See, e.g., Eve A. Kerr et al., *Profiling the Quality of Care in Twelve Communities: Results from the CQI Study*, HEALTH AFF., May-June 2004, at 247, 252 (studying the quality of preventive care, among other measures, in 12 U.S. communities).

than it does to heal a previously healthy beneficiary who has become ill.¹⁹⁷ The major drawback to MCOs is their occasional denial of care and their restriction of access to certain physicians and other providers.¹⁹⁸ While individuals in a traditional fee-for-service plan may see any physician they wish, with or without a referral from another doctor, individuals in MCOs either do not have such an option or must pay an often-substantial fee for the privilege.¹⁹⁹ Additionally, HMO and POS subscribers must obtain a referral from their primary care physician to see a specialist.²⁰⁰ If a patient consults a physician who is not affiliated with her plan, or—except in the case of PPOs—a specialist to whom she did not have a proper referral, she must pay for the visit either partially or entirely out of pocket.²⁰¹ Because MCOs generally make money by keeping what remains of a subscriber's premium after administrative costs and payment for the care rendered to her, and because of their additional function as a health care provider rather than merely an insurer, they have both an incentive and means by which to reduce not only the cost of care, but also the amount of care they cover.²⁰²

Note what this means. Because 95% of all Americans with private, employment-based coverage participate in a managed care plan, the vast majority of Americans with employment-based coverage—and thus the majority of all Americans—experience some form of health care rationing on a regular basis.²⁰³ When we consider that rationing also occurs among the uninsured and poorly-insured on an economic basis, and that many Medicaid and some

¹⁹⁷ See, e.g., Peter D. Fox, *Applying Managed Care Techniques in Traditional Medicare*, HEALTH AFF., Sept.–Oct. 1997, at 44, 50–51.

¹⁹⁸ Denials of care appear to be contingent to a large degree based on the type of care requested, and whether the request is prospective or retrospective. One study found that while inpatient care, for example, was rarely denied when requested prospectively, whereas requests for durable medical equipment and retrospective requests for emergency care were far more frequently denied. See Kanika Kapur et al., *Managing Care: Utilization Review in Action at Two Capitated Medical Groups*, HEALTH AFF. — WEB EXCLUSIVE, June 18, 2003, http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.275v1/DC1?maxto show=&HITS=10&hits=10&RESULTFORMAT=&author1=kanika+kapur&andorexactfull text=and&searchid=1107196418584_2596&stored_search=&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff (last visited Jan. 31, 2006).

¹⁹⁹ See *supra* Section III.A.

²⁰⁰ *Id.*

²⁰¹ *Id.*

²⁰² This issue led both our judicial system and Congress to consider whether MCOs should be liable under tort for damages for failure to authorize treatment and other related matters. See, e.g., *Pegram v. Herdrich*, 530 U.S. 211, 120 S.Ct. 2143 (2000); S. 1012, 109th Cong. § 402 (2005).

²⁰³ See *infra* notes 207–208.

Medicare enrollees obtain their care through MCOs, the vast majority of all Americans experience rationing of their health care, despite the fact that we have a private, ostensibly “choice”-based, system.²⁰⁴

HMOs and POS plans require pre-approval for most or all requests for in-network procedures, durable medical equipment and hospitalizations in order to qualify for coverage.²⁰⁵ The preauthorization process entails a review of the medical necessity for the proposed examination, diagnosis or treatment.²⁰⁶ If the plan turns down a subscriber’s request for care, then the subscriber must appeal the decision if she wishes to obtain coverage.²⁰⁷ Notwithstanding any appeal, an insurer may still ultimately deny coverage for the requested care.²⁰⁸

In such a case, the subscriber usually has little useful recourse to the court system, because of a federal law known as ERISA (the Employee Retirement Income Security Act of 1974). ERISA was originally intended primarily to provide uniform laws to which all employee benefit plans, such as pensions, had to adhere. Its goals were to save pension and other benefit plans from having to adhere to a plethora of differing state rules, and to protect employees’ retirement benefits.²⁰⁹ Of particular note to our analysis, it provides equitable remedies for beneficiaries who allege that a plan denied them benefits they rightfully should have received.²¹⁰ It also includes a sweeping provision causing its terms to preempt, or preclude from effect, state laws that relate to or affect benefit plans.²¹¹

ERISA says almost nothing substantive about employees’ health benefits, other than noting that its terms apply to them.²¹² Nevertheless, because of its comprehensive remedy provisions and its preemption provision, it largely removes most regulation states

²⁰⁴ See Emily Friedman, *Rationing, Managed Care and Quality: A Tangled Relationship*, HEALTH AFF., May–June 1997, at 174, 179.

²⁰⁵ See *supra* Section III.A.

²⁰⁶ See, e.g., Kapur, *supra* note 198.

²⁰⁷ See Marc A. Rodwin, *Consumer Protection and Managed Care: The Need for Organized Consumers*, HEALTH AFF., Fall 1996, at 110, 115.

²⁰⁸ See, e.g., *id.*

²⁰⁹ See 29 U.S.C.A. §§ 1001 (a)–(c); 1001a (a) & (b); 1001b (a)–(c) (West 2005); see also *Aetna Health, Inc. v. Davila*, 524 U.S. 200, 208 (2004) (“The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans.”).

²¹⁰ 29 U.S.C.A. § 1132(a) (West 2005).

²¹¹ 29 U.S.C.A. § 1144(a) (West 2005).

²¹² 29 U.S.C.A. § 1002(1) (West 2005) (defining “employee welfare benefit plan,” the primary subject of ERISA, to include plans that provide “medical, surgical, or hospital care or benefits”).

could propose regarding health insurance plans offered through employment, without offering any substantial federal remedies to replace them. “Largely,” because ERISA exempts state laws governing health insurance plans.²¹³ This exemption permits states to regulate and tax traditional health insurance carriers operating within their jurisdiction.²¹⁴ However, there is a further exemption to the first exemption: ERISA provides that self-insured plans, or plans in which the employer itself insures the risk for its employees’ health care, are subject only to ERISA, rather than to state law.²¹⁵ The majority of employees who obtain their health insurance through employment are in self-insured plans, which means that ERISA rather than state law applies where the two conflict.²¹⁶ As an additional wrinkle, even where state law does apply to a health insurance plan offered through employment, ERISA’s remedial structure preempts state law when a beneficiary brings state law claims against a plan for failing to provide benefits.²¹⁷

This has several significant effects. First, it means that ERISA precludes plaintiffs who have employment-based health insurance from bringing most common-law tort claims against MCOs (or other insurers).²¹⁸ This is because, under the rules developed in cases interpreting ERISA, most tort claims based on negligent care denials, such as wrongful death, intentional infliction of emotional distress, and medical malpractice, “relate to” an employee benefit plan, and as such are preempted by ERISA’s remedial scheme.²¹⁹ As such, the claims do not qualify for the exemption from ERISA’s preemption provisions.²²⁰ Instead, plaintiffs are often left only with the option of suing for the value of the benefit denied to them (such as

²¹³ 29 U.S.C.A. § 1144(b)(2)(A) (West 2005). For example, it does not preempt state laws mandating that certain benefits be included in all health insurance policies offered in the state. Such a law “relates to” health insurance, under the case law interpreting ERISA. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739–40 (1985). However, ERISA does preempt state medical malpractice and other traditionally common law causes of action, for example, as they “relate to” welfare benefit plans (among many other things), but are not narrowly circumscribed in their application to health insurance plans. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987).

²¹⁴ *See Metropolitan Life Ins. Co.*, 471 U.S. at 739–40.

²¹⁵ 29 U.S.C.A. § 1144(b)(2)(A) (West 2005).

²¹⁶ *See, e.g., infra* note 264 and accompanying text.

²¹⁷ *See Aetna Health, Inc. v. Davila*, 542 U.S. 200, 213–14 (2004).

²¹⁸ *See supra* note 213.

²¹⁹ *Davila*, 542 U.S. at 213–14.

²²⁰ *Id.*

the cost of an MRI scan or a mammogram that had been denied).²²¹ Second, there is a gross disparity between legal remedies available to those who have health insurance through their employment, and those who purchase their insurance on the private market.²²² Insurance obtained through the private market is not subject to ERISA, and hence is also not subject to ERISA's preemption provisions. Third, there is also a disparity between those with health insurance through an employer who self-insures, and those with health insurance through an employer who purchases health insurance from an insurance company. In the former case, ERISA preempts state regulation of such plans, whereas in the latter case, ERISA does not preempt state regulation.²²³

The case of *Corcoran v. United Health Care, Inc.*, provides an example of how ERISA prevents plaintiffs from suing health plans for allegedly improper denials of care.²²⁴ In *Corcoran*, the plaintiff's health plan denied the request of the plaintiff's physician for hospital inpatient care as Ms. Corcoran neared the due date for her pregnancy.²²⁵ Ms. Corcoran had a high-risk pregnancy, and her obstetrician wanted her fetus monitored around the clock in the hospital.²²⁶ Her health plan, however, denied the request, and instead authorized coverage only for a home nurse for 10 hours per day.²²⁷ While the nurse was off-duty, the fetus went into distress and died.²²⁸ Ms. Corcoran and her husband then sued the plan under state law for negligence, among other causes of action.²²⁹ However, the insurer successfully had the suit dismissed, arguing that ERISA preempted the plaintiffs' state law claims.²³⁰

In reaching this result, the court noted that "[t]he result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake."²³¹ The court in this case believed Congress should address the issue, if there is to

²²¹ See 29 U.S.C.A. § 1132(a)(1)(B) (West 2005).

²²² ERISA applies only to covered employee welfare benefit plans. See 29 U.S.C.A. § 1003(a) (West 2005).

²²³ See *infra* note 264 and accompanying text.

²²⁴ See *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321 (1992).

²²⁵ *Id.* at 1322.

²²⁶ *Id.* at 1322–23.

²²⁷ *Id.* at 1324.

²²⁸ *Id.*

²²⁹ *Corcoran*, 965 F.2d at 1324.

²³⁰ *Id.* at 1325.

²³¹ *Id.* at 1338.

be any remedy.²³² For the past several years, members of both the U.S. House and the Senate have offered proposals designed in part to help remedy results such as this.²³³

D. Statutes Affecting the Structure and Provision of Private Health Insurance

As noted in the foregoing discussion, managed care plans have become the most common form of private health insurance in this country.²³⁴ Yet managed care plans—HMOs, in particular—have caused what some commentators in the late 1990s called “high rates of dissatisfaction among physicians around issues of clinical autonomy, ability to do ‘what is right’ for patients, administrative complexity, referral to specialists, and referrals for care such as mental health services and physical therapy.”²³⁵ It is common knowledge that MCOs became similarly reviled by subscribers although, interestingly, at least one study has found that the same individuals who denigrate them would recommend their own MCO to other people.²³⁶

ERISA is a significant contributor to the continuation of this dissatisfaction. While the issue is complex, the most prominent problem consumers and physicians have had with managed care plans pertains to HMO or POS denial of preauthorization for a procedure, specialist visit or hospitalization.²³⁷ No one, of course, wants lengthy delays while a claims evaluator at their MCO determines whether they may expect coverage for care their doctor ordered for them. When people need medical care, they want to be able to obtain it in a timely fashion, and want to be able to afford

²³² *Id.* at 1338–39.

²³³ See *infra* notes 272–274 and accompanying text.

²³⁴ See *supra* note 160 and accompanying text.

²³⁵ See, e.g., KAREN DAVIS & CATHY SCHOEN, THE COMMONWEALTH FUND, MANAGED CARE, CHOICE, AND PATIENT SATISFACTION (Aug. 1997), http://www.cmwf.org/publications/publications_show.htm?doc_id=221423 (last visited Jan. 31, 2006)

²³⁶ Harris Interactive, *Managed Care Paradox: Many Dislike Managed Care, Yet They Like Their Own Health Plans*, 1 HEALTH CARE NEWS 1–5 (2001) (showing that, while 78% of respondents would recommend their own plan to friends who are relatively healthy (68% would recommend them to friends with a serious or chronic illness), more than half believe MCOs do not help contain costs and harm quality of care, and that the trend towards managed care is a bad thing. Also, when asked whether different types of companies help their consumers, managed care companies ranked second to last in the results . . . just above tobacco companies).

²³⁷ See *supra* notes 201, 205–208 and accompanying text.

it.²³⁸ Additionally, they presumably do not want authority for their health care vested in a corporation seeking as its primary goal to maximize its profits, whether or not any benefit to its subscribers results, but rather would prefer it to be vested in themselves or in a decision maker whom they believe has their rational best interests at heart. They want to be able to trust their physicians and other health care providers, rather than having to wonder whether their doctor's failure to refer them to a specialist or their insurer's refusal to approve the referral had more to do with the physician's or insurer's desire for increased compensation than with a genuine belief about the patient's medical needs.²³⁹ Yet, as discussed above, ERISA substantially prevents individual states from adopting protections from managed care practices that apply to all its residents with private health insurance.²⁴⁰

Despite today's managed care woes, it is important to remember how far we have already come in legislating protections for private health insurance consumers in the past two decades. Less than 20 years ago, individuals lost their health insurance on the day they lost their job, without any option to continue their coverage, notwithstanding any medical issues they or their dependents were facing at that time. Moreover, any new group health insurance for which they applied could exclude any health conditions that affected them at the time of enrollment, or could deny coverage altogether. Thus, for example, an individual with employer-sponsored health insurance who was diagnosed with a chronic heart condition would be effectively unable to change jobs or leave her employment, since she would not be able to continue coverage under her old plan and would almost certainly have her pre-existing heart condition excluded from any new coverage. In some cases, an involuntary termination could mean a virtual death sentence for employees with serious or chronic health conditions.

Because of such issues, the federal government started to expand legal protections for employees and other individuals who obtain health insurance through a group health plan. Some of these protections appear to be, in part, an outgrowth of the failure of former President Clinton's plan to provide universal access to health

²³⁸ See, e.g., Robert J. Blendon et al., *Voters and Health Care in the 2004 Election*, HEALTH AFF.—WEB EXCLUSIVE, Mar. 1, 2005, available at <http://www.healthaffairs.org> (last visited Jan. 31, 2006).

²³⁹ See, e.g., Daniel P. Maher, *Managed Care and Undividing Loyalties*, 18 J. CONTEMP. HEALTH L. & POL. 703, 704–05 (2002).

²⁴⁰ See *supra* note 217 and accompanying text.

care to all Americans in the early 1990s, as well as a response to patient and physician backlash against managed care. Others, such as COBRA, predate the Clinton plan.

In 1985, Congress enacted a continuation coverage provision with COBRA. COBRA applies to workers in covered firms (those employing 20 or more employees on an average business day) who are terminated or resign from their jobs, or who otherwise lose coverage due to the death of a covered employee, divorce from the covered employee, retirement, loss of status as the dependent child of an employee, or the bankruptcy of the firm.²⁴¹ Under COBRA, a worker who leaves her job or is terminated (for all but gross misconduct, such as theft or violence) may elect to continue her group health insurance coverage for up to 18 months.²⁴² Other events causing an individual to lose her insurance, such as divorce or death of a spouse, entitle the individual to a maximum of 36 months of continued coverage.²⁴³ The coverage is not free; rather, an employer can (and usually does) charge up to 102% of the premium cost to the individual electing coverage under COBRA.²⁴⁴ Also, coverage terminates immediately if the individual is late in paying her premium, if the employer providing coverage ceases to offer health insurance benefits to all its employees, or if the individual becomes covered by another group health plan.²⁴⁵

Another major reform came in 1996, with the passage of the Health Insurance Portability and Access Act (HIPAA)²⁴⁶. Prior to HIPAA, as described above, insurers could exclude preexisting health conditions from coverage if an employee or other group health plan subscriber changed from one insurer to another with a change of jobs, a divorce, entering or exiting school, or other event impacting access to group health insurance.²⁴⁷ This led to “job lock,” where an employee with a major health problem could not change jobs, for fear of losing health insurance coverage for that condition.²⁴⁸ Depending on one’s conception of the role of health insur-

²⁴¹ See 29 U.S.C.A. §§ 1161 & 1163 (West 2004).

²⁴² 29 U.S.C.A. § 1162(2)(A)(i) (West 2004).

²⁴³ 29 U.S.C.A. § 1162(2)(A)(iv) (2005).

²⁴⁴ 29 U.S.C.A. § 1162(3)(A) (2005).

²⁴⁵ See 29 U.S.C.A. § 1162(2)(B), (C) & (D) (West 2005).

²⁴⁶ 42 U.S.C.A. §§ 300gg et seq. (West 2005).

²⁴⁷ Rebecca Lewin, *Job Lock: Will HIPAA Solve the Job Mobility Problem?*, 2 U. PA. J. LABOR & EMPL. L. 507, 512 (2000).

²⁴⁸ For a more expansive conception of job lock, see, e.g., Lewin, *supra* note 247, at 531 (noting that while HIPAA addresses preexisting conditions, it does not definitively solve

ance and regulation of the private market with respect to it, one can perceive this phenomenon as a market failure, in which individuals lose coverage and risk becomes inadequately spread across the population. Alternatively, it may be perceived as a reasonable and predictable outcome of a private market system in which each individual ought to be responsible for her own actuarially-determined degree of risk.²⁴⁹

HIPAA has several disparate functions, one of which is to protect workers against job lock.²⁵⁰ Under HIPAA's portability provisions, group health plans may not exclude preexisting conditions from coverage for more than 12 (or, in the case of late enrollees, 18²⁵¹) months after new coverage begins.²⁵² Similarly, they cannot deny coverage to a subscriber based on health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.²⁵³ Also, depending on the length of time that the condition had been diagnosed while the subscriber was under his prior group health plan, the exclusion period may be reduced or eliminated altogether.²⁵⁴

There are a few caveats with respect to these provisions, of course. Most significantly, they do not put any controls upon the premium that insurers or employers can charge, other than to mandate that, with respect to group health coverage, no individual enrollee may be charged more than any other similarly situated enrollee in the same group plan on the basis of her health status.²⁵⁵ Thus, insurers and employers can transfer the cost of covering less desirable health risks to the whole group, in the case of group coverage, or to the individual seeking coverage under HIPAA's protec-

problems with restricting coverage for all employees or with rising premium rates, among other problems).

²⁴⁹ John Jacobi provides an excellent discussion of the issues involved with these differing conceptions of the proper function of health insurance. See John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311 (1997).

²⁵⁰ HIPAA's privacy and electronic data provisions are beyond the scope of this article.

²⁵¹ A "late enrollee" is a person who enrolls at other than the usual enrollment period or during a special enrollment period. See 42 U.S.C.A. § 300gg(b)(3) (West 2005).

²⁵² See, e.g., 42 U.S.C.A. § 300gg(a) (West 2002).

²⁵³ *Id.*

²⁵⁴ See *id.* These protections also apply to people seeking individual coverage immediately following having had insurance through a group health plan.

²⁵⁵ 42 U.S.C.A. 300gg-1(b)(1) (West 2002).

tions, in the case of individual coverage.²⁵⁶ Additionally, HIPAA's portability protections largely apply only to those individuals who were previously covered by a group health insurance plan.²⁵⁷ Those in the individual market are covered by HIPAA only in very particular circumstances.²⁵⁸ Second, one's prior group health insurance coverage must have ended no later than 63 days prior to the start of the new group health insurance coverage.²⁵⁹ Thus, if a person quits his job, does not elect COBRA continuation coverage, and is without health coverage for more than slightly over two months before his new job begins, HIPAA's protections do not apply.

HIPAA contains additional protections for subscribers in group health plans. For example, under HIPAA, health insurers must pay for at least 48 hours of post-partum hospitalization following vaginal births and 96 hours for caesarian sections.²⁶⁰ They must also pay for reconstructive surgery following a mastectomy.²⁶¹ It is uncertain how widespread the denial of such care was prior to the enactment of HIPAA; however, as "drive-by deliveries" and denial of reconstructive surgery after mastectomies received much coverage in the popular press just prior to HIPAA's congressional debate and enactment and were popularly perceived as outrageous, they managed to find their way into the bill.²⁶²

²⁵⁶ For example, in 1998, the GAO found that premiums in the individual market for HIPAA-eligible individuals were 140 to 400% higher than standard rates. See *Health Insurance Standards: Implications of New Federal Law for Consumers, Insurers, Regulators Before the Senate Committee on Labor and Human Resources*, 105th Cong. (1998) (statement of William J. Scanlon, Director of Health Financing and Systems Issues, Health, Education and Human Services Division), available at <http://www.gao.gov/archive/1998/he98114t.pdf> (last visited Jan. 31, 2006).

²⁵⁷ See, e.g., 42 U.S.C.A. § 300gg-1(a)(1) (West 2002).

²⁵⁸ See 42 USC § 300gg-41 (providing that a health insurer may not decline coverage or impose preexisting condition limitations on a person seeking coverage in the individual health insurance market whose prior period of creditable coverage was at least 18 months long and was through a group health plan, government plan or church plan. In order to be eligible for these protections, the person must moreover not be eligible for other coverage through a group plan, Social Security or Medicaid, must not have been excluded from coverage due to nonpayment of premium or fraud during most recent coverage period, must have elected COBRA coverage or state coverage if applicable, and must have exhausted COBRA continuation coverage if applicable).

²⁵⁹ *Id.*

²⁶⁰ 42 U.S.C.A. 300gg-4 (West 2005).

²⁶¹ 42 U.S.C.A. 300gg-6 (West 2005).

²⁶² Many states have individually enacted various "mandatory coverage" provisions such as these. See, e.g., VICTORIA BUNCE & J.P. WIESKE, COUNCIL FOR AFFORDABLE HEALTH INSURANCE, HEALTH INSURANCE MANDATES IN THE STATES (Jan. 2005), http://www.cahi.org/cahi_contents/resources/pdf/MandatePubDec2004.pdf (last visited Jan. 31, 2006) (providing a breakdown by state of coverage mandates such as alcoholism treatment and breast

Although the 50 states each have laws addressing mandatory benefits, pre-existing condition exclusions and other insurance reform laws, the existence of federal law on the subject is particularly crucial.²⁶³ Under ERISA, discussed above, state insurance law does not apply to “self-funded” health insurance plans for employees, but is instead preempted by federal law.²⁶⁴ This issue is important, since over half of all employees with employment-based health insurance are covered by a self-funded plan.²⁶⁵ A self-funded plan is one in which an employer, rather than pay premiums to a health insurance company, funds health insurance on its own for its employees. While an employer may have a health insurance company manage its claims, the employer itself, rather than the health insurance company, pays the claims.²⁶⁶ Because of the danger that one or more employees or dependents will have disastrously expensive medical needs, the self-funded option is usually only chosen by large firms, where the risk is better spread over a large group of employees.²⁶⁷

Despite this danger, however, many employers prefer to be self-funded, as their costs are frequently less than they would otherwise be if they purchased a plan through a health insurance company for their employees.²⁶⁸ First, the cost of health care for their

reconstruction post-mastectomy, and provider reimbursement mandates for chiropractors, acupuncturists, and others).

²⁶³ For one study of such laws, see BETH C. FUCHS, ROBERT WOOD JOHNSON FOUNDATION, EXPANDING THE INDIVIDUAL HEALTH INSURANCE MARKET: LESSONS FROM THE STATE REFORMS OF THE 1990S (June 2004), www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no4_synthesisreport.pdf (last visited Jan. 31, 2006) (evaluating the status of state individual insurance reform laws).

²⁶⁴ This is due again to ERISA. While ERISA saves state insurance laws from federal preemption, it expressly exempts self-funded employee benefit plans from the savings clause. See 29 U.S.C.A. 1144(b)(2)(A) & (B) (West 2006).

²⁶⁵ KAISER 2005 ANNUAL SURVEY, *supra* note 136, at 109.

²⁶⁶ Many employers who offer self-funded health plans also purchase “stop-loss” insurance, which kicks in when the employer’s health payments have exceeded a certain maximum sum. See, e.g., Troy Paredes, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 235 (1997) (citing data showing that more than 70% of self-funded plans are covered by some form of stop-loss insurance) (citing A. FOSTER HIGGINS & CO., FOSTER HIGGINS HEALTH CARE BENEFITS SURVEY 19 (1992)) This keeps an employer from sustaining and unforeseeable serious economic losses should an employee be diagnosed with HIV or another expensive illness.

²⁶⁷ See, e.g., Paredes, *supra* note 266, at 234.

²⁶⁸ Note, in this connection, that while the cost of health insurance premiums to employers rose 9.2% in 1999, health costs for self-funded plans rose only 3.7 percent. THE HENRY J. KAISER FAM. FOUND. AND HEALTH RES. AND EDUC. TRUST, EMPLOYER HEALTH BENEFITS 1999 ANNUAL SURVEY 14 (1999).

employees may be less than the cost of premiums would otherwise have been. Second, they avoid further costs through their exemption from state law regulating health insurance companies.²⁶⁹ Compliance with laws mandating certain types of coverage can be costly. Many states, for example, mandate that health insurance plans cover certain types of mental health care or other potentially expensive services.²⁷⁰ Self-funded plans can omit such coverage without contravening state law, if they wish, because of ERISA's preemption provision.²⁷¹

Legislation was proposed in several sessions from the late 1990s to the present to provide what is termed a "Patient's Bill of Rights," to protect patients against alleged abuses by HMOs.²⁷² Because the legislation would be enacted at the federal level, it would apply to both insurance company-issued plans and self-funded plans. Although the House and the Senate each successfully passed a version of such a bill in the 107th Congress, the differences between the two bills were never ironed out.²⁷³ The legislation died, and has not since been resurrected in any significant form.²⁷⁴

The bills would each, in their different ways, have prevented HMO plans from utilizing certain measures intended to directly or indirectly contain costs and would have imposed standards for utilization reviews and internal and external appeals.²⁷⁵ Differences between the two bills largely pertained to provisions in each allowing patients to bring suit against their plan for improper denials of

²⁶⁹ For a discussion of mandated benefits and self-insured plans, see Russell Korobkin, *The Battle Over Self-Insured Plans, or "One Good Loophole Deserves Another,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 89, 96 – 97 (2005).

²⁷⁰ See, e.g., Bunce & Wieske, *supra* note 262 at 4-5.

²⁷¹ See *supra* note 264 and accompanying text.

²⁷² For a small sample of the bills that have been proposed since 1998, see, e.g., Patients' Bill of Rights Act of 1998, H.R. 3605, 105th Cong. (1998); Patients' Bill of Rights Act of 1998, S.2529, 105th Cong. (1998); Patients' Bill of Rights Act of 1999, S.3057, 106th Cong. (1999); Patients' Bill of Rights Act of 2001, H.R. 2315, 107th Cong. (2001); Patients' Bill of Rights Act of 2004, H.R. 4628, 108th Cong. (2004); Patients' Bill of Rights Act of 2005, S.1012, 109th Cong. (2005).

²⁷³ Patients' Bill of Rights Act of 2001, S.872, 107th Cong. (2001); Patients' Bill of Rights Act of 2001, H.R. 2315, 107th Cong. (2001)

²⁷⁴ Attempts have been made, particularly since *Aetna Health, Inc. v. Davila*, to revive the movement for a patients' bill of rights. See, e.g., Patients' Bill of Rights Act of 2005, S. 1012, 109th Cong. (2005). However, more fundamental problems involving rising cost and declining private coverage have since come to the forefront. See, e.g., Julie Rovner, *The Ghost of Managed Care Past*, CONG. DAILY, Nov. 18, 2004.

²⁷⁵ See, e.g., S.872, §§ 101, 102; H.R. 2563, §§ 102; 113.

care.²⁷⁶ While abuses meant to be curbed by the proposed Patient's Bill of Rights acts likely still occur, other concerns, such as reacting to terrorism in the United States, waging wars in Afghanistan and Iraq, and, more relevantly to health care, addressing alarming increases in the cost of health care and health insurance and a corresponding decline in private coverage, have overtaken the further proposal of patients' rights legislation.²⁷⁷

Interestingly—and extra-legally—the issues addressed in the patients' rights bills have been circumvented to a certain degree by recent changes within the managed care industry. Stung by heavy criticism of a number of their cost control measures, many MCOs reduced their reliance on preauthorization for many services, the use of certain forms of withholds and bonuses to penalize and reward physician behavior, and capitation, opting instead to utilize one or more of several different strategies intended to help reduce costs for employers while keeping their own profits at a healthy level.²⁷⁸ Three of these strategies, as identified by one commentator, are (1) the loosening of control over health coverage decisions; (2) the creation of different “tiers” of coverage, in which, for example, an enrollee pays less for in-network care and more for care provided out-of-network; and (3) the offering of “consumer-driven health plans,” where the employee is given greater choice in choosing a health plan and is made to assume more financial responsibility within it, e.g., through choosing a high-deductible plan in conjunction with a personal or health savings account option.²⁷⁹

²⁷⁶ See, e.g., H.R. 2563, sec. 402(a); S.872, sec. 302(a) (6)(b).

²⁷⁷ It is possible that the Supreme Court's decision in *Aetna Health, Inc. v. Davila* could precipitate renewed interest in a patients' bill of rights; however, the present trend at the federal level seeking to protect businesses from lawsuits will likely militate against it. See, e.g., *Aetna Health, Inc. v. Davila*, 524 U.S. 200, 208 (2004); Timothy Stoltfus Jost, *The Supreme Court Limits Lawsuits Against Managed Care Corporations*, HEALTH AFF. — WEB EXCLUSIVE, Aug. 11, 2004, http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.417/DC1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=jost&fulltext=davila&andorexactfulltext=and&searchid=1130669783352_48&stored_search=&FIRSTINDEX=0&resourcectype=1&journacode=healthaff (last visited Jan. 31, 2006).

²⁷⁸ See, e.g., Glen P. Mays et al., *Managed Care Rebound: Recent Changes in Plans Cost Containment Strategies*, HEALTH AFF. — WEB EXCLUSIVE, Aug. 11, 2004, http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.427/DC1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=mays&fulltext=managed+care&andorexactfulltext=and&searchid=1130670272956_58&stored_search=&FIRSTINDEX=0&resourcectype=1&journalcode=healthaff (last visited Jan. 31, 2006).

²⁷⁹ See John V. Jacobi, *After Managed Care: Gray Boxes, Tiers and Consumerism*, 47 ST. LOUIS U. L.J. 397, 401–06 (2003). While the trend towards consumer-driven health plans was only just starting to emerge when Professor Jacobi wrote his article, more recent data confirms that the trend may indeed be on the rise. See, e.g., THE HENRY J. KAISER FAM. FOUND. AND

With respect to the first measure identified above, some would go as far as to opine that managed care's present cost control measures are causing nearly as many problems to patients as their prior incarnations did.²⁸⁰ Nevertheless, as PPO enrollment increases and HMO enrollment declines, control over coverage decision also declines to a certain degree.²⁸¹

Certainly, the second strategy identified above has in fact come about. As just noted, fewer and fewer people are enrolled in HMOs; instead, PPOs are the most common form of MCO at present.²⁸² PPOs function by offering multiple tiers of coverage, usually including in-network coverage, out-of-network but still local coverage, and non-local coverage. The PPO often covers a substantial proportion of the costs for in-network services, and far less substantial coverage for the other options.²⁸³

It further appears that the third strategy is on the verge of becoming far more widespread. With the renewed rapid inflation of health insurance costs, the federal government, in particular, has sought new methods of cost containment, largely in the form of "consumer directed" health care.²⁸⁴ The drafters of recent legislation and rules in this regard appear to have largely subscribed to the theory that, by reducing "moral hazard" in health insurance, we can help reduce health care costs. "Moral hazard" in the sphere of health insurance refers to the theory that those who are insured tend to incur greater costs with respect to it, due to the very fact that they do not have to pay for those costs out of pocket, or are only responsible for a fraction of them. Proponents of consumer directed health care therefore assume that, if individuals are made to be more responsible for the costs of the health care they consume, they will make more prudent choices with respect to it.

The first step towards consumer directed health care came—inadvertently—in the form of flexible spending accounts (FSAs),

HEALTH RES. AND EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2004 ANNUAL SURVEY 66 (2004), <http://www.kff.org/insurance/7148/upload/2004-Employer-Health-Benefits-Survey-Full-Report.pdf> (last visited Jan. 31, 2006) (showing that, among all firms surveyed, 6% were "very likely" and 21% were "somewhat likely" to offer their employees a consumer-driven health plan within the next two years, with 22% and 28 percent, respectively, of all employers with over 5,000 employees saying the same).

²⁸⁰ See, e.g., Linda Peeno, *The Second Coming of Managed Care*, 40 TRIAL 18 (May 2004).

²⁸¹ See *supra* notes 175, 177, and accompanying text.

²⁸² See *supra* note 161 and accompanying text.

²⁸³ See, e.g., *supra* note 177 and accompanying text.

²⁸⁴ See, e.g., The White House, *Making Health Care More Affordable* (Sept. 2004) <http://www.whitehouse.gov/news/releases/2004/09/20040902.html> (last visited Jan. 31, 2006).

which have been in existence in one form or another since 1978.²⁸⁵ FSAs allow employees whose employers offer a Section 125 cafeteria plan to set aside a portion of their paycheck, before any income or payroll taxes are removed from it, to pay for health care, child care, and other qualified expenses.²⁸⁶ The funds in the FSA do not earn interest, and are forfeited if unused by the end of the year.²⁸⁷

Archer Medical Savings Accounts (Archer MSAs) were enacted in 1996.²⁸⁸ Archer MSAs are trusts offered in conjunction with a high deductible plan to a limited number of individuals who purchase the high-deductible plan through the private market, or who obtain their high-deductible plan through their small employer.²⁸⁹ Unlike FSAs, unspent contributions roll over from year to year, and may be invested. Individuals may use the Archer MSA to pay for qualifying medical expenses of themselves, their spouses and dependents.²⁹⁰ Either individuals or employers, but not both, can make contributions to the Archer MSA.²⁹¹ The contributions are both excluded from the employee's gross income and are deductible as a business expense for the employer.²⁹² Additionally, distributions from Archer MSAs, including those attributable to investment income, are generally not includable in an individual's gross income, as long as the distributions are made for qualifying medical expenses.²⁹³ Total allowable contributions for any given year cannot exceed 65% of the health insurance deductible, in the coverage is individual, or 75% of the same where the coverage is other than individual.²⁹⁴ As they were limited only to use by 750,000 people, and new accounts can no longer be created, they have only a minor subscription.

²⁸⁵ See, e.g., Daniel C. Schaffer & Daniel L. Fox, *Tax Law as Health Policy: A History of Cafeteria Plans, 1978-1985*, 8 AM. J. TAX POL'Y 1, 34 (1989).

²⁸⁶ See, e.g., 33A Am. Jur. 2nd Fed. Taxation § 8235 (noting that contributions to an FSA cannot "substantially" exceed the total premium for the employee's coverage); I.R.S. Rev. Rul. 2003-102 (2003).

²⁸⁷ See, e.g., 33A Am. Jur. 2nd Fed. Taxation § 8235.

²⁸⁸ See Pub. L. 104-191, Title III, § 301(a), 110 Stat. 2037 (1996).

²⁸⁹ 26 U.S.C.A. § 220(a), (c)(1), (i) (West 2004).

²⁹⁰ *Id.* § 220(d)(1) & (2).

²⁹¹ See *id.* § 220(B)(5)(a), § 106(b).

²⁹² See *id.*; Notice 96-53, 1996-2 CB 219, Q&A-12.

²⁹³ As in the case of HRAs, see 26 U.S.C. § 213(d) for an enumeration of qualifying medical expenses.

²⁹⁴ 26 U.S.C.A. § 220 (b)(2) (West 2004).

In 2002, the IRS created a new form of a Section 125 cafeteria plan benefit, called a Health Reimbursement Arrangement (HRA).²⁹⁵ HRAs are defined contribution plans through which employers—and employers alone—can contribute a set amount per year towards their employees' qualified medical expenses.²⁹⁶ The contributions are excluded from the employee's gross income, and are a deductible expense for the employer.²⁹⁷ HRAs are considered for IRS purposes to be group health plans, and are also subject to COBRA continuation coverage.²⁹⁸ Notably, unlike an FSA, any unused balance in an HRA is carried over from year to year.²⁹⁹

In 2003, as part of the Medicare Prescription Drug Improvement and Modernization Act, Congress created Health Savings Accounts (HSAs).³⁰⁰ HSAs are by far the most ambitious of consumer directed health plans to date. They largely resemble Archer MSAs. However, the employment-related and numerical restrictions placed on who qualifies to participate in an Archer MSA do not apply to HSAs. Anyone who may not be claimed as a dependent on someone's tax return, and has not reached age 65, may qualify to open an HSA.³⁰¹ To be eligible for an HSA, an individual need only obtain—and maintain—a high-deductible health plan (HDHP).³⁰² An HDHP must have at least a \$1,000 deductible for individual coverage and \$2,000 for family coverage.³⁰³ Additionally, total out-of-pocket expenses, including deductibles and co-payments, may not exceed \$5,000 for an individual plan and \$10,000 for a family plan.³⁰⁴ An HDHP must not provide for any payment until at least the minimum allowable deductible has been paid out of pocket by the plan holder, if it is to qualify as an HDHP under the statute.³⁰⁵

Qualifying beneficiaries may deposit an amount, up to the lesser of their deductible limit or \$2,600 for an individual and \$5,150

²⁹⁵ See I.R.S. Rev. Rul. 2002-41 (2002).

²⁹⁶ *Id.* Eligible medical expenses are enumerated in 26 U.S.C.A. § 213(d) (West 2004).

²⁹⁷ *Id.*

²⁹⁸ *Id.*

²⁹⁹ *Id.*

³⁰⁰ Medicare Prescription Drug Improvement, Modernization Act of 2003, Pub. L. 108-173, § 1201, 117 Stat. 2066 (2003).

³⁰¹ 26 U.S.C.A. § 223(b)(7), § 223(c)(1)(A) (West 2004).

³⁰² Additionally, and with few exceptions, an eligible individual must have no other health plan that is *not* an HDHP. See 26 U.S.C. § 223(c)(1)(A) (West 2004).

³⁰³ 26 U.S.C.A. § 223(c)(2)(A) (West 2004). The deductible amount is indexed annually with inflation. *Id.* § 223(g).

³⁰⁴ *Id.* § 223(c)(2)(A).

³⁰⁵ 26 U.S.C. §§ 223(c)(2)(A); 223(f)(1) (West 2004).

for a family, into their HSA each year.³⁰⁶ The deposited amount is excluded from income and payroll tax if made by the employer, otherwise the amount is deductible from income.³⁰⁷ Additionally, distributions from the HSA are excludable from a beneficiary's gross income, if they are made for qualified medical expenses.³⁰⁸ If distributions are made for anything other than qualified medical expenses, they are not only taxed as part of a beneficiary's gross income, but also are subject to a 10% excise tax.³⁰⁹ However, a beneficiary may use distributions after he reaches age 65 for any purpose at all without incurring the penalty tax; but, the distributions remain taxable income.³¹⁰

HDHP/HSA plans may be the wave of the future. Already, a number of different major health insurance providers offer such plans to the public,³¹¹ and the federal government started offering them to its employees in 2005 through the Federal Employees Health Benefits Program.³¹² A discussion of their potential implications is offered below.

E. The Private Market: What to Expect

Problems with the present private health insurance system are myriad. At the most recent count, 45.8 million Americans are uninsured and millions more have insufficient insurance.³¹³ For those fortunate to have adequate private health insurance, premiums are rising and many people have difficulty accessing care when they need it most, most often due to problems obtaining authorization for coverage.

³⁰⁶ LINDA BLUMBERG & LEONARD E. BURMAN, TAX POLICY CENTER, MOST HOUSEHOLDS MEDICAL EXPENSES EXCEED HSA DEDUCTIBLES (Aug. 16, 2004), http://www.urban.org/UploadedPDF/1000678_TaxFacts_081604.pdf (last visited Jan. 31, 2006).

³⁰⁷ 26 U.S.C. § 223(a), (b); Notice 2004-2, Q&A – 19.

³⁰⁸ Blumberg & Burman, *supra* note 306. Qualified medical expenses are enumerated at 26 U.S.C. 213(d) (West 2004).

³⁰⁹ I.R.S. Notice 2004-2, 2004-1 C.B. 269, Q&A – 25.

³¹⁰ *Id.*

³¹¹ See, e.g., BlueEdge FAQs, BlueCross BlueShield of Texas, http://www.bcbstx.com/member/products/blueedge/blueedge_faqs.htm (last visited Jan. 31, 2006); Health Savings Account FAQ, CIGNA, http://www.cigna.com/health/consumer/medical/ccf/hsa_faq.html (last visited Jan. 31, 2006); Aetna HealthFund Fact Sheet, Aetna, http://www.aetna.com/presscenter/kit/aetna_healthfund/healthfund_factsheet.html (last visited Jan. 31, 2006).

³¹² See, e.g., NewsRx, *Health Savings Account; Federal Employees' 2005 Health Benefits Program Adds HSA Option*, OBESITY, FITNESS & WELLNESS WK., Oct. 9, 2004, at 647.

³¹³ See *supra* note 7 and accompanying text.

Manifestly, reform is necessary. In the current economic climate, and with the double-digit rises in the cost of health insurance premiums over the last four years, employers are searching for ways to cut back on the cost of the health benefits they offer their employees.³¹⁴ Some undoubtedly will join the thousands of employers who have stopped offering health insurance to employees over the past four years.³¹⁵ This move may be risky, as employees may be less likely to choose to work for an employer who does not offer health benefits. If, however, the government severs the tie between employment and health insurance by revoking the deductibility of employers' expenses for their employees' premiums this may cease to be an issue.³¹⁶

In the meantime, many employers likely will pass on more of their health insurance costs to employees. Between 2001 and 2005, the average deductible for PPO plans rose by 58.3 percent.³¹⁷ One 2004 study showed that 41% of all firms surveyed reported that they are "very" or "somewhat" likely to increase the portion of premiums paid by their employees for family coverage in the next two years.³¹⁸ Other related changes have already come into being. For example, employers started to raise the co-payments for prescription drug benefits in 2001, and also added financial incentives for employees to elect generic drugs over brand-name varieties.³¹⁹ As health insurance premiums continue to rise far faster than the average rate of inflation, many employers are changing to self-funded plans and passing costs to employees wherever possible.³²⁰ The change to self-funded plans likely assumes that the insurance plan cost hikes either overstate the actual costs of providing health care, or that they stem in part from costs of providing care mandated by the state legislature, such as mammograms, to which self-funded employers are not subject.³²¹

These approaches to rising health insurance premiums are problematic. Those employers changing to self-funded plans in

³¹⁴ See *infra* notes 317–320 and accompanying text.

³¹⁵ See *supra* note 109 and accompanying text.

³¹⁶ The Bush administration has sought at various times to limit or remove the ability of employers to deduct the cost of giving health benefits to their employees. See, e.g., *infra* notes 256–258 and accompanying text.

³¹⁷ See KAISER 2005 ANNUAL SURVEY, *supra* note 136, at 79.

³¹⁸ *Id.* at 139.

³¹⁹ *Id.* at 130.

³²⁰ See, e.g., KAISER 2005 ANNUAL SURVEY, *supra* note 136, at 82–83, 109.

³²¹ *Id.*

hopes of staving off enormous health care cost increases are likely to find modest respite, at best. The actual costs of providing health care are rising significantly, although some preliminary data indicates that insurers may be increasing their premium costs more than necessary to cover their expenses.³²² Some groups blame insurance cost increases in part on state coverage mandates, such as a requirement that all insurers include coverage for one mammogram per year for all female subscribers over the age of 40.³²³ Other studies have found that mandates in a number of states account largely for only modest premium increases, totaling only several percentage points in increase for all mandates considered together in each of the studied states.³²⁴ Such findings suggest that broader forces are at play in rising health care costs than can be managed simply by exiting the market for third-party funded insurance.

Certain trends suggest that many employers understand that changing to a self-funded plan is a temporary fix at best. These employers may instead switch to “consumer driven” health care plans.³²⁵ One simple solution would be to revise the PPO model to require patients to shoulder a greater share of the payment burden. A PPO could easily be modified to require subscribers to co-insure (for example, to pay 20% of the cost of a specialist consultation or a hospitalization) rather than or in addition to co-paying (for example, to pay twenty dollars per visit to a physician). As different providers may charge different fees for the same service, this could attune consumers to cost discrepancies and make them more likely

³²² Bill Brubaker, *CareFirst May Hike Premiums 20 Percent; Increased Medical, Drug Costs Blamed*, WASH. POST, Aug. 9, 2002, at E01 (citing Paul Ginsburg of the Center for Studying Health Care System Change as noting that “earnings reports confirm premiums are rising faster than insurers’ medical and prescription-drug costs”); see also Bradley C. Strunk et al., *Tackling Health Care Costs: Hospital Care Surpasses Drugs as Key Cost Driver*, HEALTH AFF. — WEB EXCLUSIVE, Sept. 26, 2001, at W47, http://content.healthaffairs.org/cgi/reprint/hlthaff.w1.39v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=strunk&andorexactfulltext=and&searchid=1138918040336_4606&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff (last visited Jan. 31, 2006).

³²³ See, e.g., VICTORIA CRAIG BUNCE & J.P. WIESKE, HEALTH INSURANCE MANDATES IN THE STATES 2005 3 (2005), http://www.cahi.org/cahi_contents/resources/MandatePubDec2004.pdf (last visited Feb. 10, 2006).

³²⁴ See, e.g., TEXAS DEP’T OF INS., HEALTH INSURANCE REGULATION IN TEXAS: THE COST OF MANDATED BENEFITS, CH. 3 (1998), <http://www.tdi.state.tx.us/reports/benefit3.html> (last visited Feb. 10, 2006).

³²⁵ See, e.g., James C. Robinson, *Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design*, HEALTH AFF. — WEB EXCLUSIVE, Mar. 20, 2002, at W139, http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.139v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=robinson&andorexactfulltext=and&searchid=1138918260918_4675&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff (last visited Jan. 31, 2006).

to take the discrepancies into account when making health care choices.³²⁶ Such a modification would also place a significantly larger cost burden on the consumer. At least one study suggests that this could translate into substantial cost savings for employers.³²⁷ In conjunction with such plans, employers would offer employees an HRA into which they would contribute a certain sum of money for the employee to access for paying deductibles, copayments, or other non-insured health care costs.³²⁸ Or, perhaps even more likely, employers may begin offering their employees an HSA, in conjunction with an HDHP. Such plans are already appearing, and may ultimately supplant the old managed care order with little debate or fanfare, perhaps even more quickly than managed care overtook the old fee-for-service order.³²⁹

In addition to altering the types of health insurance policies available, individual tax credits have been proposed as a means of relieving employers of some of the burden of paying for health care and shifting it to consumers.³³⁰ Both the Bush administration and Congress have, from time to time, proposed providing tax credits to individuals and families to assist them in purchasing health insurance policies.³³¹ Proposals over the past few years have varied based on family size and income, among other factors.³³² For the last few years, and again for the 2006 budget year, the Bush administration has proposed offering a fully-refundable tax credit of \$1,000 per individual and up to \$3,000 per family for the purchase of non-group insurance.³³³ It would target those with low incomes, and as such would be available at full value for individuals earning

³²⁶ See, e.g., *id.* at 8.

³²⁷ See, e.g., *id.* at 5–6 (discussing the effect on premiums); see also Jason S. Lee & Laura Tollen, *How Low Can You Go? The Impact of Reduced Benefits and Increased Cost Sharing*, HEALTH AFF. — WEB EXCLUSIVE, June 19, 2002, at W229, http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.229v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=tolen&andorexactfulltext=and&searchid=1138918799259_4716&FIRSTINDEX=0&resource type=1&journalcode=healthaff (last visited Jan. 31, 2006).

³²⁸ See, e.g., Robinson, *supra* note 325, at 8.

³²⁹ Notably, the Federal Employees Health Benefits Plan (FEHBP) will be offering HDHP/HSA plans starting in 2005. See, e.g., NewsRx, *supra* note 312, at 647. It remains to be seen how attractive they are to employees.

³³⁰ Jack Hadley & James D. Reschovsky, CTR. FOR STUDYING HEALTH SYS. CHANGE, *Tax Credits and the Affordability of Individual Health Insurance*, July 2002, at 1.

³³¹ *Id.*

³³² See, e.g., *id.*; S. 2893, 108th Cong. § 101 (2004).

³³³ The White House, *The President's Proposals for Health Security in the World's Best Health Care System: Health Credits*, <http://www.whitehouse.gov/infocus/medicare/health-care/health-credits.html> (last visited Feb. 9, 2006); Gruber, *supra* note 19, at 4.

no more than \$15,000 per year, and families earning up to \$30,000 per year.³³⁴ The credit thereafter would decline inversely with income, and would cease to be available for individuals earning \$30,000 or more, and families earning \$60,000 or more.³³⁵

While such a credit might be helpful for those with significant incomes or those who are young and in excellent health, it may not be as useful for those who are older, have lower incomes, or are in poorer health, as it would require them to spend far too high a percentage of their income on health insurance.³³⁶ It also may have the adverse effect of crowding out employer-sponsored health coverage for eligible individuals, although individuals in the targeted groups are less likely to have coverage through employment.³³⁷ Most notable is the cost of providing health coverage through tax credits. Studies by Jonathan Gruber and others indicate that the cost of providing coverage through tax credits can be almost ten times greater per dollar of insurance value provided than providing similar coverage through public means.³³⁸

Managed care indeed appears to be undergoing a substantial transformation as it loses its ability to contain costs, and health care costs in the meantime are rising dramatically. However, before we embrace any of the proposed private market alternatives and solutions to these issues, we need to consider what impact they likely will have on patients' access to health care and on curtailing health care costs. Consumer-driven health care plans such as the ones described above may appear at first glance to be well-calculated to reduce medical spending by consumers, because they generally require significant out-of-pocket spending. Presumably, consumers will be more careful with their own money than they are when their health care choices are reimbursed by a third party. Thus, according to this theory, spending for unreimbursed care would likely be made more prudently than spending for care that is substantially or completely covered by health insurance.

However, when we look at the breakdown of who spends what amount on medical care, we find that this theory, even if true and if fully implemented, would likely result in little real savings. A recent Urban Institute and Brookings Institution study analyzed

³³⁴ *Id.*

³³⁵ *Id.*

³³⁶ For one study analyzing the likely usefulness of proposed tax credits, see Hadley & Reschovsky, *supra* note 330.

³³⁷ *Id.*; Gruber, *supra* note 19, at 6.

³³⁸ See, e.g., *id.* at Table 5.

the probable effect of the new HSAs on consumer medical spending and found that, although nearly 60% of all individuals and one-third of all families spent less than the minimum deductibles allowed for a qualifying high-deductible plan under the federal legislation regarding HSAs, these groups also accounted for less than 10% of total medical spending in the United States.³³⁹ In other words, the groups that spent less than the deductible, and who accordingly would be expected to limit their health care spending as most or all would be out-of-pocket, accounted for only a small fraction of all health care spending. This means that those who are responsible for the vast majority of all medical spending spend more than the minimum deductible.³⁴⁰ Even more to the point, nearly 79% of all medical spending by these groups was above the deductible.³⁴¹ As spending above the deductible is covered by health insurance, there is little if any incentive to economize once one has exceeded the deductible.

This study suggests that consumer-driven health plans such as HDHP/HSA plans will do little with respect to encouraging prudent medical spending. Instead, they will just shift more of the cost of health care to the shoulders of consumers, and take some of the burden off of employers and insurers. One can be enthusiastic about HDHP/HSA plans if one is wealthy and healthy, particularly as they offer a new retirement savings vehicle in conjunction with their health savings features. If one has little, if any, income to save, however, then the plans merely disguise a method of transferring additional costs to health care consumers. At the same time, they may reduce the tax base from which priorities such as Medicaid and Medicare can be funded.³⁴²

Tax credits are another proposed solution that may work well for some people but likely will be poor options for most. Those most likely to benefit from tax credits as presently proposed are those lower-income individuals who are most likely to obtain their private health insurance outside of the group market, such as the self-employed and early retirees.³⁴³ Tax credits under a number of

³³⁹ BLUMBERG & BURMAN, *supra* note 306.

³⁴⁰ *Id.*

³⁴¹ *Id.*

³⁴² See, e.g., FAMILIES USA, TAX-FREE SAVINGS ACCOUNTS FOR MEDICAL EXPENSES: A TAX CUT MASQUERADING AS HELP TO THE UNINSURED (July 22, 2003), http://www.familiesusa.org/assets/pdfs/HSAs_July_22_2003c395.pdf (last visited Jan. 31, 2006).

³⁴³ See James D. Reschovsky & Jack Hadley, *The Effect of Tax Credits for Nongroup Insurance on Health Spending by the Uninsured*, HEALTH AFFAIRS WEB EXCLUSIVE (Feb. 25, 2004), <http://>

the proposals mentioned earlier would cover the full cost of health insurance for only the youngest and healthiest of adults.³⁴⁴ Where they do not cover the full cost of health insurance, it is uncertain at best whether low-income individuals, to whom the credits are also targeted, would utilize them. For example, in the 2002 Kaiser Health Confidence Survey, 43% of uninsured respondents said they would be willing to pay \$99 or less per month for health insurance.³⁴⁵ Eighteen percent would be willing to pay between \$100 and \$149 or \$150 and \$199 per month.³⁴⁶ Only 14% would be willing to pay \$200 per month or more.³⁴⁷ The problem is that, presuming for the moment that these figures apply to the uninsured population as a whole, this would mean that the majority of the uninsured would not likely find the proposed tax credits useful.³⁴⁸ The Center for Studying Health System Change estimated the average premium for an individual under one tax credit proposal would total \$2,686 per year.³⁴⁹ If this proposal were implemented, the average individual would still be left paying \$128 per month for his premium.³⁵⁰ While younger and healthier individuals would likely pay less, those who are older and/or in poorer health would pay more.

An additional problem is that policies on the individual market usually have thinner benefits packages and higher deductibles and copayments than those in the group market. As a result, one study suggested that lower-income individuals who are presently uninsured would end up paying *more* out of pocket for health care if they took up such plans using a proposed tax credit than they currently do without any coverage at all.³⁵¹ Under such plans, “[m]aternity coverage is rare; prescription drug and mental health benefits are limited; and annual deductibles average \$1,500–\$2,200,

content.healthaffairs.org/cgi/content/full/hlthaff.w4.113v1/DC1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=reschovsky&fulltext=tax+credits&andorexactfulltext=and&searchid=1130774340488_1382&stored_search=&FIRSTINDEX=0&resource type=1&journalcode=healthaff (last visited Jan. 31, 2006).

³⁴⁴ For a study examining this issue, *see, e.g., id.*

³⁴⁵ EMP. BENEFIT RES. INST., 2002 HEALTH CONFIDENCE SURVEY SUMMARY OF FINDINGS 12 (2002), <http://www.ebri.org/pdf/surveys/hcs/2002/hcs02sof.pdf> (last visited Feb. 10, 2006).

³⁴⁶ *Id.*

³⁴⁷ *Id.*

³⁴⁸ The sample size for the uninsured in the 2002 Health Confidence Survey was “relatively small.” *See id.*

³⁴⁹ *See* Reschovsky & Hadley, *supra* note 343.

³⁵⁰ *Id.*

³⁵¹ Reschovsky & Hadley, *supra* note 343.

far higher than those typically imposed in group health plans. Extending such coverage to uninsured persons, most of whom have limited incomes, will not adequately ensure access to care.”³⁵² In a similar vein, corrections made to the private group market through HIPAA, for example, do not generally apply to insurance purchased through the individual market.³⁵³ As such, state laws with all their variations would apply, rather than a uniform federal law.³⁵⁴ If we moved away from employment-based coverage to individual coverage, individuals could again, depending on the laws of their own state, find themselves facing refusals to cover pre-existing conditions or even to offer insurance coverage at all, without new reforms.³⁵⁵ Finally, tax credits for individual coverage are not well-suited to those with low incomes. Tax credits—even refundable tax credits—are not useful to those who may not file an income tax return at all, and those with low incomes who do file returns often will not have sufficient cash on hand to wait until after they file their return to be at least partially reimbursed for their premium costs.

While such tax credits likely would cause a further reduction in the number of individuals insured through employment, the Bush administration has proposed a far more sweeping plan to scale back the deductibility of health insurance as a business expense for employers.³⁵⁶ The administration’s Advisory Panel on Federal Tax Reform proposed in 2005 to cap the amount spent on employee health insurance that employers may deduct from their federal taxes as a business expense.³⁵⁷ It appears the panel recommended this step not to use the savings for health-related purposes, but rather to help replace funds lost through eliminating the Alternative Minimum Tax.³⁵⁸

Such a plan would move us a step closer to ultimately dismantling our present employment-based system of health insurance.

³⁵² Karen Pollitz & Richard Sorian, *Ensuring Health Security: Is the Individual Market Ready for Prime Time?*, HEALTH AFF. — WEB EXCLUSIVE, Oct. 23, 2002, at W372, http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.372v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=pollitz&andorexactfulltext=and&searchid=1138922437325_5236&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff (last visited Jan. 31, 2006).

³⁵³ *Id.*

³⁵⁴ *Id.*

³⁵⁵ *Id.*

³⁵⁶ See, e.g., David E. Rosenbaum, *Tax Panel Says Popular Breaks Should Be Cut*, N.Y. TIMES, Oct. 12, 2005, at A1.

³⁵⁷ *Id.*

³⁵⁸ *Id.*

This is not in itself a bad thing. By connecting health insurance to employment, but then failing, for example, to require all employers to offer coverage, mandate minimum standards and maximum employee contributions as percent of wages, provide subsidies for small or less-profitable concerns, and offer viable pooling mechanisms for individuals and small businesses, we have ended up with a system in which health coverage is not merely largely contingent on employment, but also on the type of employment and employer one has.³⁵⁹ As such, a comparatively large percentage of our population is uninsured.³⁶⁰ But to end our present system of private health insurance provision and replace it with, if anything, an anemic tax credit proposal, is foolhardy at best. It leaves us with our present system of private plans and the piecemeal statutes and regulations governing them and attempting to correct various market failures.

IV. WHERE TO GO FROM HERE: SUBSTANTIVE AND STRUCTURAL SUGGESTIONS

The U.S. health coverage system needs serious help—but there are certain kinds of help it does not need. It does not need new plans to further shift costs to consumers from employers and insurers, particularly where consumers cannot adequately absorb such costs.³⁶¹ It does not need further entrenchment of the private market

³⁵⁹ Moreover, even if these mandates existed, we would still be left with a private and inefficient system in which few if any effective cost-controls would exist. See *infra* Section II.

³⁶⁰ See CARMEN DENAVAS-WALT ET AL., *supra* note 7 and accompanying text.

³⁶¹ For example, in his first term, President Bush suggested providing the uninsured with up to \$1,000 in tax credits for individuals and \$3,000 for families to purchase health insurance on the individual market (rather than, for example, expanding Medicaid coverage to them). See The White House, *Remarks by the President on Health Care Reform* (Feb. 11, 2002), <http://www.whitehouse.gov/news/releases/2002/02/20020211-4.html> (last visited Jan. 31, 2006). This approach neglects to note that health insurance policies that cost only \$1,000 are simply not available in most cases. See FAMILIES USA, A TEN-FOOT ROPE FOR A FORTY-FOOT HOLE: TAX CREDITS FOR THE UNINSURED 3–5 (Nov. 2004), http://www.familiesusa.org/assets/pdfs/10_Foot_Rope_update_2004804d.pdf (last visited Jan. 31, 2006). Rather, one recent study found that the average cost of a comprehensive health insurance policy for a healthy, non-smoking 25 year-old woman (who would be in one of the lowest risk pools for adults) was \$2,403. *Id.* at 5. In the thirty-eight states in which a policy costing \$1,000 was available for a healthy, non-smoking twenty-five year-old woman, most deductibles were at least \$1,000 per year, out-of-pocket costs were high (sometimes as high as \$4,000 or more), and services such as doctor's office visits, emergency care, prescription drug coverage, and mental health services were either deficient or non-existent. *Id.* at 4–5. Of course, policies for those with different health issues or who are older than twenty-five generally cost even more. *Id.* at 5. And, as we saw earlier, the uninsured are disproportionately likely to have low incomes, making it very unlikely that

system, which has been shown to be less efficient in a number of areas than public programs such as Medicare.³⁶² And it does not need ever-increasing (and costly) layers of bureaucracy and other barriers between patients and health care professionals, such as the patient protection bills would create. While they may yield some improvements for certain segments of the population, the system also will not likely benefit from a free market approach, such as that suggested by proponents of defined contribution plans or tax credits. Rather, patients of all incomes need timely and competent medical attention from both generalists and specialists without having to withstand bureaucratic battles at the same time as they are coping with illness or injury. They need to be able to expect their plan to deal with them in good faith concerning the benefits that their policies say they are supposed to receive. They also need timely and competent primary care. The following are suggestions that I believe will help achieve these aims.

A. Keep the Current System at Least Partially Intact

Large-scale reforms of the private health care system have been attempted at various times in the last several decades.³⁶³ Such efforts, while often valiant, have ultimately consumed large quantities of time and resources, with few results. The effort on the part of the Clinton Administration in the early 1990s is instructive in this regard, particularly with respect to the role that entrenched interests played, and could be expected to play, in any further such endeavor.³⁶⁴ The interests of the insurance and pharmaceutical industries are as strong as ever before; additionally, a “one size fits all” approach to health care likely has little chance of success right now in this country.³⁶⁵ Rather than attempting to overturn the present

they would have enough money to contribute significantly to the cost of health insurance premiums, co-payments and deductibles. *See supra* Section II.

³⁶² Gruber, *supra* note 19.

³⁶³ For a discussion of these attempts *see generally* DERICKSON, *supra* note 24.

³⁶⁴ *See, e.g.*, Theda Skocpol, *The Rise and Resounding Demise of the Clinton Plan*, HEALTH AFF., Spring 1995, at 66, 75–76, available at http://content.healthaffairs.org/cgi/reprint/14/1/66?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=skocpol&andorexactfulltext=and&searchid=1138923377347_5338&FIRSTINDEX=0&resourcecetype=1&journalcode=healthaff (last visited Jan. 31, 2006).

³⁶⁵ To defeat the Clinton plan, interest groups spent over \$100 million. *See, e.g., id.* at 75. In comparison, in 2003, when the Medicare Prescription Drug Act was under consideration, insurance and pharmaceutical industry groups and entities spent nearly \$141 million lobbying Congress. *See* Craig Aaron, PUBLIC CITIZEN, *The Medicare Drug War: An Army of Nearly 1,000 Lobbyists Pushes a Medicare Drug Law that Puts Drug Company and HMO Profits*

system entirely, we should instead see what we can do to alter and improve the system we presently have, without adding to its cumbersomeness or expense. The large majority of health care consumers who have employer-sponsored health insurance are satisfied with this means of access, even if many have problems with their specific plans.³⁶⁶ Though there should be a wholesale change to the means of accessing primary care, and accordingly the types of coverage that should be available through the private market, our present system should be kept mostly intact with respect to accessing coverage for catastrophic care.³⁶⁷

B. Cease—or Retarget—the Present Move Towards “Consumer Driven Health Care”

Consumer driven health care is based on a theory that, at first glance, seems plausible. It assumes that the employment-based health insurance system that prevails in the United States is a significant cause of the rapid rise of health care costs: most Americans neither shop for a policy, nor—albeit to a shrinking extent—pay the costs of health care out of pocket.³⁶⁸ Because a majority of Americans have limited knowledge, at best, of what the costs of health care really are (so the argument goes), the theory behind consumer-driven health care assumes that they therefore do not exercise any curb on their appetite for expensive procedures, drugs and treatments.³⁶⁹ If, on the other hand, they were responsible for monitoring and paying for a significant portion of their own health care costs, then they would be more prudent in their health care spending.

There is, however, little evidence to support this theory. Health care does not function like many other consumer markets; if

Ahead of Patients and Taxpayers, (June 2004), <http://www.citizen.org/documents/MedicareDrugWarReportREVISED72104.pdf> (last visited Jan. 31, 2006). See also Theodore R. Marmor & Jonathan Oberlander, *Paths to Universal Health Insurance: Progressive Lessons from the Past for the Future*, 2004 U. ILL. L. REV. 204, 210–11 (2004).

³⁶⁶ For example, in the 2005 EBRI Health Confidence Survey, eight out of ten Americans surveyed said that, if offered the choice, they would prefer \$6,700 in health insurance benefits over \$6,700 in increased wages. EMP. BENEFITS RES. INST., 2005 HEALTH CONFIDENCE SURVEY: COST AND QUALITY NOT LINKED, 26 EBRI Notes 1, 10 (Nov. 2005), www.ebri.org/pdf/EBRI_Notes_11-2005.pdf (last visited Jan. 31, 2006).

³⁶⁷ See *infra* Section VI.C.5 for further discussion.

³⁶⁸ See *supra* Section II.

³⁶⁹ See, e.g., ROBERT MOFFIT ET AL., HERITAGE FOUND., A VISION FOR HEALTH SYSTEM CHANGE 2 (Aug. 12, 2004), <http://www.heritage.org/Research/HealthCare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=67666> (last visited Jan. 31, 2006) (remarks of Daniel Johnson).

an individual needs medical treatment, he has little control over the timing, nature, and adequate amount of his expenditures. Rather, it appears more likely that consumer driven health plans will merely serve more to push costs onto consumers and off of employers and insurers than anything else.³⁷⁰ They represent, in other words, an old-fashioned benefit cut. At the same time, they provide a new tax shelter that will further reduce state and federal tax revenues—from which, of course, priorities such as health care for the poor, disabled and elderly are funded.³⁷¹ Adding a tax credit to the mix that is inadequate to cover the cost of comprehensive health insurance for middle and lower income individuals and families does little to ameliorate these issues.³⁷² By seeking to shift more of the burden of funding health care to those with less ability to pay for it, while at the same time reducing the tax base, consumer driven health plans such as HDHP/HSAs offer no solution to rapidly rising health care costs, and may ultimately contribute to, rather than reduce, our increasing number of uninsured and underinsured Americans.

If we are to have consumer-driven health care, it should be of a genuine variety. Consumer-driven health plans do not go far enough if they are to have any real role in reducing health care costs, rather than simply transferring more of the burden of paying for health care from employers to employees. In order to truly harness the power of patient choice and responsibility, we need to transform our insurance industry. Patients who obtain health insurance through employment generally have little conception of the true cost of health insurance and health care.³⁷³ The employer generally pays for a large share of the premium cost, and while the employee may pay monthly for some or even all of the cost of family coverage, she may pay nothing for individual coverage.³⁷⁴ Additionally, she is not even taxed on the cost of the benefit she

³⁷⁰ See, e.g., BOB LYKE ET AL., CONGRESSIONAL RES. SERV., CRS REPORT FOR CONGRESS: HEALTH SAVINGS ACCOUNTS 19 (Mar. 23, 2005).

³⁷¹ See *id.* at 30 (observing that the Joint Committee on Taxation estimated that HSAs would cost \$2.4 billion in lost tax revenue between 2004 and 2008, and \$6.4 billion between 2004 and 2013).

³⁷² See *supra* note 361 and accompanying text.

³⁷³ See, e.g., THE HENRY J. KAISER FAM. FOUND., HEALTH INS. SURVEY 6 (Oct. 2004), <http://www.kff.org/insurance/upload/2003-Health-Insurance-Survey-Summary-and-Chart-pack.pdf> (last visited Jan. 31, 2006) (observing that half of those surveyed thought that they would be “very” or “somewhat” likely to find a health plan to cover themselves for the amount of the tax credit proposed by President Bush in his first term (\$1,000 for an individual, \$3,000 for a family).

³⁷⁴ See *supra* Section II.

receives.³⁷⁵ Thus, these costs may not enter her consciousness in any significant way. As she is not generally responsible for paying for a significant fraction of health costs, she may pay little if any attention to any itemized bill she may receive for health care provided to her. She also is not responsible for managing her health insurance, or for deciding what services to cover or not to cover, or even, for the most part, for determining what plan to choose from among the hundreds potentially available.

If patients were responsible for their health care choices from start to finish, they would gain a quick understanding of the true cost of health care. Patients might begin to understand the ramifications of taking one potential course of action versus another with respect to the prevention, diagnosis and treatment of a given ailment.

The response, of course, is not to scrap health insurance. Insurance plays an indispensable role in covering the health care costs of those who incur unexpected costs or experience chronic or catastrophic health conditions. Instead, we need to reformulate health coverage so that all participants, including patients, are invested in the system and take responsibility for their fair share. In order to do this, we need patients to actively determine how much money, as a group, to spend on health care, what health care costs to cover, and how to contract with the necessary health providers to cover these services, among other issues. A “group” could be any collection of people large enough to benefit actuarially from the association. It could occur on a national level, with a single-payer plan or other national, collective provision of health insurance decided through a public, deliberative process. Or it could occur at much smaller levels, with individuals and families in any given community forming affinity groups around coverage and payment questions, much as a credit union, for example, functions with respect to its members’ financial needs.³⁷⁶ Such co-ops existed in the 1930s and ’40s, before physician organizations successfully lobbied for laws to prevent their formation.³⁷⁷ Where such laws do not exist or were statutorily amended, patients could form any number of such local plans throughout the country, ideally with sufficiently small enough numbers to allow for meaningful input on the part of all interested

³⁷⁵ See *supra* note 63 and accompanying text.

³⁷⁶ See generally, *e.g.*, MICHAEL A. SHADID, *Crusading Doctor: My Fight for Cooperative Medicine* (1992).

³⁷⁷ STARR, *supra* note 21, at 301–06.

members. The members themselves would be responsible for hiring and dismissing directors to run the plan. The plan's workings and finances would be transparent to all the members and associated health care providers.

Such a plan would require a far more active role on the part of the membership, of course. However, if we are truly interested in spurring greater cost consciousness on the part of consumers in order to help control health care costs, we need to go far beyond today's conception of "consumer driven" health plans. Consumer health cooperatives provide one meaningful choice in this direction.

C. Provide Primary Health Coverage for All

Our emergency rooms are overburdened with the uninsured and publicly insured, who may have inadequate means of accessing care, and with those who are better insured but who cannot wait a month or more to have their condition examined by their regular physician.³⁷⁸ For those who are poorly insured, uninsured, or suffer from periods of unemployment, routine access to preventive and prenatal care can be inadequate at best.³⁷⁹ We need a different way for people to access routine primary care. Towards that end, we should institute a system of universal coverage for primary care services. The following discusses some of the practical, ethical, legal and economic justifications for providing universal coverage for such services, and concludes with a framework for providing primary care coverage for all U.S. residents.

1. Practical Issues

The United States is best at repairing injuries, and at heroic, technology-based treatments in general. If one experiences a catastrophic health condition—a serious collision injury, a heart attack, an unusual form of cancer, or organ failure requiring transplant, for example—our health care system is well set up to deal with such issues.

We have some of the most rapidly responsive health care in the world. In one Organization for Economic Cooperation and Development (OECD) study, for example, only 5% of patients in the United States had to wait more than four months for an elective

³⁷⁸ See, e.g., Peter Cunningham & Jessica May, *Insured Americans Drive Surge in Emergency Department Visits*, 70 CENTER FOR STUDYING HEALTH SYSTTEM CHANGE ISSUE BRIEF 2 (October 2003).

³⁷⁹ See *infra* section VI.C.1.

surgical procedure (i.e., a procedure that must be performed at some time, but which is not urgent, such as a knee replacement or gall bladder removal).³⁸⁰ In comparison, 23% of Australians, 26% of New Zealanders, 27% of Canadians, and 38% of Britons had to wait more than four months for their elective surgical procedures.³⁸¹

The United States is furthermore among the best in affording access to new and advanced technology.³⁸² For example, an OECD study regarding numbers of MRI units and CT scanners per capita places the U.S. in the top three-quarters of OECD nations.³⁸³ A comparison of care for victims of heart attacks in 17 nations furthermore showed that the United States has a pattern of adopting new cardiac procedures and treatments quickly, and rapidly diffusing their use throughout the country.³⁸⁴ Moreover, while patients in U.S. hospitals stay half as long, on average, in the hospital as do patients in other OECD nations, the number of hospital personnel per bed significantly exceeds that in all other OECD nations.³⁸⁵

We pay a significant amount for these amenities. The United States tops all developed nations in its spending on health care: in 2000, it spent \$4,887 per person on health care, representing 13.9% of its gross domestic product (GDP).³⁸⁶ In comparison, Switzerland—the next highest on the list—spent \$3,322, or 10.9% of its GDP,³⁸⁷ Germany spent \$2,808, or 10.7%,³⁸⁸ Canada spent \$2,792, or 9.7%,³⁸⁹ and France spent \$2,561, or 9.5%, respectively.³⁹⁰ Americans

³⁸⁰ Jeremy Hurst & Luigi Siciliani, *Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries*, OECD HEALTH WORKING PAPERS 12 (July 7, 2003), <http://www.oecd.org/dataoecd/24/32/5162353.pdf> (last visited Jan. 31, 2006).

³⁸¹ *Id.*

³⁸² See Elizabeth Docteur et al., *The U.S. Health Care System: An Assessment and Prospective Directions for Reform*, 350 OECD ECON. DEPT. WORKING PAPERS 33 (Feb. 27, 2003), [http://www.oecd.org/olis/2003doc.nsf/43bb6130e5e86e5fc12569fa005d004c/a17bfa31f942be2cc1256cdb00332d3c/\\$FILE/JT00140050.PDF](http://www.oecd.org/olis/2003doc.nsf/43bb6130e5e86e5fc12569fa005d004c/a17bfa31f942be2cc1256cdb00332d3c/$FILE/JT00140050.PDF) (last visited Jan. 31, 2006).

³⁸³ See *id.* at 22.

³⁸⁴ *Id.*

³⁸⁵ *Id.*

³⁸⁶ See ORG. FOR ECON. COOPERATION AND DEV. (OECD), *Health at a Glance—OECD Indicators 2003 Briefing Note* (Oct. 16, 2003), http://www.oecd.org/document/11/0,2340,en_2649_34487_16502667_1_1_1_1,00.html (last visited Jan. 31, 2006) [hereinafter OECD INDICATORS].

³⁸⁷ See OECD, *Health Data 2003—Frequently Requested Data*, at Tables 9 & 10 (Oct. 16, 2003), http://www.oecd.org/document/16/0,2340,en_2825_495642_2085200_1_1_1_1,00.html (last visited Jan. 31, 2006) [hereinafter OECD FREQUENTLY REQUESTED DATA].

³⁸⁸ OECD INDICATORS, *supra* note 386.

³⁸⁹ *Id.*

³⁹⁰ *Id.*

also pay more out-of-pocket for their health care than any other nation besides Switzerland, averaging \$722 in 2001.³⁹¹

Despite the comparatively high price we pay for our health care, we are far worse than other industrialized nations at preventing, detecting, and treating issues that significantly affect population health. The United States ranks among the lowest of the 30 OECD nations with respect to infant mortality rates, at 8.9 deaths per 1,000 live births.³⁹² Only Hungary, Turkey, and Mexico have a higher infant mortality rate among these nations.³⁹³ The United States ranks similarly low in terms of life expectancy. Females born in the United States in 2000 have a life expectancy of 79.5 years, and males of 74.1 years, placing the U.S. squarely in the bottom half of OECD nations.³⁹⁴

Perhaps not coincidentally, the United States also has one of the highest rates of uninsured people in the developed world. Among all OECD nations in one study, only Mexico and Turkey had higher numbers of uninsured individuals than the United States.³⁹⁵ It is one of the few developed nations to fail to guarantee health insurance to all its residents.³⁹⁶

Census Bureau estimates of the number of uninsured in the U.S. are frequently considered “snapshots” of the uninsured, as they measure those reporting lack of insurance on a given date, and do not distinguish between those who are temporarily uninsured, and those who remain uninsured over a long period of time.³⁹⁷ As we have seen, there are numerous methods by which one may access health care in the United States, each of which has different eligibility criteria. With respect to some, like Medicare, once an individual gains eligibility for the program, she will likely remain eligible indefinitely.³⁹⁸ With respect to others, however, an individual may cycle in and out of eligibility, gaining and losing it even several times

³⁹¹ See OECD FREQUENTLY REQUESTED DATA, *supra* note 387, at Table 16.

³⁹² See *id.* at Table 2.

³⁹³ *Id.*

³⁹⁴ See *id.* at Table 1.

³⁹⁵ INST. OF MED., INSURING AMERICA’S HEALTH 17 (2004) (citing OECD, OECD HEALTH DATA 2002: A COMPARATIVE ANALYSIS OF 29 COUNTRIES (2002)) [hereinafter INSURING AMERICA’S HEALTH].

³⁹⁶ See *id.*

³⁹⁷ See STOLL ET AL., *supra* note 8, at 9.

³⁹⁸ See, e.g., CMS, *Medicare Information Resource*, <http://www.cms.hhs.gov/medicare/> (last visited Jan. 31, 2006).

in one year.³⁹⁹ Private, employer-sponsored health insurance and Medicaid are two types of coverage that people gain and lose with relative frequency.⁴⁰⁰ If an individual loses a job through which she had health insurance, or if she was pregnant and on Medicaid and then delivered her baby, she may lose her only method of coverage and become uninsured. The same person might later find employment that offers health insurance, and again leave the ranks of the uninsured.

A Families USA study designed to distinguish between these two groups of uninsured individuals found that approximately 74.7 million people in the United States were uninsured for at least one month in 2002.⁴⁰¹ This totals a stunning 30.1% of the U.S. population.⁴⁰² In other words, according to the study's estimates, nearly one-third of the U.S. population went without health insurance for at least one month in 2002.⁴⁰³ The vast majority—70.7%—of the uninsured who went without health insurance for at least one month during the study period were either employed or a member of a family in which at least one member was employed.⁴⁰⁴ 7.2% of the uninsured during that period were actively looking for a job.⁴⁰⁵ Only 22.1% of them were unemployed and not seeking work.⁴⁰⁶

Unsurprisingly, low and low/middle income individuals experienced periods without insurance in greater numbers than those who earn more income.⁴⁰⁷ For those making less than 100% of the federal poverty level (FPL), 56.1% were uninsured at some time between 2001 and 2002.⁴⁰⁸ This compares with 48.9% of those making between 100% FPL and 199% FPL, 28.7% of those making between 200% FPL and 299% FPL, 22.6% of those making between 300% FPL and 399% FPL, and 16.5% of those making 400% FPL or more.⁴⁰⁹ The large percentage of higher-income individuals who were unin-

³⁹⁹ With respect to Medicaid, for example, one's eligibility may depend upon the fact of one's pregnancy and/or financial status, both of which can and do alter. See, e.g., CMS, *Medicaid Eligibility*, <http://www.cms.hhs.gov/medicaid/whoiseligible.asp> (last visited Jan. 31, 2006).

⁴⁰⁰ See STOLL ET AL., *supra* note 8, at 11–13.

⁴⁰¹ See *id.*

⁴⁰² *Id.*

⁴⁰³ *Id.*

⁴⁰⁴ See *id.*; see also COVERAGE MATTERS, *supra* note 11.

⁴⁰⁵ STOLL ET AL., *supra* note 8, at 13.

⁴⁰⁶ *Id.*

⁴⁰⁷ See, e.g., COVERAGE MATTERS, *supra* note 11.

⁴⁰⁸ See STOLL ET AL., *supra* note 8, at 15.

⁴⁰⁹ *Id.*

sured at some time in 2001 correlates with findings that those with private health insurance through employment are among those most likely to lose coverage.⁴¹⁰

Do the uninsured get necessary care, despite their lack of coverage? According to at least one survey, a majority of Americans—57% in 2000—believe that the uninsured get the care they need despite their lack of insurance.⁴¹¹ In the same survey, 19% of those surveyed believed that the uninsured do not receive necessary care, and that they suffer ill effects as a result.⁴¹² A smaller percentage—12%—believed that those who are unable to get care suffer no significant adverse consequences as a result.⁴¹³

The fact that so many Americans apparently believe that the uninsured receive necessary health care despite their lack of insurance may stem from false beliefs about the nature and purpose of EMTALA, among other issues. EMTALA—the federal Emergency Medical Treatment and Active Labor Act—provides generally that one must be able to obtain a medical screening examination to rule out emergency conditions upon presentation to a hospital emergency room, regardless of health insurance status. If one has an emergency medical condition, the emergency department must then stabilize it, again regardless of one's insurance status.⁴¹⁴

It appears to be true that the uninsured are making increasingly greater use of emergency departments in comparison with scheduled physician visits.⁴¹⁵ However, they do not—and in fact cannot—receive all their care there. EMTALA merely provides for a medical screening examination and for stabilization of emergency

⁴¹⁰ INSURING AMERICA'S HEALTH, *supra* note 395, at 22.

⁴¹¹ See JACK HADLEY, THE HENRY J. KAISER FAM. FOUND., SICKER AND POORER: THE CONSEQUENCES OF BEING UNINSURED 35 (May 2002), <http://www.kff.org/uninsured/20020510-index.cfm> (last visited Jan. 31, 2006) (citing Blendon RJ, Young JT, DesRoches C., *Report on Americans' Views on the Consequence of Not Having Health Insurance*, INST. OF MED. (Dec. 14, 2000)).

⁴¹² *Id.*

⁴¹³ *Id.*

⁴¹⁴ The penalties available under EMTALA apply to all hospitals with emergency departments that are Medicare providers. 42 U.S.C.A. §§ 1395dd(d), (e)(2) (West 2005). Nearly all hospitals in the United States are subject to EMTALA.

⁴¹⁵ See, e.g., Peter J. Cunningham & Jessica H. May, CTR. FOR STUDYING HEALTH SYS. CHANGE, *Insured Americans Drive Surge in Emergency Department Visits*, Issue Brief No. 70 (Oct. 2003), <http://www.hschange.org/CONTENT/613/> (last visited Jan. 31, 2006) (noting that physician visits by the uninsured declined 36.9% during the study period, and that, while the uninsured relied on ED visits for 17% of their care at the start of the study period, they relied on ED visits for nearly 25.2% of their care by the end of the study period).

medical conditions.⁴¹⁶ It does not provide for medical care in general.⁴¹⁷ If it is true that the public generally believes EMTALA provides for necessary medical care for the uninsured, it is unfortunate that a statute that was intended only to ensure emergency treatment to anyone in need of it could help foster a complacent attitude among Americans concerning access to health care for the uninsured.

Health, of course, is not a luxury. Studies show that significant adverse health consequences do in fact occur for the uninsured when they cannot obtain necessary health care.⁴¹⁸ One cannot always go without health care and get by, merely because one cannot afford it. Those who lack health coverage yet who need medical care often do obtain care, but that care often comes later than it would have if the individual had been insured.⁴¹⁹ Moreover, it is often inadequate to restore the individual to a reasonable degree of health.⁴²⁰

Those who are uninsured tend to report being in poorer health than those who have health insurance.⁴²¹ Data evaluating the health of the uninsured in comparison with those who have health insurance tend to show that the uninsured receive medical care less often, and are sicker once they do receive medical care, than the insured.⁴²² The uninsured are significantly less likely to receive cancer screening services, such as Pap smears and mammograms.⁴²³ They are far more likely to be diagnosed with late-stage cancer than the insured.⁴²⁴ Their cancer survival rates are significantly lower; for example, one study found that uninsured women with cancer had a five-year survival probability that was two-thirds lower than privately insured women with similar diagnoses, and another found that uninsured and publicly-insured women with breast cancer were one and a half times more likely to die than privately-insured

⁴¹⁶ 42 U.S.C.A. §§ 1395dd(a) & (b) (West 2005).

⁴¹⁷ *C.f. id.*, 42 U.S.C.A. § 1395dd(e)(1) (defining “emergency medical condition,” the only type of condition with respect to which the law requires hospitals with EDs to stabilize).

⁴¹⁸ *See generally* INST. OF MED., CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE (2002) [hereinafter CARE WITHOUT COVERAGE].

⁴¹⁹ *Id.*

⁴²⁰ *Id.*

⁴²¹ CARE WITHOUT COVERAGE, *supra* note 418, at 47.

⁴²² *See generally* Hadley, *supra* note 411, at 35–40.

⁴²³ *Id.* at 16–18.

⁴²⁴ *Id.* at 18–19.

women during the study period.⁴²⁵ Similar results with respect to screening, stage of diagnosis and treatment outcomes were found with respect to cardiovascular disease, diabetes, and other conditions.⁴²⁶

A number of studies have shown that poor health correlates with lower earnings and early retirement from the job market.⁴²⁷ On average, it appears that those who are in fair or poor health earn approximately 15 to 30% less than those in good health, though whether this relation is causative or merely correlative is undetermined.⁴²⁸

There also exist significant differences in the health status of those with different types of health coverage. People with Medicaid coverage, for example, tend to be in worse health than those with private health insurance.⁴²⁹ There are likely multiple reasons for this. First, as noted earlier, Medicaid is designed not merely to cover impoverished children and families, but also the disabled and elderly, both of whose members may have significant health problems.⁴³⁰ Additionally, those with Medicaid coverage gain and lose coverage frequently.⁴³¹ As such, they may defer necessary medical care and treatment when uninsured and put off screening examinations, as is common among the uninsured.⁴³² Medicaid recipients also are impoverished or low-income.⁴³³ Income and health have been shown to have a direct correlation with each other.⁴³⁴

2. Moral Issues

The case for universalizing access to health care in the United States will likely be made on the basis of practical and economic issues, rather than moral or ethical ones. This is due as much to

⁴²⁵ See *id.* at 19 (citing JZ Ayanian, et al., *The Relationship Between Health Insurance Coverage and Clinical Outcomes Among Women with Breast Cancer*, 329 NEW ENG. J. OF MED. 326 (1993) and A. Lee-Feldstein et al., *The Relationship of HMOs, Health Insurance, and Delivery Systems to Breast Cancer Outcomes*. 388 MED. CARE 705 (2000)).

⁴²⁶ See *id.* at 21–34.

⁴²⁷ See HADLEY, *supra* note 411, at 82–83.

⁴²⁸ *Id.* at 83–84.

⁴²⁹ See, e.g., *id.* at 72.

⁴³⁰ *Id.* at 73.

⁴³¹ See, e.g., STOLL ET AL., *supra* note 8, at 17–19.

⁴³² See *supra* note 422 and accompanying text.

⁴³³ Medicaid eligibility requirements dictate that the recipients earn no more than a given percentage of the federal poverty level. See 42 U.S.C.A. § 1396a(a)(1)(10)(A)(i) (West 2005).

⁴³⁴ See generally CARE WITHOUT COVERAGE, *supra* note 421 (summarizing findings correlating income, insurance status and health); see also HADLEY, *supra* note 411, at 82–84.

tradition in this country as anything else; only in recent years have health care access and quality increasingly been seen as moral or ethical issues, in addition to practical and economic ones.⁴³⁵ The strong focus on individual autonomy and a perhaps concordant revulsion to discussions of “rationing” in this country that inevitably accompany discussions of affording universal access have contributed to the relatively minor role that moral and ethical considerations have played in the development of health policy.⁴³⁶

That being said, it is difficult, morally, *not* to justify some level of universal access to health care. Norman Daniels, who is one of the more influential American scholars concerning the ethics of health care access, justifies universal access on the basis of affording all people fair “equality of opportunity.”⁴³⁷ Access to health care is a moral issue, he posits, as it “helps to preserve our status as fully functioning citizens.”⁴³⁸ Using a contractarian approach, Daniels argues that justice requires that all societies provide health care in a democratic and fair—though not necessarily equal—manner to its citizens.⁴³⁹ Within the discussion, Daniels necessarily takes account of issues such as rationing of scarce resources, whether any tiering of services would be permitted, and the process by which a society might justly determine the nature and amount of health care services to provide to its members.⁴⁴⁰

Daniels’ approach is not without flaws. For example, grounding his account on “fair equality of opportunity,” where “fair equality of opportunity” pertains largely to opportunities in the public sphere,⁴⁴¹ fails to capture the moral breadth of health care’s importance. Under Daniels’ approach, we would arguably be justified in denying coverage for palliative care for the terminally ill, even though we would cover other sorts of care for other people. Palliative care would not likely help restore the terminally ill to a level in which they could participate in the public sphere, and is not con-

⁴³⁵ See, e.g., DERICKSON, *supra* note 24, at 146–47.

⁴³⁶ See, e.g., Larry R. Churchill, *What Ethics Can Contribute to Health Policy*, in *ETHICAL DIMENSIONS OF HEALTH POLICY* 51–52 (Marion Danis et al., eds. 2002).

⁴³⁷ Norman Daniels, *Justice, Health, and Healthcare*, 1 *AM. J. BIOETHICS* 2, 2 (2001).

⁴³⁸ *Id.* at 4.

⁴³⁹ *Id.*

⁴⁴⁰ See *id.* at 5, 9–10. Daniels indeed refers to access to care, rather than access to coverage. His discussion additionally notes the social determinants of health, which he argues must be accounted for, in addition to affording access to medical care and other health care services. See, e.g., *id.* at 6.

⁴⁴¹ See *id.* at 3.

templated as such.⁴⁴² However, most of us would find value in allowing the terminally ill to end their lives in relative comfort, rather than agony, and would consider it both unjust and immoral to deny coverage for such care to them, if we provided universal coverage to most other people for other conditions.⁴⁴³

Nevertheless, many commentators would agree that justice is the appropriate lens through which to view the ethics of access to health care. Daniel Callahan argues that health care should be both equitable and sustainable.⁴⁴⁴ Daniels, Bruce Kennedy, and Ichiro Kawachi argue that using justice as the key principle by which to analyze the ethics of access to care aptly permits one to take into account not merely the medical but also the social determinants of health which, as they and others note, are also of prime importance in contributing to people's overall health.⁴⁴⁵ E. Haavi Morreim agrees that it is appropriate to analyze the issue of access to health care using the concept of distributive justice, but argues that one must add further nuance to one's conception of justice, including an analysis of the effect of decisions not only on an individual but also group or societal basis, in order to obtain a more complete evaluation.⁴⁴⁶

Other theories place primacy not on abstract principles or process, but rather on the substantive values held by a given community. In a communitarian approach, Charles Taylor argues that some goods are not merely social, in the sense of being capable of being enjoyed by multiple individuals, but in fact irreducibly social, in the sense that, without a communal context, the goods could not in fact exist.⁴⁴⁷ He starts with the familiar example of language and speech: an atomistic account of language and speech must fail, as individuals speak, but their speech makes no sense without the referent of a common language that all in the linguistic community share, which in turn is not static but develops through neologisms and turns of

⁴⁴² Cf. *id.*

⁴⁴³ See, e.g., Ronald M. Green, *Access to Healthcare: Going Beyond Fair Equality of Opportunity*, 1 AM. J. BIOETHICS 22 (2001).

⁴⁴⁴ Daniel Callahan, *Ends and Means: The Goals of Health Care*, in ETHICAL DIMENSIONS OF HEALTH POLICY 3, 16–17 (Marion Danis et al., eds. 2002).

⁴⁴⁵ Daniels, *supra* note 437, at 19, 29–30.

⁴⁴⁶ E. Haavi Morreim, *Moral Justice and Legal Justice in Managed Care: The Ascent of Contributive Justice*, 23 J.L. MED. & ETHICS 247, 249 (1995).

⁴⁴⁷ Charles Taylor, *Socially Irreducible Goods*, in CHARLES TAYLOR, PHILOSOPHICAL ARGUMENTS 134–35 (1995).

phrase and changes in culture as developed through speech.⁴⁴⁸ Similarly, one's culture, for example, is irreducible to individual preferences, desires or values.⁴⁴⁹ One's culture not only provides the milieu in which one's actions are or become intelligible, but also is, at base, communal.⁴⁵⁰ It is not the result of an atomistic aggregation of the values and social practices of a collection of individuals, but instead is the result of a common understanding in regard to behavior, mores, etc., among members of a group. It both shapes and is shaped by its members.⁴⁵¹ Because of the irreducibly social nature of values and communal practices, we have a duty to preserve and further them at the communal level. Thus, if we fundamentally value caring for the sick, if we value health, if we value justice and equal opportunity, then we should further all of these values by ensuring that everyone is entitled to a decent minimum of health care.

Daniel Callahan believes we have not enacted a system of universal health coverage in the United States because we lack, as he aptly puts it, a sense of "social solidarity," such as one sees in many European nations.⁴⁵² Public works for the common good are far more common in many European nations that also have some form of universal health coverage.⁴⁵³ Ubiquitous and well-developed public transportation systems, welfare services, and even generous provision of public toilets all evidence a more robust public sphere and stronger provision for basic human needs than we enjoy in the United States. These amenities are based not on an appeal to individual rights, as would be more common in this country, but instead based on a strong ethic of social solidarity.⁴⁵⁴ Callahan suggests that we will see little movement in the U.S. towards universal coverage without first developing our own sense of social solidarity.⁴⁵⁵

Callahan may be in part correct. Even today, a clear majority of Americans support the creation of a universal, taxpayer-financed, government-run health plan, much like Medicare.⁴⁵⁶ A clear major-

⁴⁴⁸ *Id.*

⁴⁴⁹ *See id.*

⁴⁵⁰ *Id.*

⁴⁵¹ *Id.*

⁴⁵² Daniel Callahan, *It's the Culture, Stupid: Why We Don't Have Universal Health Care*, COMMONWEAL 8 (Feb. 11, 2000).

⁴⁵³ *Id.*

⁴⁵⁴ *Id.*

⁴⁵⁵ *Id.*

⁴⁵⁶ *See infra* note 526 and accompanying text.

ity supported a system of universal coverage, as well, when the Clinton plan was being developed, and when single-payer coverage was being contemplated in the 1970's.⁴⁵⁷ Nevertheless, we have yet to see any such universal coverage come into being, and in fact are presently drifting farther and farther from the immediate possibility of any such enactment. This may be, in part, because of the atomistic focus many Americans have on their individual self-interest, to the detriment of the social good. Another finding from the recent survey cited above suggests that Americans strongly oppose rationing care by, for example, not covering treatments that are "too costly, not essential or have too little chance of success."⁴⁵⁸ Yet such rationing would likely need to occur if any universal, government-run, taxpayer-financed system of coverage were to come about.

On the other hand, social solidarity may not be crucial in instituting at least *some* system of universal access to primary health coverage. In 1983, President Ronald Reagan's Commission on the Study of Ethical Problems in Medicine found that "society has an ethical obligation to ensure equitable access to health care for all:

Equitable access to health care requires that all citizens be able to secure an adequate level of care without excessive burdens. . . . When equity occurs through the operation of private forces, there is no need for government involvement, but the ultimate responsibility for ensuring that society's obligation is met, through a combination of public and private sector arrangements, rests with the Federal Government.⁴⁵⁹

This commission was appointed by a Republican president who claimed in his State of the Union address in 1983, the same year the commission report came out, that America's deficits were not caused by defense spending, but rather by spending on domestic programs.⁴⁶⁰ Yet even the commission came to the conclusion that we have a moral obligation to ensure a decent minimum of health care to all Americans. Surely we can do no less.

⁴⁵⁷ See Marmor & Oberlander, *supra* note 365, at 211–12 (citing Lawrence R. Jacobs, *The Politics of American Ambivalence Toward Government*, in *THE POLITICS OF HEALTH CARE REFORM* 378 (James A. Morone & Gary S. Belkin eds., 1994)).

⁴⁵⁸ See *Washington Post-ABC News Poll: Health Care*, WASH. POST, Oct. 20, 2003, at Questions 36, 37, available at <http://www.washingtonpost.com/wp-srv/politics/polls/vault/stories/data102003.html> (last visited Jan. 31, 2006).

⁴⁵⁹ PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *SECURING ACCESS TO HEALTH CARE*, v.1 (1983).

⁴⁶⁰ Ronald Reagan, *President Ronald Reagan's Address Before a Joint Session of The Congress on the State of the Union*, (Jan. 25, 1983), http://www.c-span.org/executive/transcript.asp?cat=current_event&code=bush_admin&year=1983 (last visited Jan. 31, 2006).

3. *Legal Issues*

As we have seen, different laws regulate each of the primary methods and programs through which U.S. residents typically access health care.⁴⁶¹ Most, while systematic, of course concern only the particular program with respect to which they were enacted. Moreover, most have become increasingly convoluted through repeated tinkering over the years, or through finely detailed and sometimes unintuitive judicial and regulatory interpretation.⁴⁶²

Certain aspects of health care regulation are necessarily complex. However, the multiplication of programs developed to provide care for segments of the population not covered by private health insurance is not. In fact, the proliferation of programs affording access to care has been conceived with no unifying design. The piecemeal approach we have taken to developing health care programs for needy segments of the population reveals a lack of both broad vision and collective political will. To date, no single program—whether in the form of universal health insurance, an individual mandate with refundable individual tax credits for all, or otherwise—has been enacted that would afford at least some coverage to all Americans. This is not to say that we ought not to afford access via public programs for those without health care. Rather, there is no reason that new programs, with new eligibility and regulatory requirements, should be created, when existing ones could be expanded, or—better yet—other solutions that would not add to the already cumbersome health care regime could be devised.

Rather than, for instance, revising and expanding the federal/state Medicaid program, which has been in existence for nearly forty years, both federal and state governments have instead added new, non-entitlement programs to provide health care to segments of the population who lack it. The SCHIP program, covering lower-income children who do not qualify for Medicaid, and programs such as the state of Washington's Basic Health program, are examples of such plans.⁴⁶³ Both were enacted in order to provide health coverage to individuals who do not qualify for Medicaid, as tradi-

⁴⁶¹ See *supra* Section IV.

⁴⁶² See, e.g., Sarah Rosenbaum & David Rousseau, *Medicaid at Thirty-Five*, 45 ST. LOUIS U. L.J. 7, 17 (2001).

⁴⁶³ See, e.g., 42 U.S.C.A. § 1397bb(b)(4) (West 2005) (providing that SCHIP is not an entitlement program); WASHINGTON STATE HEALTH CARE AUTHORITY, BASIC HEALTH FAQ, <http://www.hca.wa.gov/faq/bh.shtml> (last visited Jan. 31, 2006).

tionally conceived.⁴⁶⁴ Both provide benefits that are neither an entitlement, nor are cost-free to the recipient.⁴⁶⁵ Each has detailed rules concerning eligibility, implementation and oversight.⁴⁶⁶ Similar plans have been enacted in a multiplicity of jurisdictions, at the state and local levels.⁴⁶⁷

The multiplicity of different programs that provide health care for individuals and families meeting various criteria leads to several problems. First, the programs often contain significant areas of overlap. Individuals may be dually eligible for both Medicare and Medicaid, which leads to a rash of complex rules governing payment protocols where the both programs may provide for the same service.⁴⁶⁸ Those seeking care under the VA or Indian Health Care systems also face similar issues.⁴⁶⁹ Detailed assessments must be performed with respect to those who apply for a SCHIP program, or state or county indigent care, in order to ensure that they do not qualify for a different program instead.⁴⁷⁰ Where individuals are dually eligible for two or more federal programs, significant problems can arise concerning billing and payment, resulting in either insufficient or untimely payment to health care providers or overpayment when multiple programs are billed.⁴⁷¹

⁴⁶⁴ See, e.g., 42 U.S.C.A. §1397aa(a) (West 2005). SCHIP, for example, expressly excludes those who are eligible for Medicaid, and provides coverage to children whose incomes are too high to qualify for Medicaid. See 42 U.S.C.A. §§ 1397bb(b)(1)(B), (b)(3) (West 2005).

⁴⁶⁵ See 42 U.S.C.A. §§ 1397bb(b)(4), 1397cc(e) (West 2005); WASHINGTON STATE HEALTH CARE AUTHORITY, *supra* note 463.

⁴⁶⁶ See generally 42 U.S.C. §§ 1397aa–jj; WA. REV. CODE. §§ 70.47.001–901 (West 2005).

⁴⁶⁷ See, e.g., HB 806, 9th Gen. Assembly (Ill. 2005) (bill creating “All Kids” plan in Illinois, intended to provide coverage for more than 250,000 children in the state who presently lack coverage and do not qualify for an existing public program); HB 4463, 184th Gen. Court (Mass. 2005) (bill would institute an individual mandate to have health insurance in Massachusetts, and provide a public plan for those whose income does not exceed 300% of the Federal Poverty Level and who meet other criteria); Paul Fronstin & Jason Lee, *The Muskegon Access Health “Three Share” Plan: A Case History*, EMP. BENEFITS RES. INST. ISSUE BRIEF NO. 282 (June, 2005) (providing the history of the creation of the “three share” plan implemented in Muskegon, Michigan).

⁴⁶⁸ See, e.g., 42 U.S.C. § 1396m(a)(1) & (2) (providing for adjustments in federal matching payments in certain events in which payment has already been made under Medicare).

⁴⁶⁹ See, e.g., 42 U.S.C.A. § 1396j (West 2005) (providing conditions for eligibility for Indian Health Service facilities to receive reimbursement under Medicaid);

⁴⁷⁰ Congress expressly provided that SCHIP coverage is to be provided in coordination with other sources of health insurance such as Medicaid. See 42 U.S.C.A. § 1397aa(a) (West 2005). Thus, states must institute sufficient procedures to ensure that applicants are placed appropriately into SCHIP, Medicaid or another public plan, and that they are not eligible for other group coverage. See 42 U.S.C. § 1397bb(b)(3).

⁴⁷¹ See, e.g., the issue addressed in 42 U.S.C.A. § 1396m (West 2005).

The difficulties are compounded by the variation that one encounters from state to state. This is largely due to the different eligibility criteria each state has for Medicaid, as well as for any indigent care programs that it might have at the state and/or municipal level.⁴⁷² Federal law provides only a floor for Medicaid eligibility. For example, if a state wishes to participate in Medicaid (and receive federal matching funds in doing so), it cannot set the eligibility level for children between the ages of six and eighteen at 75% FPL, but instead must set it at least at 100% FPL.⁴⁷³ However, it can expand eligibility if it wishes, and many states do.⁴⁷⁴ An increasing number of states have also taken advantage of the waivers available under federal law for Medicaid programs to institute criteria that differ significantly from federal law, as a “demonstration program.”⁴⁷⁵

While the divergence of many states’ eligibility criteria from the floor set by federal law is often beneficial for Medicaid applicants, it can also contribute to confusion among applicants and beneficiaries concerning the program’s requirements, eligibility, and renewal requirements. Each state has its own test for determining Medicaid and other program eligibility, with its own income and asset guidelines.⁴⁷⁶ States also differ above the baseline with respect to the benefits they provide and whether and to whom they charge any copayments.⁴⁷⁷ It can be difficult for beneficiaries to obtain precise eligibility requirements from states, as usually only general information is offered.⁴⁷⁸

⁴⁷² See, e.g., EDITORIAL STAFF, CCH, 1999 MEDICARE AND MEDICAID BENEFITS 33 (1999).

⁴⁷³ The federal floor is mandatory with respect to children under the age of 18. See 42 U.S.C.A. § 1396a(a)(10)(A)(i)(III) (West 2005)

⁴⁷⁴ See, e.g., Sarah Rosenbaum & David Rousseau, *Medicaid at Thirty-Five*, 45 ST. LOUIS U. L. J. 7, 20 (2001).

⁴⁷⁵ See 42 U.S.C.A. § 1315 (West 2005); JEANNE LAMBREW, SECTION 1115 WAIVERS IN MEDICAID AND THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM: AN OVERVIEW 3 (July 2001), <http://www.kff.org/content/2001/4001/4001.pdf> (last visited Jan. 31, 2006).

⁴⁷⁶ See generally Donna Cohen Ross & Laura Cox, *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families* (Oct. 2005), <http://www.kff.org/medicaid/upload/In-a-Time-of-Growing-Need-State-Choices-Influence-Health-Coverage-Access-for-Children-and-Families-Report.pdf> (last visited Jan. 31, 2006) (surveying eligibility requirements imposed by the 50 states between July 2004 and July 2005).

⁴⁷⁷ For one example among many, see, e.g., KAISER COMM’N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAM. FOUND., BENEFITS BY SERVICE: CLINIC SERVICES, BY AN ORGANIZED FACILITY OR CLINIC NOT PART OF A HOSPITAL: FREESTANDING AMBULATORY SURGERY CENTER (Oct. 2004), <http://www.kff.org/medicaid/benefits/service.jsp?nt=on&so=0&tg=0&yr=2&cat=12&sv=4> (last visited Jan. 31, 2006).

⁴⁷⁸ For example, the information that the State of Texas provides for its residents concerning Medicaid and other public health programs provides only the following regarding eligibility requirements:

Legal complications are not limited to the public sphere. Because the McCarran-Ferguson Act of 1945 relegated regulation of insurers largely to each state, laws concerning private health insurance can differ significantly from state to state.⁴⁷⁹ Not only does this mean that each private insurer must comply with different laws of operation in each of the states in which it does business, rather, it also means that it must comply with various “mandated coverage” and other requirements from state to state that affect the composition of the benefit packages it may offer for sale.⁴⁸⁰ ERISA, as discussed above, also leads to a tangle of different regulations that apply to individuals’ health care not merely based on the state in which they live, but also on certain characteristics of the source through which they obtain their health insurance.⁴⁸¹

Significant additional complexity is added by the tangle of healthcare fraud and antitrust regulations that have arisen and proliferated in the past thirty years. Medicare was modeled on the Blue Cross/Blue Shield plan, which had few cost containment measures, and in fact contained the seeds for significant cost inflation.⁴⁸² Prior to the inception of Medicare and Medicaid, the federal government had little reason to be concerned about health care cost inflation, as it was generally not in the business of providing health care on a large scale.⁴⁸³ However, after the passage of Medicare and Medicaid in 1965 and, in ensuing years, a concomitant escalation in health care costs and rapid advances in expensive medical technology, the federal government began to realize it needed to take steps to put a

To qualify for Medicaid, you or your children must: Be a Texas resident. Be a U.S. citizen or a legal resident. Meet certain resource and income limits. Fit into one of these groups: Families and children with limited income; Children; Pregnant women; Non-U.S. citizen needing emergency medical services; Children who are medically needy due to high medical bills (under 19 years of age); Recipients of Supplemental Security Income (SSI) from Social Security Administration; Persons having low-income and needing long-term care or help with daily activities.

See TX HEALTH AND HUMAN SERVS. COMM’N, A CONSUMER GUIDE TO BETTER HEALTH CARE 7 (2005).

⁴⁷⁹ 15 U.S.C.A. §§ 1011, 1012 (West 2006).

⁴⁸⁰ See, e.g., Janet Stokes Trautwein, *Options and Opportunities for Individuals and Families in the Private Health Insurance Market*, HEALTH AFF. — WEB EXCLUSIVE, Oct. 23, 2002, http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.387v1/DC1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=%22mandated+benefits%22&andorexactfulltext=and&searchid=1130963087772_3235&stored_search=&FIRSTINDEX=0&resourcetype=1&journalcode=healthaff (last visited Jan. 31, 2006).

⁴⁸¹ See *supra* notes 213–217 and accompanying text.

⁴⁸² See *supra* notes 83–88 and accompanying text.

⁴⁸³ Only federal military, veteran, Native American and prison health care systems were extant in some form prior to the inception of Medicare.

check on costs.⁴⁸⁴ It accomplished this via several means over the following decade. Rather than allowing providers to set their own fees, the federal government instituted a prospective payment system that went into effect in 1983.⁴⁸⁵ It altered laws intended to combat fraud and abuse, such as the False Claims Act, in order to modernize them and increase their applicability to health care.⁴⁸⁶ It enacted new laws to help prevent kickbacks and provider self-referral.⁴⁸⁷ And it increasingly began to apply and enforce antitrust laws against health care providers.⁴⁸⁸

These changes have helped lead, unwittingly, to the evolution of health care regulation from a relatively small discipline concerned primarily with medical malpractice, licensure, and bioethical matters to a comparatively vast and ever-growing field with fraud and abuse, anti-kickback measures, and antitrust at its center.⁴⁸⁹ The sheer volume of regulation is daunting. A 1999 Mayo Clinic study found, for example, that hospitals must comply with 132,720 pages of Medicare rules alone.⁴⁹⁰ These laws and regulations can change substantially from year to year, and providers must keep up with all of them. The penalties for noncompliance—often even if unintentional—can be severe.⁴⁹¹

Countries with single-payer systems, conversely, lack this convoluted and enormous health law landscape. Canada, for example, has few if any regulations specifically relating to health care

⁴⁸⁴ See *supra* section I.D.

⁴⁸⁵ See *supra* note 98 and accompanying text.

⁴⁸⁶ See, e.g., Joan H. Krause, *Regulating, Guiding and Enforcing Health Care Fraud*, 60 N.Y.U. ANN. SURV. AM. L. 241, 243 (2004).

⁴⁸⁷ See, e.g., Joan H. Krause, *A Conceptual Model of Health Care Fraud Enforcement*, 12 J.L. & POL'Y 55, 68–69, 77–78 (2003).

⁴⁸⁸ Clark C. Havighurst, *Health Care as a (Big) Business: The Antitrust Response*, 26 J. HEALTH POL. POL'Y & L. 939, 942–43 (2001).

⁴⁸⁹ See, e.g., Clark C. Havighurst, *American Health Care and the Law—We Need to Talk!*, HEALTH AFF., July–Aug. 2000, at 85.

⁴⁹⁰ See, e.g., *Task Force on Health of the Budget Committee of the U.S. House of Representatives*, 106th Cong. (May 18, 2000) (testimony of Katherine Murray).

⁴⁹¹ For example, the penalties for violating the Medicare and Medicaid Anti-Kickback Statute include incarceration for up to five years and a fine of \$25,000 per violation, as well as exclusion from all federal health care programs. 42 U.S.C. §§ 1320a-7a, 1320a-7b, 1320-7(a)(1) & (3) (West 2005). In 2002, the federal government won \$1.6 billion from false claims actions. See DEPT. OF HEALTH AND HUMAN SERVS. AND DEPT. OF JUSTICE, HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM: ANNUAL REPORT FOR FY 2002 (Sept. 2003), <http://www.usdoj.gov/dag/pubdoc/hcfacreport2002.htm> (last visited Jan. 31, 2006); 42 U.S.C.A. 1320a-7a (2005); 42 U.S.C.A. 1320a-7b (2005).

fraud.⁴⁹² Laws such as ERISA and the access portions of HIPAA are largely unnecessary in the United Kingdom. In such nations, health law largely resembles what it resembled in the United States prior to the inception of Medicare and Medicaid.⁴⁹³ Ironically, this is the case despite the dominance of government in the provision of health care in such countries. It may be that the relative simplicity and universality of the system of healthcare finance in these countries and the fact that all citizens and legal residents are entitled to the same basic package of benefits have necessitated far less regulation than the multifaceted and incomplete system found in the United States.

Accidental features of the American health care landscape have resulted in significant unnecessary legal complexity. This complexity not merely makes it difficult for people to determine the rules of the health care regime under which they operate, but also significantly increases the operating costs for all the plans concerned.⁴⁹⁴ A simplified system would be more intuitive and comprehensible for participants, and should lead to increased coverage. Additionally, many of the expenses associated with navigating our present web of overlapping and duplicative legislation at the state and federal levels would no longer apply, leading to reduced health care costs.

4. *Economic Issues*

Providing health care to the tens of millions of Americans who lack insurance is an expensive proposition.⁴⁹⁵ Although the uninsured receive far less care than the insured, they still utilize health care.⁴⁹⁶ The Hadley and Holahan study cited earlier estimated that the uninsured received an average of \$1,253 per person in care in

⁴⁹² For example, Ontario's Health Insurance Act appears to contain only one primary provision prohibiting health care fraud. See R.S.O. 1990, c. H.6, s. 43 (Lexis 2005).

⁴⁹³ Compare, e.g., Timothy Stoltzfus Jost, *Comparative and International Health Law*, 14 HEALTH MATRIX 141 (2004) (evaluating the growth of comparative and international health law and the themes studies therein), with Mark A. Rothstein, *The Growth of Health Law and Bioethics*, 14 HEALTH MATRIX 213 (2004) (charting the development of health law into a discipline driven significantly by federal and state regulatory statutes since the mid-1960s).

⁴⁹⁴ See, e.g., Kenneth E. Thorpe, *Inside the Black Box of Administrative Costs*, HEALTH AFF., Summer 1992, at 41, 43 (identifying regulatory compliance as one of the primary drivers of administrative costs for health insurance in the United States).

⁴⁹⁵ Jack Hadley & John Holahan, *How Much Medical Care Do the Uninsured Use, and Who Pays for It?*, HEALTH AFF. — WEB EXCLUSIVE, Feb. 12, 2003, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.66v1/DC1> (last visited Jan. 31, 2006).

⁴⁹⁶ *Id.*

2001, as compared to \$2,484 per person spent on care for the insured during the same year.⁴⁹⁷ This is in keeping with numerous other studies showing that the uninsured use significantly less medical care, on average, than the insured.⁴⁹⁸ Hadley and Holahan estimate that the uncompensated cost of care used by the uninsured in 2001 totaled approximately \$35 billion.⁴⁹⁹ While this is a substantial sum, it is useful to put it in perspective. For example, it comprises only 2.8% of total U.S. health care expenditures for that year.⁵⁰⁰ In comparison with government expenditures on Medicare (\$247 billion), Medicaid (\$226 billion), and tax subsidies to support private health insurance (\$188.5 billion) in 2004, it is modest at most, if not insignificant.⁵⁰¹

Interestingly, the study found that most of those “uncompensated” costs were likely made up by a patchwork of public and private revenues. The study’s estimate of the share of various payments, such as disproportionate share hospital (DSH) payments, made through Medicare and Medicaid, in addition to payments by state and local governments, totals \$30.6 billion.⁵⁰² Private philanthropy raises that amount even higher, to an estimated \$38.1–40.4 billion.⁵⁰³

It is worth a moment to examine the governmental sources of payments to help cover uncompensated costs of treating the uninsured more closely. The first are DSH payments made through the Medicare and Medicaid programs. DSH payments are upward adjustments to the Medicare and Medicaid reimbursement rates for services rendered to Medicare and Medicaid patients at hospitals that treat an unusually large number of poor patients.⁵⁰⁴ They are intended to help keep such hospitals solvent, in part by helping make up for uncompensated costs for medical treatment.⁵⁰⁵ Hadley and Holahan note that Medicare and Medicaid DSH adjustments to

⁴⁹⁷ *Id.*

⁴⁹⁸ See, e.g., COVERAGE MATTERS, *supra* note 11.

⁴⁹⁹ See Hadley & Holahan, *supra* note 495.

⁵⁰⁰ *Id.*

⁵⁰¹ See, e.g., *id.*; see also *supra* notes 116–117 and accompanying text.

⁵⁰² *Id.*

⁵⁰³ *Id.*

⁵⁰⁴ See, e.g., Theresa A. Coughlin et al., *States’ Use of UPL and DSH Financing Mechanisms*, HEALTH AFF., Mar.–Apr. 2004, at 245, 246–47.

⁵⁰⁵ *Id.* at 246.

all U.S. hospitals totaled approximately \$20.6 billion in 2001.⁵⁰⁶ Another source of revenue used in part to make up for uncompensated costs of treating the poor and uninsured are indirect medical education (IME) payments through Medicare.⁵⁰⁷ While a significant portion of that revenue is intended to compensate teaching hospitals for training physicians, part of it is also intended to compensate for care provided to the poor and uninsured.⁵⁰⁸ In 2001, IME payments totaled \$3.7 billion.⁵⁰⁹ Medicaid upper payment limit (UPL) mechanisms raise Medicaid payment rates to certain hospitals.⁵¹⁰ UPL mechanisms draw additional federal Medicaid funds that are supposed to be (but are not always) used to support public hospitals.⁵¹¹ In 2001, UPL payments totaled approximately \$1.2 billion.⁵¹² Lastly, the federal government also funds FQHC, IHS, and other clinics that provide significant amounts of care to the uninsured.⁵¹³

Additionally, states and localities often have special programs to provide limited health care to the uninsured. As one example, Texas counties are required by law to fund limited amounts of health care to impoverished uninsured residents who do not qualify for other health insurance.⁵¹⁴ Although the services offered are relatively regular from county to county, each county has different eligibility requirements.⁵¹⁵ In 2001, total reported spending in Texas's county indigent health care programs was over \$71 million, with more than \$61 million spent by individual counties and the remainder contributed by the state.⁵¹⁶

⁵⁰⁶ Hadley & Holahan, *supra* note 495 (citing Congressional Budget Office, "CBO April 2001 Baseline: Medicare" (Washington: CBO, May 18, 2001)).

⁵⁰⁷ See, e.g., Linda E. Fishman & James D. Bentley, *The Evolution of Support for Safety Net Hospitals*, HEALTH AFF., July–Aug. 1997, at 30, 40–41.

⁵⁰⁸ *Id.*

⁵⁰⁹ Hadley & Holahan, *supra* note 495 (citing Congressional Budget Office, "CBO April 2001 Baseline: Medicare" (Washington: CBO, 18 May 2001)).

⁵¹⁰ *Id.*

⁵¹¹ See Coughlin, *supra* note 504, at 246–47.

⁵¹² Hadley & Holahan, *supra* note 495 (citing T.A. Coughlin and B. Bruen, *State Use of Medicaid UPL and DSH Financing Mechanisms*, prepared for the Kaiser Commission on Medicaid and the Uninsured (Washington: Kaiser Family Foundation, forthcoming)).

⁵¹³ See, e.g., *id.*

⁵¹⁴ See, e.g., TX. HEALTH & SAFETY CODE § 61.006 (West 2002).

⁵¹⁵ See Laura D. Hermer & William J. Winslade, *Access to Health Care in Texas: A Patient-Centered Perspective*, 35 TEX. TECH. L. REV. 33, 73–74 (2004).

⁵¹⁶ See TX DEP'T OF HEALTH, COUNTY INDIGENT HEALTH CARE PROGRAM, SUMMARY FOR FY 2001 (Jan. 23, 2002), http://www.tdh.state.tx.us/cihcp/Spending_Data/ihc_down.htm (last visited Jan. 31, 2006).

This patchwork of funds intended to help cover the costs of providing unreimbursed care to the impoverished and uninsured is not only complex, incomplete and untied to actual compensation for medical services rendered to the uninsured, but it is also distressingly unstable. While many of the funds are given in reimbursement for services provided under the entitlement programs of Medicare and Medicaid, there is of course no “entitlement” for providers to receive DSH, IME, and UPL payment adjustments. Congress can decide to limit or cut such payments at any time, as the Bush Administration recently proposed with respect to UPL adjustments.⁵¹⁷ Additionally, such payments are only incidentally or in part designed to make up for some of the unreimbursed costs of treating the uninsured. If a hospital’s actual expenses incurred from providing graduate medical education go up, for example, but their IME payments do not, then less money is left to help make up for the costs of uncompensated care.

Unsurprisingly, when revenues decline, providers can lose their ability to offer their services to those who cannot pay, or who cannot pay enough to offer a profit. Providers do not merely face the prospect of shrinking governmental payments to make up for unreimbursed care for the uninsured. Rather, they also face shrinking payments from the Medicaid, SCHIP, and local indigent care programs. In FY 2003, for example, a survey by the Kaiser Commission on Medicaid and the Uninsured found that every state in the union, as well as the District of Columbia, undertook at least one cost-containment measure in their Medicaid programs.⁵¹⁸ The same survey found that all fifty states and the District of Columbia intend to implement more such measures in FY 2004.⁵¹⁹ For forty-nine out of fifty states, Medicaid cost containment measures included freezing or reducing provider reimbursements.⁵²⁰ At least one recent

⁵¹⁷ See, e.g., LEIGHTON KU & EDWIN PARK, CTR. ON BUDGET AND POLICY PRIORITIES, ADMINISTRATION’S REGULATION TO REDUCE MEDICAID “UPPER PAYMENT LIMIT” WOULD FURTHER WORSEN STATE BUDGET CRISES (Dec. 11, 2001), <http://www.cbpp.org/12-11-01health.pdf> (last visited Jan. 31, 2006).

⁵¹⁸ VERNON SMITH ET AL., KAISER COMM’N ON MEDICAID AND THE UNINSURED, STATES RESPOND TO FISCAL PRESSURE: STATE MEDICAID SPENDING GROWTH AND COST CONTAINMENT IN FISCAL YEARS 2003 AND 2004, 2 (Sept. 2003), <http://www.kff.org/medicaid/upload/States-Respond-to-Fiscal-Pressure-State-Medicaid-Spending-Growth-and-Cost-Containment.pdf> (last visited Jan. 31, 2006).

⁵¹⁹ *Id.*

⁵²⁰ *Id.*

study has shown that low reimbursement rates decreases provider participation in Medicaid.⁵²¹

Of course, during an economic downturn, the need for Medicaid and SCHIP rises at the same time as funds supporting the program decline. Because the government provides health care through these programs only to the impoverished or less well-to-do, the number of individuals who qualify for the program tends to fluctuate inversely with the country's economic fortunes, among other factors. One study found that if the unemployment rate rose from 4.5% to 5.5%, the number of individuals on Medicaid would correspondingly rise by 1.6 million—an increase in the Medicaid population of 3.6%—at a cost of over \$1 billion to the state.⁵²² Despite the need for increased funding, however, states tend to budget less during economic downturns, due to decreased revenues and the balanced budget amendments passed by many states in the flush years of the 1990s.⁵²³ Thus, at a time when the federal and state governments should be budgeting more money for public health programs, they often are constrained, sometimes under their very own laws, to budget less.

5. *Universal Primary Care Access*

The revolving door posed by private employer-based coverage and the Medicaid and SCHIP programs, particularly when considered in conjunction with issues of poor provider reimbursement, makes for inadequate and frequently unstable health care for those who make use of the programs. Health care provided to the uninsured is frequently even worse, as we saw earlier. Because of the uncertainty of funding, the uninsured frequently seek care later than those with insurance, receive less health care than those with insurance, are sicker than those with insurance once they finally obtain medical service, and tend to experience worse outcomes than those with health insurance.⁵²⁴

⁵²¹ See R. E. Santerre, *The Inequity of Medicaid Reimbursement in the United States*, 1 APPLIED HEALTH ECON. & HEALTH POL'Y, 25, 31 (2002).

⁵²² KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAM. FOUND., MEDICAID COVERAGE DURING RISING UNEMPLOYMENT (Dec. 2001), <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&pageID=13897> (last visited Jan. 31, 2006).

⁵²³ Numerous states were plagued with this problem in the early 2000s. See, e.g., DONALD BOYD, KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE CURRENT STATE FISCAL CRISIS AND ITS AFTERMATH 8-9 (Sept. 2003), <http://www.kff.org/medicaid/upload/The-Current-State-Fiscal-Crisis-and-Its-Aftermath-PDF.pdf> (last visited Jan. 31, 2006).

⁵²⁴ See *supra* notes 421–426 and accompanying text.

Americans strongly support the provision of universal health insurance. In an ABC News/Washington Post survey conducted in October, 2003, one thousand randomly selected adults were asked:

Which would you prefer—the current health insurance system in the United States, in which most people get their health insurance from private employers, but some people have no insurance; or a universal health insurance program, in which everyone is covered under a program like Medicare that's run by the government and financed by taxpayers?⁵²⁵

Sixty-two percent of respondents replied that they would favor the universal, taxpayer-financed, and government-run system.⁵²⁶ The same percentage would support such a system even if it meant that there would be waiting lists for some non-emergency treatments.⁵²⁷ Fifty-seven percent would support such a system even if it restricted their choice of physician.⁵²⁸

There is a better way than our present system to provide health care, one that is less wasteful, that would cost little more than we already spend, and that would provide everyone with a better and more consistent quality of care. One answer is primary health care for all. By providing universal access to coverage for primary health care, we could solve the problems faced by tens of millions of Americans with respect to continuity of coverage. This, in turn, would help ensure not only that everyone would have access to primary care when they need it, but also could remain with the same health care provider, rather than having to continually switch as their type of coverage changes. Thus, both patients and health care providers benefit. Universal access to coverage could also lead to dramatic improvements in basic measures of public health by providing everyone with economic access to basic provider services such as checkups and prenatal care. By ensuring that everyone had access to coverage for basic primary care, we could significantly improve the overall health of our population. Everyone—not just those fortunate enough to have access to present systems of coverage—could benefit.

Primary health care services that would be covered under this plan include those typically covered by community health centers:

⁵²⁵ See *Washington Post-ABC News Poll*, *supra* note 458, at Question 47.

⁵²⁶ *Id.*

⁵²⁷ *Id.* at Question 49.

⁵²⁸ *Id.* at Question 48.

- (1) health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and midwives;
- (2) diagnostic laboratory and radiological services;
- (3) preventive health services, including—
 - (a) prenatal and perinatal services;
 - (b) screening for breast and cervical cancer;
 - (c) well-child services;
 - (d) immunizations against vaccine-preventable diseases;
 - (e) screenings for elevated blood lead levels, communicable diseases, and cholesterol;
 - (f) pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care;
 - (g) voluntary family planning services; and
 - (h) preventive dental services;
- (4) emergency medical services;
- (5) outpatient pharmaceuticals;
- (6) referrals to providers of other health-related services (including substance abuse and mental health services);
- (7) services that enable individuals to use covered health services (including outreach and transportation services and, if a substantial number of the individuals in the population are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals); and
- (8) education of patients and the general population regarding the availability and proper use of health services.

These services cover the basic health care needs of most Americans.⁵²⁹ They also cover those medical services that are most likely to have a significant positive impact on the overall health of the American population. Providing for all Americans' basic medical needs and preventative care such as evaluation of health problems, care for normal pregnancies, well-child visits, vaccinations, consultation regarding healthy life habits, yearly physical examinations, and screening for issues such as hypertension, diabetes, high cholesterol and breast, cervical, and prostate cancer will go a long way towards improving the health of everyone in this country. Such ser-

⁵²⁹ For a discussion of services for the disabled, those with less common chronic conditions, and the uninsured who experience a health catastrophe, see *infra* Section VI.C.5.

vices are relatively inexpensive and technologically non-intensive.⁵³⁰ Many of the services can be provided by nurse practitioners, physician assistants, midwives, in addition to or in lieu of physicians.⁵³¹

By providing primary health care to all U.S. residents, we will be able to coordinate care that is presently often haphazard and sporadic at best. Individuals on Medicaid, SCHIP, and—to a lesser but still significant degree—private health insurance often jump between having coverage and being uninsured. Those with no consistent source of coverage often also have no consistent health care provider, which can lead to duplication of efforts and confusion about earlier treatment and services.⁵³² It also can often lead to inadequate or late treatment, both of which can, and do, have disastrous health consequences for those without a consistent and reliable source of health care coverage.⁵³³

Providing primary health care to all U.S. residents would require few changes to the system already in place, other than substantial revisions to the legal code. Private practitioners could remain in their present groups, and would retain the same autonomy that they presently do. Hospitals would continue to run just as they do at present. Much as occurred with the vast migration to managed care, most primary care practitioners would likely need to accept the payment offered for services through the primary health care program in order to remain economically viable. Because the vast majority of most primary care providers' revenues would come from income from the primary care program, such providers will have to be paid reasonable rates, unlike those they receive under the Medicaid and SCHIP programs in many states.⁵³⁴ Additionally, we

⁵³⁰ See, e.g., A.M. Annis et al., *Family History, Diabetes, and Other Demographic and Risk Factors Among Participants of the National Health and Nutrition Examination Survey 1999-2002*, 2 PREVENTIVE CHRONIC DISEASE A19 (Mar. 2005); P.A. Ubel et al., *The Influence of Cost-Effectiveness Information on Physicians' Cancer Screening Recommendations*, 56 SOC. SCIENCE & MED. 1727 (2003); L.J. Lessure & H.M. Griffith, *Putting Prevention Into Clinical Practice: A Program for Occupational Health Nurses*, 43 OFFICE J. AM. ASS'N OCC. HEALTH NURSES 72 (1995).

⁵³¹ See, e.g., Leah B. Sansbury et al., *Physicians' Use of Nonphysician Health Care Providers for Colorectal Cancer Screening*, 25 AM. J. PREVENTIVE MED. 179 (Oct. 2003); K. R. Yabroff et al., *Effectiveness of Interventions to Increase Papanicolaou Smear Use*, 26 J. AM. BOARD FAM. PRAC. 188 (2003); Mikel Gray, *The Importance of Screening, Assessing and Managing Urinary Incontinence in Primary Care*, 15 J. AM. ACAD. NURSE PRACTITIONERS 102 (Mar. 2003).

⁵³² See, e.g., COVERAGE MATTERS, *supra* note 11.

⁵³³ See *infra* notes 421–426 and accompanying text.

⁵³⁴ Provider reimbursement rates for Medicaid and SCHIP are lower in most states than reimbursement under Medicare or private health insurance plans. For one example of such rates in comparison with Medicare rates, see, e.g., Texas Medicaid & Healthcare Partnership, Fee Schedules, <http://www.tmhpc.com/file%20library/default.aspx?RootFolder=%>

would need to train significantly more primary care practitioners, for example by increasing practice incentives.

While providing primary health care for all U.S residents may appear to be a costly proposition, many if not most of the costs could be recouped from savings in other areas. For example, money to support federally funded health clinics and other primary care services for poor and underserved populations could be funneled to the primary care program. Money that would have otherwise funded primary health services for Medicaid, SCHIP and Medicare populations would also be similarly allocated, as would funds such as those provided under the DSH and UPL payment systems.

Additionally, the enormous tax subsidy that the federal government provides to employers for employee health insurance could be phased out in part, or entirely. As employers would only need to provide catastrophic health coverage, the government would permit them only to deduct those funds, at most. More robust coverage—for example, full service plans providing “Cadillac” coverage for services otherwise provided through the primary health program—would not qualify for any tax exemption, though employers would not be prevented from offering it.

Notably, the universal primary care plan would not provide catastrophic or specialty health coverage. “Catastrophic” coverage encompasses coverage for significant unexpected or long-term medical conditions that are not addressed by primary health care. Individuals and families would need to make their own arrangements in this regard. Employers could, if they wished, offer catastrophic and specialty coverage to their employees as a benefit; however, as universal primary care access would be funded at least in part by eliminating the tax deductibility of employee health insurance benefits for employers, health insurance would cease to be as strongly linked as it is now to employment. Therefore, other options would be necessary.

If they could not obtain such coverage through an employer, individuals and families above a certain income level would need to purchase private catastrophic and specialty health insurance for themselves. Private health insurers would still exist, as there would certainly be a market for such policies. If individuals or families wished to purchase coverage on the private market, they could do so through a purchasing cooperative that would exist in each state.

A single cooperative—either public or private—would exist in order to greatly expand the risk pool. Different insurers would negotiate with the cooperative to offer different policies at varying rates to the cooperative's members. The cooperative would be run by individuals selected directly or indirectly by the cooperative's members. The selection process in a private system would be akin, for example, to the choosing of board members by the shareholders of a corporation. Each member would exercise one vote. The cooperative would specify the minimum benefit package available, and would offer a variety of packages not only at the baseline, but also with expanded benefits.

The disabled, low-income elderly, indigent, and low- to middle-income individuals and families would also need catastrophic and specialist coverage. For such individuals and families, the federal government would administer an entitlement program to provide the necessary coverage. Below a certain income level—for example, 200% FPL—the program would be free of charge to anyone who is eligible for it. After that, a charge would gradually be implemented on a sliding scale for individuals and families earning between 201% FPL and 400% FPL. Anyone earning over 400% FPL could participate in the program if they wished, but would need to pay full price for it.

Public catastrophic and specialist coverage would likely include reasonable coverage for all inpatient hospitalizations and procedures, outpatient surgeries and procedures, chemotherapy, prescription drug supplies for conditions anticipated to exist for more than thirty days, therapeutic and rehabilitative services, long-term psychological and psychiatric services, home health services, hospice care, and services provided by long-term care facilities.

Such a system, therefore, would not be a wholesale turn to single-payer coverage. Rather, it leaves a place for private insurance and other providers within the framework that presently exists, albeit with significantly reduced confines. Yet it also sets the stage for an ultimate transition to a single-payer system, should we wish to proceed further in that direction. Most important of all, it makes an excellent start towards providing coverage for all U.S. residents, within a system that can far more readily control costs at the level of allocation, rather than demand.

V. CONCLUSION

Our system of health coverage, which is primarily based on private coverage, is in significant need of an overhaul. The rising cost of health services, and in turn health coverage, is unsustainable.⁵³⁵ Since the 1970s, America has increasingly (though certainly not solely) sought remedies for problems in coverage and rising health care costs through the private rather than public market.⁵³⁶ Yet in recent years, health care costs have skyrocketed and the number of uninsured Americans has risen to record levels, while the present administration sought and obtained myriad forms of increased private market reliance as ostensible remedies to these and other issues.⁵³⁷ Increased reliance on the private market has not controlled costs.⁵³⁸ It has not led to increased private coverage.⁵³⁹ The out-of-pocket costs of health coverage are increasing for many Americans, both privately and publicly insured, yet benefits are either remaining the same or, more often, slipping.⁵⁴⁰ Yet at the same time, profits in certain sectors of the health industry outstrip by many times the average profits in other industries.⁵⁴¹

Increasing reliance on a system that is not functioning to benefit patients, in contradistinction to private shareholders and other financial stakeholders, is not the answer to our system's present problems. This is particularly the case when the contemplated reforms, which will likely increase reliance on the individual market, will likely also fail to extend present group market protections to the individual market. Rather, we must consider other avenues.

Rather than further supporting the growth of HSA/HDHPs, formally encouraging small, locally based consumer cooperatives

⁵³⁵ The 109th Congress and the Bush administration both realize this, though it appears their reaction to the issue might be somewhat different than suggestions of the sort proposed here. See, e.g., Robert Pear, *Applying Brakes to Benefits Gets Wide G.O.P. Backing*, N.Y. TIMES, Jan. 9, 2005, at A17.

⁵³⁶ See, e.g., DERICKSON, *supra* note 24, at 160–65.

⁵³⁷ See *supra* Sections II, IV.

⁵³⁸ See *supra* notes 95–103 and accompanying text.

⁵³⁹ See, e.g., John Holahan & Allison Cook, *Changes in Economic Conditions and Health Insurance Coverage*, HEALTH AFF. — WEB EXCLUSIVE, Nov. 1, 2005, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.498/DC1> (last visited Jan. 31, 2006). Use of Health Insurance Flexibility and Accountability (HIFA) waivers led to slightly expanded coverage within some of the Medicare and SCHIP programs that employed them, but that is another matter. See, e.g., KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID SECTION 1115 WAIVERS: CURRENT ISSUES 2 (2005), http://www.kff.org/medicaid/upload/50201_1.pdf (last visited Jan. 31, 2006).

⁵⁴⁰ See *supra* Section II.

⁵⁴¹ See *supra* notes 2–3 and accompanying text.

for health insurance would be one positive step. Contrary to the likely effects of HSAs and other consumer-driven health plans, membership in such a consumer cooperative would genuinely require at least indirect participation in and consideration of difficult issues concerning health care coverage, cost and reimbursement. Legislators and policymakers who honestly believe health care consumers must become more responsible for their own health care costs and decisions should give serious thought to encouraging the formation of such cooperatives.

Yet even genuinely expanded health coverage decision-making by consumers will not, alone, likely stem the tides of rising costs, diminished coverage, poor public health outcomes, and other present health care woes. The time has come to embrace at least a limited form of guaranteed coverage. Universal single-payer primary care coverage could afford access to the basic health services most needed by all U.S. residents.⁵⁴² These services will be most likely to improve the basic health and longevity of all Americans.⁵⁴³ It would make everyone a stakeholder in a single system, rather than perpetuating our present piecemeal methods of access. And both improvements in efficiency and consolidation of services and payments already provided through a number of other programs would likely reduce significantly the price tag of such a program.⁵⁴⁴ All U.S. residents, no matter what their present health insurance status, stand to gain through such a system, especially since it should close the present revolving coverage door, make general health services available to everyone, and institute a global budget through which costs can be far more easily controlled than through our present system. Certain financial stakeholders would take significant losses; however, a reduced private market would still exist that would largely serve those whom it presently does. This, however, should not be a primary consideration of our health care system. Rather, the needs of those who access it should be the primary focus of our health care system. Instituting a system of universal, single-payer, primary health coverage would be a first step toward reorienting the goals of our health care system from satisfying the needs of financial stakeholders to satisfying the health care needs of all Americans.

⁵⁴² See *supra* Section VI.C.5.

⁵⁴³ See, e.g., *supra* Section VI.C.1.

⁵⁴⁴ See, e.g., *supra* note 19 and accompanying text.