

# THE REGULATORY VISION OF UNIVERSAL HEALTHCARE IN THE UNITED STATES: STRATEGIC, ECONOMIC, AND MORAL DECISION- MAKING

Miriam F. Weismann\*  
Dr. Irving Jorge\*\*

## ABSTRACT

The U.S. Constitution does not include healthcare as a fundamental legal right nor have the courts declared it so. The clear reluctance of the Supreme Court to find constitutional support for equal access to healthcare makes some sense given the synergy between the economics of the healthcare delivery in the U.S. and the national public health policy limiting access to medical treatment. Specifically, the current fragmented system of healthcare delivery and reimbursement is grounded in an economic system of free market competition. Thus, the notion of universal coverage is antithetical to a system that makes a profit from limiting access and rationing care based on profit motive. The best prospect for reform, as opposed to the piecemeal reforms of the well-intentioned Affordable Care Act, requires Congress to remove “basic coverage” from private sector financing and substitute a single payer system that includes core coverage health services for all. National access to basic coverage would become the normative baseline for healthcare access and delivery and a positive policy of healthcare reform.

---

\* J.D., LLM (TAXATION) Miriam Weismann is a Professor of Business Law and Tax and the Academic Director of the Healthcare MBA, Florida International University. She served as the United States Attorney for the Southern District of Illinois and was the Assistant Supervisory Special Counsel to the Office of Special Counsel, John C. Danforth, WACO investigation. Her most recent book, *Money Laundering-Legislation, Regulation & Enforcement*, was published in 2015. A special thank you to Dr. Raymond Gailitis, Margate, FL for his wise editorial assistance.

\*\* MD,MBA Dr. Irving Jorge is a Surgeon at Mt. Sinai Hospital, Miami, FL.

I. THE LEGAL DECISION: HEALTHCARE IS NOT A FUNDAMENTAL	
LEGAL RIGHT.....	649
No Constitutional Right .....	649
No Support in Case Law .....	650
II. THE MORAL DECISION: OWNING A GUN IS A FUNDAMENTAL	
CONSTITUTIONAL RIGHT.....	652
Morality.....	652
A Built-in Conflict of Interest .....	653
A Call for Intervention: Economists and Legislators.....	656
III. THE SPENDING CRISIS: IT'S NOT LIKE WE DON'T SPEND .....	659
The Efficiency Principle .....	660
Data Analysis .....	661
Cost/Benefit Analysis: Distortions in the Free Market system.....	664
IV. THE FRAGMENTED HEALTHCARE SYSTEM: PROFIT-MAXIMIZING	
PRICE DISCRIMINATION .....	667
The Five System Fragments.....	668
V. THE PROBLEM OF THE UNINSURED: COST SHIFTING.....	673
VI. THE UNINTENDED CONSEQUENCES OF THE ACA: WHY IT DIDN'T	
REFORM.....	677
Emasculation of Medicaid Expansion.....	678
Insurance Companies Back Out of the ACA Insurance	
Exchange Marketplace: Guaranteed Issue, Community	
Rating and the Individual Mandate.....	679
VII. THE FAILURE OF FREE MARKETS: WHAT OTHER DEVELOPED	
COUNTRIES DO .....	682
The Fear of Rationing .....	682
The Global Perspective: System Comparisons.....	683
VIII. THE REGULATORY SOLUTION: SINGLE PAYER SYSTEM AND	
UNIVERSAL HEALTHCARE.....	687
Guidance for a Blueprint.....	687
Regulatory Vision.....	688
Selecting the Core Set of Services.....	689
Step 1. Topic Nomination .....	690
Step 2. Draft and Final Research Plans.....	690
Step 3. Draft Evidence Review and Draft Recommendation	
Statement.....	691
Step 4. Final Evidence Review and Final Recommendation	
Statement.....	691
Financing: Lessons Learned.....	692
IX. THE CONCLUSION: THE NEW SOCIAL CONTRACT.....	694

*These characteristics of the health system—its complexity, its resistance to change, and the diversity of perspectives within it—give health-sector reform an episodic and cyclical character. When some internal or external shock does focus national attention on health-sector reform, a specific feature of the system is often identified as critical, and this then becomes a target for major reform efforts. But the initial reform steps often lead to further, unanticipated problems. And additional rounds of reform (often less dramatic) can be expected. As a result, the initial changes are adapted, perfected, and modified (or even disassembled) by subsequent actions.<sup>1</sup>*

## I. THE LEGAL DECISION: HEALTHCARE IS NOT A FUNDAMENTAL LEGAL RIGHT

### A. *No Constitutional Right*

There is no shortage of scholarly articles asserting that access to healthcare *is* a fundamental right in the United States or *must be* a fundamental right or *should be* a fundamental right. In truth, the United States Constitution does not include a provision granting citizens any right to healthcare.<sup>2</sup> It is worth noting that in 1944, President Franklin D. Roosevelt, in his State of the Union address, advanced his idea of a “Second Bill of Rights” which would include “[t]he right to adequate medical care and the opportunity to achieve and enjoy good health.”<sup>3</sup> It is somewhat of an embarrassment for the United States to acknowledge that the right to healthcare is recognized in international law and guaranteed in the constitutions of many nations.<sup>4</sup>

Because business operates in a regulatory environment that defines the contours of its activity, it is critical to study the regulatory reality of the current healthcare system to understand both what is and is not possible. Indeed, recent events surrounding the attempted passage of the American Health Care Act of 2017<sup>5</sup> (AHCA) have so far demonstrated that, for better or worse, the legislative process controls national healthcare policy and outcomes.

---

1. MARC J. ROBERTS ET AL., GETTING HEALTH REFORM RIGHT 5 (2003).

2. *See generally* U.S. CONST.

3. President Franklin D. Roosevelt, State of the Union Message to Congress (Jan. 11, 1944).

4. TIMOTHY JOST, DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 3 (2003).

5. American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017).

Some scholars have proposed a judicial shortcut around this regulatory logjam; namely, that the courts find that the right to healthcare is somehow implicit in the constitutional “concept of ordered liberty.”<sup>6</sup> While the courts might engage in such an end run, the Supreme Court of the United States has shown great reluctance to *infer* a right to equal access to healthcare under the Equal Protection Clause of the 14th Amendment or any other constitutional provision for that matter.<sup>7</sup> The recently hard-fought court battles over the Patient Protection and Affordable Care Act (ACA) explain the reasons for this reluctance. For the most part, those reasons are economic—the Court exercises demonstrable caution when the advocated change has some potential impact on the private sector and detracts from the operation of the free market system.<sup>8</sup>

*B. No Support in Case Law*

For example, in the case *National Federation of Independent Business (NFIB) v. Sebelius*, the Supreme Court concluded, among other things, that the federal government could not condition the receipt of Medicaid funding by the States on the States’ agreement to expand Medicaid coverage under the ACA.<sup>9</sup> Instead, any program expansion must be a voluntary choice by each state. It is evident from the legislative history of the ACA that Medicaid expansion was written into the plan in a way to create almost universal health insurance coverage. The Court observed in *Sebelius* that the legislative goal of the ACA was to,

‘provide’ near universal medical coverage . . . and without 100% State participation in the Medicaid program, attainment of this goal would be thwarted. Even if States could elect to remain in the old Medicaid program, while declining to participate in the Expansion, there would be a gaping hole in coverage.<sup>10</sup>

---

6. See *Griswold v. Connecticut*, 381 U.S. 479, 484, 500 (1965) (stating that “the foregoing cases suggest that specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance.”).

7. Elizabeth Weeks Leonard, *State Constitutionalism and the Right to Healthcare*, 12 J. CONST. L. 1325, 1329-31 (2010).

8. See, *FDA v. Brown & Williamson Tobacco Co.*, 529 U.S. 120, 125-26 (2000) (asserting the proposition that regulatory agencies have no authority to regulate industry in the private sector beyond the express authority given by Congress); see also, *Nat’l Fed’n Indep. Bus. v. Sebelius*, 567 U.S. 519, 606 (2012) (concurring with the assertion that “it is Congress’ role, not the Court’s, to delineate the boundaries of the market the Legislature seeks to regulate.”).

9. *Sebelius*, 567 U.S. at 519.

10. *Sebelius*, 567 U.S. at 519; see also 42 U.S.C. § 18091(2) (D) (2010) (describing

As discussed in part VII below, when the mandatory expansion provision was declared unconstitutional, the decision had a severe negative impact on the success of the plan, just as predicted by the Supreme Court in the *Sebelius* decision.<sup>11</sup>

Justice Roberts, writing for the majority, found the Medicaid expansion provisions under the ACA to be a “fundamental change” in national healthcare; one that unconstitutionally coerced States to accept the universal healthcare insurance mandate. This, he determined under the Coercion Doctrine, the federal government could not constitutionally do:

The Medicaid expansion, however, accomplishes a shift in kind, not merely degree. The original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children. See 42 U. S. C. §1396a(a)(10). Previous amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories. Under the Affordable Care Act, Medicaid is transformed into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level. It is no longer a program to care for the neediest among us, *but rather an element of a comprehensive national plan to provide universal health insurance coverage*. Indeed, the manner in which the expansion is structured indicates that while Congress may have styled the expansion a mere alteration of existing Medicaid, it recognized it was enlisting the States in a new health care program . . . .

Congress has no authority to order the States to regulate according to its instructions. Congress may offer the States grants and require the States to comply with accompanying conditions, but the States must have a genuine choice whether to accept the offer. The States are given no such choice in this case: They must either accept a basic change in the nature of Medicaid, or risk losing all Medicaid funding. The remedy for that constitutional violation is to preclude the Federal Government from imposing such a sanction.<sup>12</sup>

Many have touted the later Supreme Court decision in *King v. Burwell*, which upholds the individual mandate under the ACA, requiring

---

how the requirement achieves near-universal coverage by strengthening the private employer-based health insurance system).

11. *Sebelius*, 567 U.S. at 519; *see also* *Gonzales v. Raich*, 545 U.S. 1, 24–25 (2005) (holding that the minimum coverage provision is thus an “essential par[t] of a larger regulation of economic activity”; without the provision, “the regulatory scheme [w]ould be undercut” (quoting *United States v. Lopez*, 514 U.S. 549, 561 (1995))).

12. *Sebelius*, 567 U.S. at 583–84, 588 (emphasis added).

individuals to purchase healthcare insurance or pay a “tax,” as a victory in the name of broad-based health reform.<sup>13</sup> However, this pyrrhic victory could not ameliorate the real damage already done to the launch of near universal healthcare coverage by the earlier *Sebelius* decision. As a result, the data shows that more than 26 million Americans remain without insurance coverage after the implementation of the ACA.<sup>14</sup> The subsequent gap in Medicaid coverage occasioned by the substitution of “voluntary” Medicaid expansion contributed in large measure to this result. That data is reviewed in greater detail below. In short, the courts have been both unwilling and unable to bridge the regulatory gap.

## II. THE MORAL DECISION: OWNING A GUN IS A FUNDAMENTAL CONSTITUTIONAL RIGHT

### A. *Morality*

Unquestionably, the United States is an outlier in the major industrialized global community when it comes to providing basic universal healthcare (UHC) for all. As reported by the Organization for Economic Development and Cooperation (OECD):

The majority of OECD member countries have achieved UHC today, offering all of their citizens affordable access to a core set of health services. . . . Only a handful of OECD countries report that a very small or greater proportion of their populations do not have health coverage (Austria, Belgium, Chile, Greece, Japan, Luxembourg, Mexico, Turkey, and the United States).<sup>15</sup>

The United States remains the only major industrialized country that fails to guarantee access to universal healthcare.<sup>16</sup>

Perhaps, framing the issue as one of legal entitlement to a core set of

---

13. *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015).

14. Henry J. Kaiser Family Foundation, *Key Facts About the Uninsured Population*, KFF (Sept. 19, 2017), <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/> [<https://perma.cc/2AWS-YQTN>].

15. OECD, *UNIVERSAL HEALTH COVERAGE AND HEALTH OUTCOMES* 8 (July 22, 2016), <https://www.oecd.org/els/health-systems/Universal-Health-Coverage-and-Health-Outcomes-OECD-G7-Health-Ministerial-2016.pdf> [<https://perma.cc/4MW3-LK4U>].

16. Cathy Shoen et al., *Learning From High Performance Health Systems Around the Globe*, *Hearing on “Health Care Coverage and Access: Challenges and Opportunities,”* (2007), [https://www.commonwealthfund.org/sites/default/files/documents/\\_\\_\\_media\\_files\\_publications\\_testimony\\_2007\\_jan\\_learning\\_from\\_high\\_performance\\_health\\_systems\\_around\\_the\\_globe\\_996\\_davis\\_learning\\_from\\_high\\_perform\\_hlt\\_sys\\_around\\_globe\\_senate\\_help\\_testimony\\_01\\_10\\_2007\\_pdf.pdf](https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_testimony_2007_jan_learning_from_high_performance_health_systems_around_the_globe_996_davis_learning_from_high_perform_hlt_sys_around_globe_senate_help_testimony_01_10_2007_pdf.pdf) [<https://perma.cc/8KTL-9HF5>].

healthcare services may be putting the proverbial cart before the horse. That appears to be the view of the Harvard healthcare economist William Hsiao who concurs that the “creation of a national healthcare system involves legal, political, economic, and medical decisions;” however, “the primary decision,” he concludes, “is a moral one.”<sup>17</sup> Thus, as a condition precedent to the resolution of the legal entitlement question, a moral decision must be made by a nation to provide real certitude that all should have equal access to basic care.

Hsiao is followed closely by Professor Reinhardt of Princeton, one of the world’s preeminent healthcare economists, who concludes that every nation’s healthcare system reflects that nation’s basic moral values as a baseline for determining the contours of its healthcare system. He states that “[t]he fundamental truth about healthcare in every country. . . is that national values, national character, determine how each system works.”<sup>18</sup> Additionally, “[o]nce a nation decides that it has a moral obligation to provide healthcare for everybody” and every day, then and only then, does it begin to build the infrastructure necessary to implement that healthcare system.<sup>19</sup>

Morality and economic policy most surely have this symbiotic relationship identified by Reinhardt. Indeed, “[u]nderstanding the social conditions that affect resource allocation is at the very heart of economic thinking.”<sup>20</sup>

### *B. A Built-in Conflict of Interest*

Moral decision-making is a very difficult starting point for the United States given its economic commitment to free enterprise control in the healthcare markets. “Most countries rely on free-market enterprise to *provide* health care—but not to *pay* for it.”<sup>21</sup> Accordingly, providers can make profit in the delivery (fee for service) but cannot make profit in the payment (non-profit financing).<sup>22</sup> That model well describes the healthcare

---

17. T.R. REID, *THE HEALING OF AMERICA* 215 (Penguin Books ed., 2010) [hereinafter Reid].

18. Newsweek Staff, *Universal Healthcare is a Moral Choice*, NEWSWEEK (Sept. 9, 2009, 8:00 PM), <http://www.newsweek.com/universal-health-care-moral-choice-79223> [<http://perma.cc/8HM4-2NF7>].

19. Reid, *supra* note 17, at 269-70.

20. R.D. Scott et al., *Applying Economic Principles to Health Care*, 7 EMERGING INFECTIOUS DISEASES (SPECIAL ISSUE) 282, 282 (2001).

21. Reid, *supra* note 17, at 239 (emphasis added).

22. *Id.* at 239-40.

system currently in effect in Canada, for example.<sup>23</sup> In contrast,

[t]he United States is the only nation that lets insurance companies extract a profit from basic health coverage” in the payment system.<sup>24</sup> It is the only nation where healthcare for most of the population is financed by for-profit, minimally regulated private insurance companies.<sup>25</sup> Not surprisingly, these financing arrangements have guaranteed that at least one-sixth of the population will be “uninsured at any given time, and it leaves others at risk of losing insurance as a result of [normal life course events] (such as losing one’s job).<sup>26</sup>

Here is where the “condition precedent” moral policy judgement collides with managerial capitalism.<sup>27</sup> The result of free market control of the healthcare industry is an apparent conflict of interest between the moral principle of providing a baseline of equal access and the free market pursuit of profit.

Reinhardt’s study examining access to pharmaceutical specialty drugs helps to contextualize this point.<sup>28</sup> Fiduciary duty, a central legal organizing principle for managerial capitalism in the United States, dictates that officers and directors must act within the law to maximize shareholder wealth.<sup>29</sup> Accordingly, pharmaceutical companies, as any other product manufacturer, will naturally seek by any legal means the maximum revenue for a new product, including specialty lifesaving drugs.<sup>30</sup> This includes the economic practice of profit-maximizing price discrimination, which means charging different prices to different customers for identical items with identical production costs.<sup>31</sup> (This point will be discussed in greater detail below in the context of payer mix and cost shifting). Reinhardt notes that: “[t]he investor-owned producers of new specialty drugs properly call this approach ‘value pricing,’ because it is based on their subjective estimate of the maximum value society imputes to the added [quality adjusted life

---

23. *Id.* at 134-39.

24. *Id.* at 239.

25. *Id.* at 239-40.

26. Jill Quadagno, *Why the United States Has No National Health Insurance: Stakeholder Mobilization Against the Welfare State, 1945–1996*, 45 J. HEALTH & SOC. BEHAV. 25, 25 (2004).

27. T.R. Reid observes: “That’s why U.S. Health insurance companies are loathed by their customers but loved by Wall Street.” Reid, *supra* note 17, at 239.

28. Uwe Reinhardt, *The JAMA Forum Probing Our Moral Values in Healthcare: The Pricing of Specialty Drugs*, 314 J. AM. MED. ASS’N n.10 981, 982 (2015).

29. *Id.*

30. *Id.*

31. Kenneth Arrow, *Uncertainty and the Welfare Economics of Healthcare*, 53 AM. ECON. REV. 941, 958-67 (1963).



years] QALYs these products can produce.”<sup>32</sup>

However, in the pursuit of this pricing strategy, specialty drug producers are hardly free-enterprisers operating within competitive markets. On the contrary, the drug producers benefit from government protectionism that shields their operation from free competition by granting valuable patents to these producers and creating an artificial monopoly.<sup>33</sup> Patent protections also prohibit resale of these specialty drugs among customers, such as reimporting drugs from countries that have been granted lower prices.<sup>34</sup>

The problem of drug patents inhibiting the dissemination of lifesaving drugs to disease sufferers was most pronounced with the refusal of U.S. companies to provide compulsory patents for AIDS drugs in Kenya.<sup>35</sup> Given the obvious conflict between the moral decision to release lifesaving drugs and the fiduciary duty to maximize shareholder wealth, Reinhardt postulates that the line has been crossed from the need to protect private enterprise to the need to regulate for the health, safety and welfare of the citizens.<sup>36</sup>

The government has to be mindful of the social opportunity costs of high health care spending, which means beneficial activities such as education and infrastructure that are displaced by high spending on health care.

The social opportunity costs of high drug prices depend heavily on the incidence and prevalence of the disease being targeted by a drug. For a genuine orphan drug that could benefit only a small number of patients, a high price would have only a small effect on total health spending (although its cost would be devastating for an uninsured individual unless that person received financial assistance to acquire the drug).<sup>37</sup>

Undoubtedly, free enterprisers will counter by arguing that denying investors return on investment will discourage private investors to foster medical innovation. And, it is an economic truth that “[i]nvestors’ compensation should help them not only recover their outlays for developing new products but also include a premium for assuming the financial risk that such investments may” fail.<sup>38</sup> This economic tautology,

---

32. Reinhardt, *supra* note 28.

33. *Id.*

34. *Id.*

35. Ben Sihanya, *Patents, Parallel Importation and Compulsory Licensing of HIV/AIDS Drugs: The Experience of Kenya*, WORLD TRADE ORGANIZATION, [https://www.wto.org/english/res\\_e/booksp\\_e/casestudies\\_e/case19\\_e.htm](https://www.wto.org/english/res_e/booksp_e/casestudies_e/case19_e.htm) [<https://perma.cc/2DBH-QRNU>].

36. Reinhardt, *supra* note 28.

37. Reinhardt, *supra* note 28.

38. Reinhardt, *supra* note 28.

combined with the historic resistance to universal health coverage by the powerful American Medical Association, insurance company lobbyists, and the labor unions engaged in collective bargaining, has created a stonewall preventing UHC and equal access to available treatment.<sup>39</sup> The existence of a clear conflict of interest between profit and equal access to treatment is evident. Market competition in the delivery of healthcare may, however, continue to have a place in the supplemental insurance market.

Arguably, the free enterprise model, as it relates to both the financing and delivery of healthcare, is not fully aligned with the moral decision to provide an UHC system. As noted below, this is a conclusion reached by several healthcare economists.

*C. A Call for Intervention: Economists and Legislators*

Indeed, the call for government intervention and the acknowledgement that ordinary free enterprise is a proven failed economic model when it comes to managing healthcare is not new. The Pulitzer Prize winning Stanford economist, Kenneth Arrow, made the case for government regulation of healthcare in 1963.<sup>40</sup> Arrow argued that healthcare does not neatly fit into the confines of ordinary free market enterprise for many reasons including, totally unpredictable individual demand, lack of sure knowledge of what will cure, the built-in gross imbalance of knowledge between seller and buyer, and an inevitable lack of transparent prices.<sup>41</sup> For example, a typical consumer has no need for healthcare for decades and then is suddenly stricken with an illness or catastrophic event that will cost hundreds of thousands of treatment dollars. The consumer, due to this severe medical condition, is likely to be unable to make any reasoned free-market choice. Under the best of circumstances, the consumer can't know how well a particular treatment will work or what further treatment may be necessary or how much the cost will be and over what period. Comparison shopping is simply inapposite in this market.<sup>42</sup> Instead, the patient must rely on the provider's medical judgment given that the consumer lacks independent competing knowledge in the specialized field of medicine. The patient experience operates in a market environment that encourages doctors and hospitals to do as much as possible, and

---

39. Quadagno, *supra* note 26.

40. Arrow, *supra* note 31.

41. *Id.*

42. See, e.g., Mariam Koshy, *Is Healthcare a Market?* 24 (Nov. 24, 2015) (unpublished M.S. thesis, DELFT University of Technology) (on file with the DELFT University of Technology) (explaining consumer rationality related to comparing prices).

insurers to pay for as little as possible.<sup>43</sup> The free market consumer is thus, the most disadvantaged stakeholder in the process in terms of knowledge and access to information.

Others agree with the Arrow analysis as well. Like Arrow, some argue that the paradigm of healthcare delivery defies the model of free enterprise, a sort of round peg in a square-hole analysis. Scott and his co-authors maintain:

[The] [e]xamination of resource allocation in the healthcare industry is complicated because the market characteristics differ from those in a perfectly competitive market.<sup>44</sup> The market for health-care services is considered an imperfect market because: 1) healthcare is a heterogeneous product, as the patient can experience a range of outcomes; 2) patients who are insured have third-party payers covering their direct medical expenses; and, 3) a “market price” is lacking, i.e., no feedback mechanism exists that reflects the value of the resources used in health care.<sup>45</sup>

They conclude that while the perspectives of consumers, producers, and society converge in a perfectly competitive market, hospital patient costs in the healthcare market are different for patients (consumers), healthcare providers (suppliers), insurance companies (third-party payers), and society.<sup>46</sup>

Hsiao and Heller likewise observe:

The supply side dominates the demand side in the health services market. Professional dominance prevails due to the asymmetry of information between physicians and patients. If left unchecked, the medical profession can exercise its monopolistic power to induce demand and set high prices, leading to rapid health cost inflation and a deterioration in the quality of services.<sup>47</sup>

However unpalatable in a free market economy, the model of free enterprise may not be necessarily suitable for every economic activity including healthcare. Hsiao and Heller conclude that:

Although many countries have tried regulatory remedies to

---

43. Patrick Rivers & Sandra Glover, *Healthcare Competition, Strategic Mission, and Patient Satisfaction: Research Models and Propositions*, 22 J. HEALTH ORGAN. MANAG. 627, 627-30 (2008).

44. Scott et al., *supra* note 20.

45. *Id.*

46. *Id.*

47. William Hsiao & Peter S. Heller, *What Should Macroeconomist Know About Healthcare?* 6 (Int'l Monetary Fund, Working Paper, 2007).

correct the market failures in the voluntary private insurance market, no country has succeeded. On the other hand, international experience shows that government-managed “free” public health services tend to be inefficient and nonresponsive to patients’ needs. Market mechanisms can provide services that are more efficient and higher in quality than government-managed free services.<sup>48</sup>

Thus, the regulatory vision of reform should be one suitably designed to find a solution to the failures that characterize the voluntary private insurance market. As discussed below, the states may provide some guidance in this regard.

In any case, having arguably settled the long debate between free enterprise and increased regulation in favor of government intervention, the moral determination should be easy. But it’s not. Over fifty years have passed since Arrow called for regulatory intervention. It may be fair to conclude that the politics of healthcare and the special interest groups who may impact legislative judgment have refuted both conventional moral and economic judgment. This is true at least at the federal level in the U.S. Interestingly, in a break from traditional political and special interest thinking, the California legislature recently proposed in 2017 the Healthy California Act.<sup>49</sup> The Act introduces a single payer healthcare system that provides universal coverage within the state. Parenthetically, Colorado voters overwhelmingly rejected a similar proposal in 2016 amid widespread concerns about the cost.<sup>50</sup> The single payer plan introduced in Vermont also failed to pass in 2014 after the legislature disagreed about how to finance it.<sup>51</sup>

In 2017, the Pew Research Center conducted a national survey to determine public opinion and found that “60% of Americans say the government should be responsible for ensuring health care coverage for all Americans, compared with 38% who [disagree and] say this should not be the government’s responsibility.”<sup>52</sup> Those supporting government

---

48. *Id.* at 9.

49. SB 562, Reg. Sess. (Ca. 2017).

50. Bruce Jaspens, *Colorado Rejects Single-Payer Healthcare Insurance*, FORBES MAGAZINE (Nov. 9, 2016, 12:57 AM), <https://www.forbes.com/sites/brucejaspens/2016/11/09/colorado-rejects-single-payer-healthcare-insurance/#1820dd547067> [https://perma.cc/V7PH-MTJZ].

51. Jay Fitzgerald, *Costs Derail Vermont’s Dream of a Single Payer Healthcare System*, BOSTON GLOBE (Jan. 25, 2015), <https://www.bostonglobe.com/business/2015/01/25/costs-derail-vermont-single-payer-health-plan/VTAEZFGpWvTen0QFahW0pO/story.html> [https://perma.cc/P9CZ-Q4WL].

52. Kristen Bialik, *More Americans say government should ensure health care*

regulation increased from 51% in 2016 and is at the “highest point in nearly a decade”<sup>53</sup> perhaps signaling a shift in support of universal healthcare.

The Second Amendment to the U.S. Constitution reads: “A well-regulated Militia, being necessary to the security of a free State, the right of the people to keep and bear Arms, shall not be infringed.”<sup>54</sup> It could be argued that a guarantee of equal access to basic healthcare should have equal footing with whatever moral decision was made by the framers to ensure the constitutional right of the citizenry to own a gun.

### III. THE SPENDING CRISIS: IT’S NOT LIKE WE DON’T SPEND

An important question confronting all countries is the appropriate level of healthcare spending.<sup>55</sup> Although health care spending is one of the most important determinants of health status, health spending may be too high in developed industrial countries.<sup>56</sup> Given the large inefficiencies of health care systems, attacking these inefficiencies may be the best route to improve health outcomes, rather than increasing spending. In any case, the U.S. is the biggest spender per capita in the world.<sup>57</sup> Based upon data supplied by the Centers for Medicare and Medicaid Services (CMS) National Health Expenditures Data, “U.S. health care spending grew 3.9 percent in 2017, reaching \$3.5 trillion or \$10,739 per person. As a share of the nation’s Gross Domestic Product, health spending accounted for 17.9 percent.”<sup>58</sup>

---

coverage, PEW RESEARCH CENTER (January 13, 2017), <http://www.pewresearch.org/fact-tan k/2017/01/13/more-americans-say-government-should-ensure-health-care-coverage/> [<https://perma.cc/S3UD-QLSU>].

53. *Id.*

54. U.S. CONST. amend. II.

55. William D. Savedoff, *What Should a Country Spend on Health Care?*, 26 HEALTH AFF., 962, 962–70 (2007).

56. Burton A. Weisbrod, *The Health Care Quadrilemma: An Essay on Technological Change, Quality of Care and Cost Containment*, 29 J. ECON. LITERATURE, 523, 523–52 (1991); Elizabeth Docteur & Howard Oxley, *Health-Care Systems: Lessons from the Reform Experience*, (Directorate for Emp’t, Labour and Soc. Aff., OECD Health Working Paper No. 9, 2003).

57. Joseph Burns, *Hey, Big Spender! Why Does Your Quality Lag So Far Behind Other Countries?*, MANAGED CARE (Sept. 3, 2018), <https://www.managedcaremag.com/archives/2018/9/hey-big-spender-why-does-your-quality-lag-so-far-behind-other-countries> [<https://perma.cc/7NPG-CMT7>].

58. *National Health Expenditure Data: Historical*, CMS.GOV, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html> (last modified December 11, 2018) [<https://perma.cc/JG6T-QX32>].

### A. *The Efficiency Principle*

CMS data is used in this paper to analyze funding sources and health spending by major sources of funds and spending by type of service or product. The question examined in this analysis is whether the country that spends the highest percentage of GDP on healthcare and the most money per capita in the world is getting the best “bang for its buck” in terms of efficient healthcare delivery and quality.

If not, then arguably the analysis supplies additional support for the conclusion that the free enterprise system of healthcare is not more efficient than other spending models. Those spending models may include single payer systems utilized by other OECD countries that show better overall healthcare results in terms of quality of care. That would lead to the further conclusion that a single payer system is not “socialism” or “welfare spending.” Instead, a single payer system combined with a managed care agenda might provide the most efficient delivery of a basic core of healthcare services to everyone.

This analysis also benefits from the application of the Efficiency Principle. The textbook definition describes the Efficiency Principle as “[a]n economic theory that states that the maximum social benefit that is received from any type of action is received when the marginal social costs of resource allocation is equal to the benefits from such an allocation of resources.”<sup>59</sup> From a purely pragmatic viewpoint, the Efficiency Principle is another way of talking about the cost benefit analysis and decision making in the business context.

Interestingly, the Efficiency Principle has been applied to healthcare, albeit with some difficulty. Economists point out that “[t]he application of basic textbook principles to understanding economic behavior in the healthcare industry is not [easy] because of the complex nature of healthcare as a service or product.”<sup>60</sup> They observe that healthcare can’t be pulled off a shelf and paid for like most goods.<sup>61</sup> Not to mention that whatever the desired result, nothing is certain in treatment and healthy results cannot be guaranteed or provided with a warranty.<sup>62</sup> Indeed, the ultimate success or failure of healthcare delivery depends on various factors, many of which are beyond the control of the healthcare provider. Accordingly, the economic analysis here focuses on the “fundamental

---

59. *What is Efficiency Principle*, THE LAW DICTIONARY, <https://thelawdictionary.org/efficiency-principle/> [https://perma.cc/Y8J2-666R] (last visited Apr. 16, 2019).

60. Scott et al., *supra* note 20.

61. *Id.*

62. *Id.*

notion of efficient use of available resources.”<sup>63</sup> In the healthcare context, the focus is narrowed to two basic concepts: “(1) economics is about resource allocation, and (2) efficiency in resource use (getting the most from available resources).”<sup>64</sup>

### B. Data Analysis

CMS National Health Expenditure Data is harvested from a variety of sources, of which the most important is provider claims filed for all types of services provided.<sup>65</sup> CMS also collects and retains extensive cost information based on regular cost reports submitted by participating facilities.<sup>66</sup> “Quality information is collected from surveys done by the Joint Commission and state agencies and is entered into the Online Survey Certification and Reporting (OSCAR) database.”<sup>67</sup> Individual source data is not publicly available due to privacy concerns. External secondary use of the data is part of CMS’ mission to encourage further research.<sup>68</sup> The CMS data further analyzes where the healthcare dollars are coming from and how those dollars are being spent.<sup>69</sup> Also using the CMS data, a comparison can be made regarding the relative health benefits derived from the current system using global OECD data.<sup>70</sup> Finally, the data will be examined in terms of the Efficiency Principle applying a cost benefit analysis.

In 2015, the federal government accounted for the largest share of health care spending 29%, followed by households 28.1%, private businesses 19.9%, and state and local governments 17.1%.<sup>71</sup> As

---

63. *Id.*

64. *Id.*

65. *National Health Expenditure Data: Historical*, *supra* note 58.

66. *Id.*

67. *Sources and Uses of Data Within the Centers for Medicare and Medicaid Services*, NCBI (2012) available at <https://www.ncbi.nlm.nih.gov/books/NBK189626/> [<https://perma.cc/QS82-PVXL>].

68. NATIONAL RESEARCH COUNCIL OF THE NATIONAL ACADEMIES, STRATEGIES AND PRIORITIES FOR INFORMATION TECHNOLOGY AT THE CENTERS FOR MEDICARE AND MEDICAID SERVICES 147 (Edward Shortliffe & Lynette Millett eds., 2012).

69. CMS, NATIONAL HEALTH EXPENDITURE DATA BY TYPE OF SERVICE AND SOURCE OF FUNDS, (1960-2017), <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html> [<https://perma.cc/SLK4-B7BL>].

70. OECD, HEALTH AT A GLANCE 2015: OECD INDICATORS 3 (2015), [http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/health-at-a-glance-2015\\_health\\_glance-2015-en#.WVkwYjysdU](http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/health-at-a-glance-2015_health_glance-2015-en#.WVkwYjysdU) [<https://perma.cc/M3Y4-BHF6>].

71. *NHE Fact Sheet*, CMS.GOV, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html> (last modified

summarized in Table I, Chart 1, Healthcare Spending by Source of Funds, 74% of the \$3.2 trillion dollars for 2015, comes from public and private health insurance.<sup>72</sup> Thus, the health insurance percentage is comprised of the following varied payer mix. Medicare has a 20% share.<sup>73</sup> Medicare spending grew 4.5% to \$646.2 billion in 2015, which was a slight reduction from the 4.8% growth percent in 2014.<sup>74</sup> Medicaid has a 17% share.<sup>75</sup> Total Medicaid spending also slowed slightly in 2015 to 9.5% but continued the strong growth that began in 2014 of 11.5%.<sup>76</sup> State and local Medicaid expenditures grew 1.6%, while Federal Medicaid expenditures increased 12.5% in 2015.<sup>77</sup> Private Health Insurance had a 33% share.<sup>78</sup> Total private health insurance expenditures increased 7.2 % to \$1.1 trillion in 2015, faster than the 5.8 % growth in 2014.<sup>79</sup> According to CMS, the increase in 2015 was influenced by the expansion of insurance coverage under the ACA and the corresponding drop in the number of individuals without health insurance.<sup>80</sup> Even with increases in coverage in the insurance markets under the ACA, the Out-of-Pocket 11% share is instructive. Out-of-pocket spending grew 2.6% in 2015 to \$338.1 billion, slightly faster than the growth of 1.4% in 2014.<sup>81</sup> Evidence that the gap in coverage remains a continuing problem.

As summarized in Table I, Chart 2, Health Spending by Type of Service or Product:

---

Feb. 20, 2019) [<https://perma.cc/6GTP-BP5T>]. See *infra* Table I, Chart 1.

72. See *infra* Table I, Chart 1.

73. *Id.*

74. *CMS Releases 2015 National Health Expenditures*, CMS.GOV (Dec. 16, 2016) <https://www.cms.gov/newsroom/press-releases/cms-releases-2015-national-health-expenditures> [<https://perma.cc/AKA3-L9XZ>].

75. See *infra* Table I, Chart 1.

76. *Press Release CMS Office of the Actuary Releases 2016 National Health Expenditures*, CMS.GOV (Dec. 06, 2017), <https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2016-national-health-expenditures> [<https://perma.cc/46XH-2N8P>].

77. *National Health Care Spending in 2016*, CMA, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE-Presentation-Slides.pdf> [<https://perma.cc/Q7X3-FJ3R>] (last visited Mar. 8, 2019).

78. NATIONAL HEALTH EXPENDITURE DATA BY TYPE OF SERVICE AND SOURCE OF FUNDS, *supra* note 69.

79. *CMS Releases 2015 National Health Expenditures*, *supra* note 74.

80. Micah Hartman et al., *National Health Care Spending In 2016: Spending And Enrollment Growth Slow After Initial Coverage Expansions*, 37 HEALTH AFFAIRS (Dec. 6, 2017), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1299> [<https://perma.cc/6DFC-CBKX>].

81. *CMS Releases 2015 National Health Expenditures*, *supra* note 74.



Spending for hospital care increased 5.6% to \$1.0 trillion in 2015 compared to 4.6% growth in 2014. The faster growth in 2015 was driven by continued growth in non-price factors such as the use and intensity of services . . . . Spending on physician and clinical services increased 6.3% in 2015 to \$631.1 billion. This was an increase in growth of 4.8% in 2014 and was the first time since 2005 that the growth rate exceeded 6.0%.<sup>82</sup>

According to CMS, “as with hospitals, the faster growth in overall physician and clinical services spending was driven by continued growth in nonprice factors.”<sup>83</sup> Spending for other professional services reached \$87.7 billion in 2015, this was an increase of 5.9% and an acceleration from growth of 5.1% in 2014.<sup>84</sup> “Spending in this category includes establishments of independent health practitioners (except physicians and dentists) that primarily provide services such as physical therapy, optometry, podiatry, or chiropractic medicine.”<sup>85</sup> Retail prescription drug spending decelerated in 2015, increasing 9% to \$324.5 billion.<sup>86</sup> The CMS observes that spending on prescription drugs outpaced all other services in 2015, even though growth in 2015 was slower than the 12.4% growth in 2014.<sup>87</sup> The strong spending growth for prescription drugs is attributed to the “increased spending on new medicines [], price growth for existing brand name drugs, increased spending on generics,” and fewer expensive drugs going off-patent.<sup>88</sup>

The total healthcare spending in the U.S., as a percentage of overall GDP, according to data provided by the Commonwealth Fund, is the highest in the world and the highest among major industrialized countries.<sup>89</sup>

---

82. *CMS Report: Health Care Spending Reached \$3.2 Trillion in 2015*, MANAGED CARE (Dec. 5, 2016), <https://www.managedcaremag.com/news/cms-report-health-care-spending-reached-32-trillion-2015> [https://perma.cc/7Y7X-VXRD].

83. *Id.*

84. Clayton Chau, *Mental Health Services*, PROVIDENCE ST. JOSEPH HEALTH, <https://residency-scal-kaiserpermanente.org/healthpolicyelective/wp-content/uploads/sites/8/2018/05/Clayton-Chau-MENTAL-HEALTH-SERVICES.2018.pdf> [https://perma.cc/U4VT-MUNT] (last visited Mar. 9, 2019).

85. *Id.*

86. Greg Jacobson, *Rise in U.S. health care spending outpaces economic growth*, CHAIN DRUG REVIEW (Jan. 2, 2017), <https://www.chaindrugreview.com/rise-in-u-s-health-care-spending-outpaces-economic-growth/> [https://perma.cc/E9AN-CLCR].

87. *CMS Report: Health Care Spending Reached \$3.2 Trillion in 2015*, *supra* note 82.

88. *CMS Releases 2015 National Health Expenditures*, *supra* note 74.

89. *U.S. Spends More Income on Health Than Other Nations But Has Lower Life Expectancy, Worse Health*, THE COMMONWEALTH FUND (Oct. 8, 2015), <http://www.commonwealthfund.org/publications/press-releases/2015/oct/us-spends-more-on-health-care-than-other-nations> [https://perma.cc/8KM2-CTTD] (last visited Jan. 23, 2019) [hereinafter THE COMMONWEALTH FUND].

The global comparison chart of OECD countries is in Table II. OECD data in Table III shows that the U.S. is ranked number one in healthcare spending among major industrialized countries.<sup>90</sup> It is ranked in the bottom one-third of doctors and hospital beds per capita and in the middle one-third of nurses per capita.<sup>91</sup> Consistent with the CMS data, the U.S. is ranked number one in technology spending for MRI units and CT scanners per capita.<sup>92</sup> Given the superiority in expenditure, the resulting quality outcomes are at best disappointing.

OECD data from 2015 compares select health care outcomes among major industrialized countries. As demonstrated in Table IV, the results show that the U.S. has the lowest life expectancy rate and highest child mortality rate by comparison.<sup>93</sup> This is not surprising given that the OECD lists the U.S. in the bottom one-third performers for overall access to care.<sup>94</sup> As reflected in Table V, OECD Table, the top performers in terms of access to care are countries with the lowest expenditure as a share of household consumption, the lowest unmet care needs or lowest waiting times.<sup>95</sup> Table VI, OECD data compares quality of care indicators.<sup>96</sup> Again, by comparison, the U.S. is in the bottom one-third for asthma and COPD admission and diabetes hospital admission.<sup>97</sup> It is also in the bottom one-third for cervical cancer survival.<sup>98</sup> It is in the middle one-third for colorectal cancer survival.<sup>99</sup> The U.S. is in the top one-third in three of the reported categories: case fatality for ASI, case fatality for ischemic stroke admission, and breast cancer survival.<sup>100</sup>

Thus, the assumption that spending more produces superior population health outcomes is flawed. The bottom line is that the U.S. is spending much more for much less.

### C. Cost/Benefit Analysis: Distortions in the Free Market System

As reflected in the data, the U.S. spent more per person on healthcare than 12 other high-income nations in 2015, while seeing the lowest life

---

90. See *infra* Table III.

91. *Id.*

92. *Id.*

93. See *infra* Table IV.

94. OECD, *supra* note 70, at 24.

95. See *infra* Table V.

96. See *infra* Table VI.

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

expectancy and some of the worst health outcomes among this group. The analysis further shows that in the U.S., which spent an average of \$9,990 per person annually, life expectancy was 78.8 years. Switzerland, the second-highest-spending country, spent \$6,325 per person and had a life expectancy of 82.9 years. Mortality rates for cancer were among the lowest in the U.S., but rates of chronic conditions, obesity, and infant mortality were higher than those abroad.<sup>101</sup>

In short, the amount of money being spent is not gaining comparable health outcomes.

Some free enterprisers rebuke the suggestion of a system of UHC as nothing more than socialism. However, the data indicates that the current U.S. system of payment subsidies per capita for Medicare and Medicaid may well exceed the per capita expenditures made by other national healthcare systems.<sup>102</sup> “Despite being the only country in the [OECD] study without universal health care coverage, government spending on health care in the U.S.,” principally for Medicare and Medicaid, “was high as well, at \$4,197 per person. . . . By comparison, the U.K., where all residents are covered by the National Health Service, spent \$2,802 per person.”<sup>103</sup> While some free enterprisers complain that universal healthcare begets a form of socialism, it looks by the size of current U.S. government subsidies that the U.S. subsidizes more healthcare than the socialist economies but less efficiently. Thus, healthcare subsidies in the U.S. free market system cost more per capita than if the U.S. simply adopted a single payer national healthcare system more akin to other major globalized countries.

Moreover, the data reveals another flawed assumption which is that most of the money being spent is on basic healthcare services.<sup>104</sup> In fact, CMS data reflects that over 50% of spending in the United States by products and services is expended on physicians and hospital care.<sup>105</sup> The Commonwealth Fund study in 2015 concluded, however, that this amount of “healthcare spending per person is highest in the United States not because Americans go to doctors and hospitals more often, but because of greater use of medical technology and healthcare prices that are higher than

---

101. THE COMMONWEALTH FUND, *supra* note 89.

102. *America is a health-care outlier in the developed world*, THE ECONOMIST (Apr. 26, 2018) <https://www.economist.com/special-report/2018/04/26/america-is-a-health-care-outlier-in-the-developed-world> [<https://perma.cc/4BXB-9JPS>].

103. THE COMMONWEALTH FUND, *supra* note 89.

104. *National Health Expenditure Data: Historical*, *supra* note 58.

105. *Id.*

those in other nations.”<sup>106</sup> For example, in terms of both pricing and use:

People in the United States visit doctors an average of four times per year; only residents of Switzerland, New Zealand, and Sweden have fewer visits. Americans also go to the hospital relatively infrequently, with 126 visits per every 1000 people, compared to 252 visits in Germany, where the rate is highest.<sup>107</sup>

Americans receive the most diagnostic imaging exams, including MRIs, CT scans, PET exams. The average U.S. adult also takes more prescription drugs than adults in all the other countries except New Zealand.<sup>108</sup>

Prescription drugs are most expensive in the U.S., with prices twice as high as in the U.K., Australia, and Canada.<sup>109</sup>

Prices for health services are considerably higher in the United States than elsewhere. On average, heart bypass surgery costs \$75,345 in the United States, compared to \$15,742 in the Netherlands, where the procedure is least expensive.<sup>110</sup>

Simply put, it is not just that U.S. consumers may have higher utilization of services than other countries, but those services cost more to provide than the provision of similar services in countries with national health systems. Indeed, the costs for the same healthcare services vary nationwide. The following provides illustrations of the type of healthcare cost inflation forewarned by Reinhardt and others:

□ The average inpatient hospital charges for a patient getting a joint replacement may range “from \$5,300 at a hospital in Ada, Okla[homa] to \$223,000 at a hospital in Monterey Park, Calif[ornia].”<sup>111</sup>

□ A Medicare patient with heart failure in Denver can cost anywhere from \$21,000 to \$46,000. Meanwhile, in Jackson, Mississippi, heart failure care may cost from \$9,000 to \$51,000.<sup>112</sup>

The typical checks and balances of a free enterprise system, relying on the movement of natural market forces of supply, demand, and optimum

---

106. THE COMMONWEALTH FUND, *supra* note 89.

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.*

111. Rich Daley, *CMS Data Show Wide Variation in Hospital Billing*, MODERN HEALTHCARE (May 8, 2013, 2:30 PM), <https://www.modernhealthcare.com/article/20130508/NEWS/305089960> [<https://perma.cc/JM2P-CELW>].

112. *Id.*; Medicare Provider Payment and Utilization Data, CENTERS FOR MEDICARE & MEDICAID SERVICES (2013), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/index.html> [<https://perma.cc/6PX8-Q6KV>].

price point, seemingly do nothing to reduce those costs as in other markets. That is not surprising given Arrow's reasoning that the current delivery system is not designed to utilize the principles of a free market economy in the provision of healthcare services.<sup>113</sup> In fact, the United States depends on a fragmented delivery system that controls the delivery and pricing of domestic healthcare.<sup>114</sup> That system is not a free enterprise system but is instead one that is a mixture of payer systems that continually shift the costs of the healthcare to those with greater ability to bear the burden.<sup>115</sup> The data supports the conclusion that the fragmented healthcare system in the United States is costly, unfair and inefficient.

#### IV. THE FRAGMENTED HEALTHCARE SYSTEM: PROFIT-MAXIMIZING PRICE DISCRIMINATION

The economic practice of profit-maximizing price discrimination is a corollary of a fragmented multilayer payer system found in the United States. Charging different prices to different customers for identical items with identical production costs is a hallmark of the U.S. system and referred to as "value pricing."<sup>116</sup> Here, the notion of "value" is measured wholly based upon a subjective estimate of the maximum value society imputes to the added quality adjusted life years (QALYs) these products produce.<sup>117</sup> Pricing is, therefore, disconnected from the traditional free market analysis, and, instead, the pricing is determined by the threshold of what one is willing and able to pay to prolong one's life.<sup>118</sup> This, of course, gives the economic notion of "demand" an entirely different meaning. Pricing turns on a life or death decision instead of supply, demand, and obsolescence.

Additionally, different prices are charged to different customers for identical services because there are at least five payer systems in the United

---

113. Arrow, *supra* note 31. For example, one study found that United States spending on health care could be reduced by \$36 billion a year if the 108 million Americans with employer-sponsored coverage comparison shopped for 300 common medical procedures. BOBBI COLUNI, SAVE \$36 BILLION IN U.S. HEALTHCARE SPENDING THROUGH PRICE TRANSPARENCY 1 (Feb. 2012).

114. Arrow, *supra* note 31.

115. *Id.*

116. Martha Hostetter & Sarah Klein, *Healthcare Price Transparency: Can it Promote High-Value Care?*, THE COMMONWEALTH FUND, <https://www.commonwealthfund.org/publications/newsletter-article/health-care-price-transparency-can-it-promote-high-value-care> [https://perma.cc/9P6E-5C4G].

117. Mathew D. Adler, *QUALYs and Policy Evaluation: A New Perspective*, 6 YALE J. HEALTH POL'Y & ETHICS 1-2 (2006).

118. *Id.* at 2, 35-37.

States, some more richly endowed with cash than others.<sup>119</sup> This also leads to the inevitable conclusion that the burden of healthcare cost is not borne equally by healthcare recipients nor do all recipients have equal access to treatment given different payer systems with different coverage limitations.<sup>120</sup> Many are not covered at all.<sup>121</sup>

These multiple payer systems target different populations and the system designs are themselves variants of several pre-existing European and North American single payer systems.<sup>122</sup> Some of those systems use government delivery mechanisms while others use private sector delivery systems.<sup>123</sup> Accordingly, in the aggregate, the U.S. system shares some similarities with these individual country models but does not neatly fit into any one of them.<sup>124</sup> In short, the United States maintains separate but unequal systems of healthcare access for separate classes of people while other countries have adopted a single-payer system for everyone based upon equitable access principles, efficiency, and overall bureaucratic simplicity.<sup>125</sup>

#### A. *The Five System Fragments*

The Beveridge Model, originating in Great Britain, was adopted in the United States to cover health services for veterans, active duty-duty military personnel, and Native Americans.<sup>126</sup> The system is operated by the U.S. government through the Veteran's Administration using the Tri-Star system.<sup>127</sup> Physicians are government employees working in government owned hospitals and clinics.<sup>128</sup> The recipient never receives a bill.<sup>129</sup>

The Medicare Model, originating in Canada, (even the name was invented there) was adopted by the United States for people over sixty-five.<sup>130</sup> It is the closest that the United States comes to a universal healthcare system. The system is funded by payroll tax dollars deposited into a government trust fund earmarked solely for this program. The

---

119. Reid, *supra* note 17, at 20-24.

120. *Id.* at 42.

121. *Id.* at 20.

122. *Id.* at 17-21.

123. *Id.* at 41-42.

124. *Id.* at 21.

125. *Id.* at 41.

126. *Id.* at 17-18, 20.

127. *Id.* at 20.

128. *Id.*

129. *Id.*

130. *Id.*

Medicare budget is not included in the regular annual U.S. budget but resides in the tax expenditures budget and is not discretionary like other regular budget items. Because Medicare does not fund 100% of all medical costs, many recipients purchase supplemental insurance in the private insurance marketplace.<sup>131</sup>

The Bismark Model, utilized in some variation in Germany, France, Japan, Switzerland, and others is for fulltime employees who get coverage through an employer.<sup>132</sup> Here, the employer and employee share the premium payment and the insurer pays the lion's share for the treatment with the patient making copayments and accepting responsibility for the deductible under the policy.<sup>133</sup> This is particularly attractive to employers in the United States because the employer portion of the premium is a deductible expense for tax purposes and the employee receives the compensation benefit tax free.<sup>134</sup> For highly paid executives, employers can provide "Cadillac" health insurance plans to boost the executive's compensation without creating a taxable event.<sup>135</sup> There is a cap on the amount of coverage under these plans.<sup>136</sup> However, the additional ACA requirement that small businesses with fifty or more fulltime employees provide employee health insurance or pay a penalty was not well received due to relatively high out-of-pocket costs to small business owners.<sup>137</sup> It is not unusual for small business owners to either pay the ACA penalty or side step the requirement by refusing to hire employees full-time and instead providing only part time employment. This is an otherwise

---

131. *Market Trends: Medicare Supplement*, GORMAN HEALTH GROUP, LLC (Dec. 1, 2016), <https://www.gormanhealthgroup.com/wp-content/uploads/2016/12/GHG-Medicare-Supplement-Market-Trend-Analysis.pdf> [<https://perma.cc/Z6DW-QWDB>].

132. Reid, *supra* note 17, at 17.

133. *Id.* at 20.

134. *See Small Business & Self-Employed: Employee Benefits*, IRS, <https://www.irs.gov/businesses/small-businesses-self-employed/employee-benefits> [<https://perma.cc/4HTV-QC3E>] (last updated Nov. 2, 2018) ("If an employer pays the cost of an accident or health insurance plan for his/her employees, including an employee's spouse and dependents, the employer's payments are not wages and are not subject to Social Security, Medicare, and FUTA taxes, or federal income tax withholding.").

135. *AARP Health Law Answers: What is a Health Cadillac Plan?*, AARP (2018), <https://healthlawanswers.aarp.org/en/en/what-cadillac-plan> [<https://perma.cc/43FR-Q9GC>].

136. Mathew Fiedler, *How to Interpret the Cadillac Tax Rate: A Technical Note*, BROOKINGS (Feb. 1, 2018), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/02/01/how-to-interpret-the-cadillac-tax-rate-a-technical-note/> [<https://perma.cc/2QDW-2TAC>].

137. *How the Affordable Care Act Affects Small Business?*, HEALTHCARE.GOV (2018), <https://www.healthcare.gov/small-businesses/health-care-law-and-businesses/how-aca-affects-businesses/> [<https://perma.cc/P8VB-X89V>].

unforeseen negative economic consequence.<sup>138</sup>

The Medicaid Model was enacted into law during the Johnson administration to finance state healthcare programs in partnership with the federal government for the disabled, blind, elderly, and needy families with children.<sup>139</sup> Medicaid represents one dollar out of every six dollars spent on health care in the United States and is the major source of financing for states to provide coverage.<sup>140</sup> The Medicaid program is jointly funded by the states and the federal government. The federal government guarantees matching funds to states based on actual costs for qualifying Medicaid expenditures; states are guaranteed at least one dollar in federal funds for every one dollar in state spending on the program.<sup>141</sup> The ACA broadened Medicaid's role, in an attempt to create universal coverage for nearly all low-income Americans with incomes up to 138% of the federal poverty level (FPL) (\$16,242 per year for an individual in 2015).<sup>142</sup>

As noted previously, the Supreme Court rendered expansion by the states optional. For those states that chose the option to expand Medicaid coverage under the ACA, the federal government will pay 100% of Medicaid costs of those newly eligible for Medicaid from 2014 to 2016.<sup>143</sup> The federal share will gradually phase down to 90% in 2020, where it will remain well above traditional federal medical assistance percentage (FMAP) rates.<sup>144</sup> As of March 2015, 29 states (including the District of Columbia) adopted the Medicaid expansion.<sup>145</sup> For those remaining states

---

138. Michael F. Cannon, *New Kaiser Survey Suggests Obamacare is Killing Jobs*, FORBES (Sept. 16, 2016, 11:49 AM), <https://www.forbes.com/sites/michaelcannon/2016/09/16/new-survey-suggests-obamacare-killing-jobs/#4c01f0437654> [<https://perma.cc/EPA6-8TSS>].

139. *About CMS: History*, CMS.GOV (Jun. 20, 2018, 2:36 PM), <https://www.cms.gov/About-CMS/Agency-information/History/> [<https://perma.cc/A8KP-4XMR>].

140. Laura Snyder & Robin Rudowitz, *Medicaid Financing: How Does it Work and What are the Implications?*, HENRY J. KAISER FAMILY FOUNDATION (May 20, 2015), <https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/> [<https://perma.cc/RB95-KPGA>].

141. *Id.*

142. Matthew Buettgens et al., *Medicaid Expansion, Health Coverage, and Spending*, HENRY J. KAISER FAMILY FOUNDATION (Apr. 29, 2015), <https://www.kff.org/medicaid/issue-brief/medicaid-expansion-health-coverage-and-spending-an-update-for-the-21-states-that-have-not-expanded-eligibility/> [<https://perma.cc/7ZCX-9XWB>].

143. Robin Rudowitz, *Understanding How States Access the Enhanced Medicaid Match Rates*, HENRY J. KAISER FAMILY FOUNDATION (Sept. 29, 2014), <https://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicaid-match-rates/> [<https://perma.cc/98TP-GLE4>].

144. *Id.*

145. HENRY J. KAISER FAMILY FOUNDATION, *Status of State Action on Medicaid Expansion Decision*, <https://www.kff.org/health-reform/state-indicator/state-activity-around>



that did not expand;

The basis of the state and federal partnership is governed by the federal medical assistance percentage (FMAP). . . . The FMAP is calculated annually using a formula set forth in the Social Security Act which is based on a state's average personal income relative to the national average; states with lower average personal incomes have higher FMAPs.<sup>146</sup>

The Out-of-pocket Model means that those who are uninsured or underinsured pay for healthcare out of their own pocket. Not surprisingly, most can't pay at all. Even with the multiple payer systems, at least 28 million America remain uninsured, and many remain underinsured.<sup>147</sup> According to a Harvard study, approximately 700,000 Americans declare bankruptcy annually due to inability to pay for medical bills.<sup>148</sup> Congressional findings provide that 62% of all personal bankruptcies in the U.S. are caused in part by medical expenses.<sup>149</sup> In Britain, France, Japan, Germany, the Netherlands, Canada, and Switzerland, the same study's data indicates that there are no bankruptcies due to inability to pay medical bills.<sup>150</sup> The dilemma is more pronounced in the states that have not expanded Medicaid under the ACA. Individuals and families who are not below the FPL or not in the group of eligible Medicaid recipients do not qualify for state Medicaid benefits and may also not qualify for subsidized insurance plans in the ACA insurance marketplace—this is known as the “coverage gap.”<sup>151</sup> While the ACA does impose a penalty for failure to purchase health insurance, many find it cheaper to simply pay the penalty. “For 2015, the ACA penalty for no health insurance was \$325 per person

---

-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/LQ93-EZLG] (last visited Sept. 11, 2018).

146. Snyder & Rudowitz, *supra* note 140.

147. MICHAL MARTINEZ, EMILY ZAMMITTI, & ROBIN COHEN, HEALTH INSURANCE COVERAGE: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, JANUARY-SEPTEMBER 2016, <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201702.pdf> [https://perma.cc/Q8ES-QX9K].

148. David Himmelstein et al., *Illness and Injury As Contributors to Bankruptcy*, 24 HEALTH AFFAIRS (WEB EXCLUSIVE) W5-63, W5-66, W5-67 (2005), <https://www.ncbi.nlm.nih.gov/pubmed/15689369> [https://perma.cc/9AVU-CVWQ].

149. 42 U. S. C. §18091(2) (2006).

150. Reid, *supra* note 17, at 31.

151. Rachel Garfield, Anthony Damico, & Kendall Orgera, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, THE KAISER FAMILY FOUNDATION, <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/> [https://perma.cc/6W9H-PV24] (last visited June 12, 2018).

or 2% of the annual household income; whichever was higher. For 2016, the fee [was] \$695 or 2.5% of income—whichever was higher.”<sup>152</sup>

Henry Aaron, Healthcare economist of the Brookings Institution, sums up the U.S. fragmented healthcare system in plain terms:

[L]ike many other observers, I look at the U.S. health system and see an administrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that differ for no socially beneficial reason, as well as staggeringly complex public systems with mind-boggling administered prices and other rules expressing distinctions that can only be regarded as weird.<sup>153</sup>

Likewise, the U.S. Government Accountability Office concluded that if the U.S. could reduce its administrative costs for healthcare, which are also the highest in the world, to the costs incurred by its neighboring Canada, the savings could pay for healthcare for all uninsured Americans.<sup>154</sup>

In short, the poor and unemployed, the most vulnerable in America, are simply left out. That does not always equate, however, to no access to healthcare. By federal regulation, laws such as the Emergency Medical Treatment and Labor Act (EMTALA) have transformed the hospital emergency room into the access point for this group.<sup>155</sup> The nagging problem here is that those with health insurance end up financing those without it—known as cost shifting.

---

152. *Understanding the Fee for Not Having Healthcare Coverage in 2016*, HEALTHCARE.GOV, <https://www.healthcare.gov/blog/the-fee-for-not-having-health-insurance-2016/> [<https://perma.cc/3A7P-6YYP>] (last visited Dec. 11, 2015).

153. Henry Aaron, *The Costs of Health Care Administration in the United States and Canada – Questionable Answers to a Questionable Question*, 349 NEW ENG. J. OF MED., 801, 801-03 (2003).

154. Reid, *supra* note 17, at 44.

155. Consolidated Omnibus Budget Reconciliation Act of 1985, 42 U.S.C. § 1395dd (1986). Congress passed EMTALA, part of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, in April of 1986 to address the problem of “patient dumping.” The term “patient dumping” refers to certain situations where hospitals fail to screen, treat, or appropriately transfer patients. According to Section 9121 of COBRA, Medicare participating hospitals must provide a medical screening exam to any individual who comes to the emergency department and requests examination or treatment for a medical condition. If a hospital determines that an individual has a medical emergency, it must then stabilize the condition or provide for an appropriate transfer. *Id.* The hospital is obligated to provide these services regardless of the individual’s ability to pay and without delay to inquire about the individual’s method of payment or insurance status. *Id.*

## V. THE PROBLEM OF THE UNINSURED: COST SHIFTING

As part of the enactment of the ACA, Congress made several “Findings” which were included in the ACA legislation.<sup>156</sup> Astonishingly, Congress found that the “cost of providing uncompensated care to the uninsured was \$43 [billion] in 2008 [and] [t]o pay for this cost, health care providers pass[ed] on the cost to private insurers, which [was] pass[ed] on the cost to families.”<sup>157</sup> The size of this subsidy was considerable. This “cost shifting” “increase[d] family premiums by on average over \$1,000 a year.”<sup>158</sup>

In 2013, a study found that the cost of “uncompensated care” provided to uninsured individuals soared to \$84.9 billion.<sup>159</sup> The study further noted that only \$53.3 billion was paid to help providers offset uncompensated care costs. “Most of these funds (\$32.8 billion) came from the federal government through a variety of programs including Medicaid and Medicare, the Veterans Health Administration, and other programs. States and localities provided \$19.8 billion, and the private sector provided \$0.7 billion.”<sup>160</sup> Parenthetically, the study did not address the amount of private sector premium increases resulting from the shortfall. While an increase in premiums is reasonable to assume given the pattern found by Congress, it is difficult to find exact data because the increase in uninsured payments in 2014 coincided with an increase in deductibles and some premium costs in the ACA marketplace as well.<sup>161</sup>

In any case, as Reinhardt observes, the system of cost shifting relies heavily on private health insurers as agents of cost control in healthcare.<sup>162</sup> Given that the imbalances in the allocation of market power persist between providers—especially hospitals—and private insurers, cost control

---

156. 42 U.S.C. § 18091 (2018).

157. 42 U.S.C. § 18091(2)(F) (2018).

158. *Id.*

159. Teresa Coughlin et al., *Uncompensated Care for the Uninsured in 2013: A Detailed Examination*, THE KAISER FAMILY FOUNDATION (2014), <http://www.kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/> [https://perma.cc/YU9P-Y33V].

160. *Id.*

161. Jon Gabel et al., *Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums*, THE COMMONWEALTH FUND (2014), <http://www.commonwealthfund.org/publications/blog/2014/dec/zero-inflation-nationwide-for-marketplace-premiums> [https://perma.cc/2SWQ-UTKV].

162. Uwe Reinhardt, *The Many Different Prices Paid to Providers and The Flawed Theory of Cost Shifting: Is It Time For A More Rational All-Payer System*, 30 HEALTH AFF. 2125, 2128 (2011).

by private insurers remains an anomaly.<sup>163</sup> The “cost control” system, premised upon cost shifting and premium subsidies paid for by the privately insured, obviously does not work given the large amount of unreimbursed provider costs due to the uninsured and the large number of Americans driven into bankruptcy because of the exorbitant costs incurred due to serious illness. Bottom line: with cost shifting, the free market is still not determining pricing.

How do the uninsured find treatment? Federal and state law, as well as the mission of many providers, require hospitals and physicians to provide care when it is most needed, regardless of the patient’s ability to pay.<sup>164</sup> As just observed, healthcare providers deliver significant amounts of care to the uninsured for which the providers receive no payment or less payment than the cost actually incurred.

For example, in 2011, 48.6 million people—15.7% of the U.S. population—were uninsured.<sup>165</sup> That same year hospitals lost \$41.4 billion dollars from providing uncompensated care to the uninsured.<sup>166</sup> From 1990—four years after EMTALA was promulgated—through 2016, hospitals lost more than \$576 billion from providing uncompensated care to the uninsured.<sup>167</sup> Unfortunately, hospitals have no say in the matter. EMTALA requires hospitals that receive any federal funding to provide stabilization care for indigent patients and cannot turn away these patients until their medical condition is in fact stabilized.<sup>168</sup> This is true even though low acuity patients could be better served at a lower cost in a primary care setting or urgent care setting.<sup>169</sup>

---

163. *Id.*

164. *See, e.g.*, 42 U.S.C. §1395dd; FLA. STAT. ANN. §395.1041(3)(f) (West 2017); TEX. HEALTH & SAFETY CODE ANN. §61.028 (West 2017) (requiring health providers to provide care when it is most needed).

165. *See* AM. HOSPITAL ASS’N, Trendwatch Chartbook 2016: Trends Affecting Hospitals and Health Systems, at A-34 (2016) <https://www.aha.org/system/files/research/reports/tw/chartbook/2016/2016chartbook.pdf> (reporting the number of emergency department visits annually from 1994 through 2014, including but not limited to 90 million in 1994, 103.1 million in 2000, 114.8 million in 2005, and 129.5 million in 2011).

166. AM. HOSPITAL ASS’N., AMERICAN HOSPITAL ASSOCIATION: Uncompensated Hospital Care Cost Fact Sheet 3 (2017) <https://www.aha.org/system/files/2018-01/2017-uncompensated-care-factsheet.pdf>. Uncompensated care cost is a combination of a hospital’s charity care and bad debt. *Id.* at 2. It is appropriate to combine charity care and bad debt because “[b]ad debt is often generated by medically indigent and/or uninsured patients”; therefore, there is no meaningful distinction between the two categories. *Id.* at 2.

167. *See id.* at 3.

168. 42 U.S.C. § 1395dd(a).

169. *See* Lawrence Singer, *Gloria Jean Ate Catfood Tonight: Justice and the Social Compact for Health Care in America*, 36 LOY. U. CHI. L.J. 613, 625 (2005) (“EMTALA incentivizes individuals to seek care at the E.D., because they know they will be seen, even

The reason for this rests on the shoulders of Congress. Legislative mandates such as EMTALA were never funded by Congress after mandating treatment for the uninsured.<sup>170</sup> This lack of funding to pay for care for which the federal government now refuses to pay.<sup>171</sup> Undoubtedly, healthcare providers cannot absorb these bad debts and continue to operate profitably either. Instead, they raise their prices, shifting the cost of uncompensated care to those who do pay reliably; namely, the government and private insurance companies.<sup>172</sup>

In response, private insurers increase their premiums, shifting the cost of the elevated bills from providers onto those who carry insurance.<sup>173</sup> The net result is that those with health insurance subsidize the medical care of those without it.<sup>174</sup> “Higher premiums, in turn, render health insurance less affordable, forcing more people to go without insurance and leading to further cost-shifting.”<sup>175</sup> And it is hardly just the currently sick or injured

---

though a less-intensive setting may be more appropriate.”); *Emergency in the Emergency Rooms*, N.Y. TIMES, June 21, 2006, at A16; see also Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS HEALTH L. 145, 166 (2004) (“Uninsured persons and Medicaid enrollees often seek care in the emergency department, rather than in a physician’s office.”).

170. MEGAN HEALY, BEYOND THE SAFETY NET: AMERICA’S EMERGENCY DEPARTMENTS KEEP THE SYSTEM AFLOAT, (July 1, 2017), <https://www.aem.org/UserFiles/BeyondtheSafetyNet.pdf> [<https://perma.cc/C58S-929K>].

171. “EMTALA is a federal law that requires hospital emergency departments to medically screen every patient who seeks emergency care and to stabilize or transfer those with medical emergencies, regardless of health insurance status or ability to pay — this law has been an unfunded mandate since it was enacted in 1986.” *EMTALA (Emergency Medical Treatment And Labor Act)*, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (2009), <http://newsroom.acep.org/2009-01-04-emtala-fact-sheet> [<https://perma.cc/GYW2-KKEV>].

172. Austin Frakt, *How Much Do Hospitals Cost Shift?: A Review of the Evidence*, 89 MILLBANK Q. 90, 92 (2011), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160596/> [<https://perma.cc/8BT6-QT8D>]. (“Karen Ignagni, the president and CEO of America’s Health Insurance Plans (AHIP) described cost shifting as follows: ‘If you clamp down on one side of a balloon, the other side just gets bigger.’”). *Id.* (quoting Catherine Arnst & Jane Sasseen, *Why Business Fears the Public Option*, BLOOMBERG BUSINESS WEEK (Oct. 1, 2009), available at [http://www.businessweek.com/magazine/content/09\\_41/b4150026723556.html](http://www.businessweek.com/magazine/content/09_41/b4150026723556.html)).

173. INSTITUTE OF MEDICINE, HIDDEN COSTS, VALUE LOST: UNINSURANCE IN AMERICA 55 (2003).

174. See Frakt, *supra* note 172, at 53 (stating that “[t]he estimated \$35 billion burden of uncompensated care is shared among governments and private sponsors, although ultimately individuals bear the costs of these uncompensated services as taxpayers, providers, employees, and health care consumers.”).

175. THE AFFORDABLE CARE ACT DECISION: PHILOSOPHICAL AND LEGAL IMPLICATIONS 328 (Fritz Allhoff & Mark Hall eds., 2014).

among the uninsured who prompt elevation of the price of health care and health insurance. As observed by Justice Ginsburg in the *Sebelius* decision:

Insurance companies and healthcare providers know that some percentage of healthy, uninsured people will suffer sickness or injury each year and will receive medical care despite their inability to pay. In anticipation of this uncompensated care, health-care companies raise their prices, and insurers their premiums. In other words, because any uninsured person may need medical care at any moment and because health-care companies must account for that risk, every uninsured person impacts the market price of medical care and medical insurance.<sup>176</sup>

Moreover, the multiple payer system results in cost shifting in the form of profit-maximizing price discrimination as well.<sup>177</sup> If, for example, Medicare cuts reimbursement to a hospital for a particular procedure, the hospital will raise the price for the same procedure to other more reliable payers, like private insurance companies, to make up the difference. This practice accounts for different pricing for the same procedure on the same day in the same hospital depending on the source of payment. Even among private insurers, there will be different payment for the same procedure depending upon different insurance plans from the same company. Harvard professors and authors Michael Porter and Elizabeth Teisberg observe:

The administrative complexity of dealing with multiple prices [for the same service] adds costs with no value benefit. The dysfunctional competition that has been created by price discrimination far outweighs any short-term advantages individual system participants gain from it, even for those participants who currently enjoy the biggest discounts.<sup>178</sup>

Data from a 2008 joint study commissioned by health insurance and hospital industries well illustrates these added costs of profit-maximizing price discrimination.<sup>179</sup> The study estimates that the overall size of the cost shift in 2007 within the multiple payer system was \$88.8 billion.<sup>180</sup> Of that

---

176. *Nat'l. Fed'n. Of Indep. Bus. v. Sebelius*, 567 U.S. 519, 593-94 (2012) (Ginsburg, J., dissenting).

177. Reinhardt, *supra* note 162.

178. MICHAEL E. PORTER & ELIZABETH O. TEISBERG, *REDEFINING HEALTH CARE: CREATING VALUE-BASED COMPETITION ON RESULTS* 66 (2006).

179. WILL FOX & JOHN PICKERING, *HOSPITAL AND PHYSICIAN COST SHIFT: PAYMENT LEVEL COMPARISON OF MEDICARE, MEDICAID, AND COMMERCIAL PAYERS* (2008), [us.milliman.com/insight/research/health/pdfs/Hospital-and-physician-cost-shift/](http://us.milliman.com/insight/research/health/pdfs/Hospital-and-physician-cost-shift/) [<https://perma.cc/UK8M-ZU6R>].

180. *Id.* at 2 (Chart 1).

total, \$51 billion was estimated to have been shifted by hospitals to private insurers: \$34.8 billion because of low Medicare payments to hospitals and \$16.2 billion because of Medicaid.<sup>181</sup> Another \$37.8 billion was shifted by physicians to private insurers: \$14.1 billion because of low Medicare payments and \$23.7 billion because of Medicaid.<sup>182</sup>

The claim that cost shifting is a form of dysfunctional market competition has merit whether due to the problem of the uninsured or due to the complexities of the multiple payer system. Arguably, a single payer system, financing a basic core of health services to all Americans as in the U.K., could be cheaper and more efficient than the economic burden that more than 25 million uninsured people place on the current healthcare system.

#### VI. THE UNINTENDED CONSEQUENCES OF THE ACA: WHY IT DIDN'T REFORM

Of all the things that the ACA did do, its downfall is in part tied to what it did not or could not do. The ACA left in place the fragmented multiple payer system and all the attendant problems of price discrimination, value pricing and cost shifting.

And it was long. So long in fact that not many legislators read it before voting on it.<sup>183</sup>

In enacting the ACA, healthcare reform was at the forefront, but the reform agenda was and still remains unclear. The ACA simply failed to address health policy reform. While laudable in its purpose, getting everybody insured by some plan of insurance, insurance coverage with high deductibles or unaffordable premiums without subsidy relief has failed to alleviate many of the problems in the current system of healthcare delivery and access. A discernible healthcare policy agenda that addresses access to care, cost containment, complexity of administration, and diminishing healthcare outcomes is necessary to address many of the issues reflected in the data. The consequences of the failure to fix policy were underscored when litigation began to marginalize certain provisions of the ACA legislation.<sup>184</sup> Much of what remains post ACA is the same catalogue

---

181. *Id.* at 6.

182. *Id.* at 7.

183. David Bernstein, *Let's Recall Why the Affordable Care Act is So Messed Up*, WASH. POST, (June 25, 2015), [https://www.washingtonpost.com/news/volokh-conspiracy/wp/2015/06/25/lets-recall-why-the-affordable-care-act-is-so-messed-up/?noredirect=on&utm\\_term=.a9fd13b6a25f](https://www.washingtonpost.com/news/volokh-conspiracy/wp/2015/06/25/lets-recall-why-the-affordable-care-act-is-so-messed-up/?noredirect=on&utm_term=.a9fd13b6a25f) [https://perma.cc/K5SR-9VS7].

184. *Id.*

of problems that existed before its passage.

*A. Emasculation of Medicaid Expansion*

As noted previously, it was the intention of Congress to achieve almost universal healthcare by requiring all states to expand Medicaid coverage beyond the limited list of vulnerable groups to include all individuals with incomes below the poverty level. It was anticipated that those below the poverty level would be covered by the state Medicaid program and therefore, rendered ineligible for federal subsidies in the insurance market place where other uninsured above the poverty level would be required under the individual mandate to purchase insurance. The individual mandate provided that if those required to purchase insurance failed to do so, then a tax penalty would be imposed by the IRS.<sup>185</sup>

As noted above, after the *Sebelius* decision struck down mandatory Medicaid expansion by states, those below the poverty level who did not fit into the list of vulnerable groups covered by Medicaid were dropped into a “gap” of the uninsured under the ACA.<sup>186</sup> Not only did the below poverty individuals not qualify for Medicaid, they were also ineligible to obtain premium subsidies in the insurance market exchanges making coverage unaffordable. It is for that reason that millions of Americans remain uninsured under the ACA.<sup>187</sup>

Twenty-six states joined the suit opposing the mandatory expansion of Medicaid.<sup>188</sup> The reasons were for the most part tied to the economic uncertainty that the new burden of coverage would place on the states. The sheer size of the program was most disconcerting as the states would now be required to insure one in four Americans.<sup>189</sup> While the costs of covering the newly eligible was supposed to be covered by the federal government, paying 100% of medical assistance costs associated with the expansion group in most states for the first three years (2014–16) and declining annually to 95% in 2017–19 and to 90% in 2020, etc.<sup>190</sup> But even with this

---

185. THE FEE FOR NOT HAVING HEALTH INSURANCE, HEALTHCARE.GOV (2019), <https://www.healthcare.gov/fees/fee-for-not-being-covered/> [https://perma.cc/H764-AUQC].

186. Garfield, Damico, & Ogera, *supra* note 151, at 6.

187. *Id.*

188. Sara Rosenbaum & Timothy Westmoreland, *The Supreme Court's Surprising Decision on Medicaid Expansion: How Will the Federal Government and the States Proceed?*, 31 HEALTH AFF. 1663, 1665 (2012).

189. *Id.*

190. *Id.*



federal contribution, states would still incur costs. By 2020 the states were “expected to contribute 10[%] toward the cost of medical assistance for the newly” enrolled group.<sup>191</sup> The federal contribution was also to remain at its then current level in the case of medical assistance for the existing vulnerable groups covered under Medicaid which ranged from 50% to 83% “of total medical assistance costs.”<sup>192</sup> States were barely able to cover those costs.<sup>193</sup> Finally, the ACA did not repair “the existing [inadequate] Medicaid formula controlling payments for state administration costs, which range[d] from 50[%] to 90[%] of the cost of administration.”<sup>194</sup>

Like the EMTALA initiative before it, the federal government sought to impose the responsibility on the states without fully funding the mandate. While there were other non-economic state objections, the failure to offer a sound economic plan to support almost universal healthcare under the current fragmented system was the most problematic.

*B. Insurance Companies Back Out of the ACA Insurance Exchange Marketplace: Guaranteed Issue, Community Rating and the Individual Mandate*

The ACA created another shift in the private insurance market through the guaranteed issue and guaranteed mandate provisions. Congress recognized that the guaranteed issue and community rating provisions were only two legs of a three-legged stool and the plan would result in economic failure unless partnered with the individual mandate. To date, the plan has shown marked instability. . . a wobbly stool at best.

The “guaranteed issue” and “community rating” provisions were styled by Congress as real insurance reform.<sup>195</sup> The former provides that, with a few exceptions, “each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.”<sup>196</sup> This means that an insurer may not deny coverage based on any pre-existing medical condition and the insurance plan must cover that condition.<sup>197</sup> Under ordinary circumstances, insurers would respond by

---

191. *Id.*

192. *Id.*

193. *Id.*

194. *Id.*

195. 42 U.S.C. §§ 300gg-1 to 300gg-4 (2018).

196. 42 U.S.C. § 300gg-1(a) (2018).

197. *See* 42 U.S.C. § 300gg-3 (2018) (stating a group health plan may not impose any pre-existing condition exclusion).

charging high premiums to individuals with pre-existing conditions. If so, this would trigger the feared “adverse-selection death spiral” in the marketplace where high premiums would increase the number of the uninsured and insurance companies would simply exit the federal health insurance markets.<sup>198</sup> The community-rating provision was added to prevent this result.

In short, the community-rating provision requires insurers to calculate an individual’s insurance premium based on only four factors: (1) whether the individual’s plan covers just the individual or his family, (2) the “rating area” in which the individual lives, (3) the individual’s age, and (4) whether the individual uses tobacco.<sup>199</sup> Using this criterion, the Act does not allow an insurer to factor the individual’s health characteristics into the price of the insurance premium.

However, the individual mandate provision--the requirement that every individual buy insurance--was the third leg of the stool. The insurers needed to have a guaranteed customer base to ensure a broad enough risk pool to pay for the guaranteed issue. Those with lower actuarial risk in the pool would subsidize those with higher risk. Unfortunately, the economic soundness of the plan failed once again. Many of the younger and healthier uninsured simply decided that purchasing health insurance was not an economically sound decision because the guaranteed issue provision would allow them to purchase the same insurance at the same cost in later years, even with the later development of a pre-existing condition.<sup>200</sup> The tax penalty for non-compliance for many was a cheaper alternative than paying insurance premiums.<sup>201</sup> Unfortunately, without the contribution of above-risk premiums from the young and healthy, the community-rating provision failed to incentivize insurers to take on high-risk individuals without a concomitant substantial increase in premiums.<sup>202</sup> The subsequent migration out of the federal health insurance exchanges by private insurers was

---

198. David M. Cutler & Richard J. Zeckhauser, *Adverse Selection in Health Insurance*, 1 FORUM FOR HEALTH ECON. & POL’Y 1, 8 (1998).

199. 42 U.S.C. § 300gg(a)(1)(A) (2018).

200. American Medical Association, *Improving the Health Insurance Marketplace: Guaranteed Issue and Renewability*, AMA (2015), <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/guaranteed-issue-and-renewability.pdf> [<https://perma.cc/D939-9HPX>].

201. Abby Goodnough, *Many See IRS Penalties More Affordable Than Insurance*, N.Y. TIMES (Jan. 3, 2016), <https://www.nytimes.com/2016/01/04/us/many-see-irs-fines-as-more-affordable-than-insurance.html> [<https://perma.cc/PBU4-WH2X>].

202. Olga Khazan, *Why So Many Insurers Are Leaving Obamacare*, THE ATLANTIC, (May 11, 2017), [www.theatlantic.com/health/archive/2017/05/why-so-many-insurers-are-leaving-obamacare/526137/](http://www.theatlantic.com/health/archive/2017/05/why-so-many-insurers-are-leaving-obamacare/526137/) [<https://perma.cc/B55P-8UB6>].

palpable.<sup>203</sup>

A 2016 Kaiser Family research study provided data to illustrate the migration of several major health insurers from the federal markets.<sup>204</sup> The report concludes that because of losses in the federal insurance exchange markets, major insurers like UnitedHealth and Aetna:

[A]nnounced their withdrawal from the ACA marketplaces or the individual market in some states. In 2016, the number of insurers participating in each state (grouped by parent company) ranged from 1 in Wyoming to 16 in Texas. In states that use Healthcare.gov, it was estimated that the average number of insurers participating in the marketplace will be 3.9 in 2017 (down from 5.4 companies per state in 2016, 5.9 in 2015 and 4.5 in 2014). Marketplace insurer participation in states using Healthcare.gov in 2017 ranges from 1 company in Alabama, Alaska, Oklahoma, South Carolina, and Wyoming, to 15 companies in Wisconsin.<sup>205</sup>

Not only were companies leaving the market, the same study reveals that those who remain are increasing premiums in some but not all states. The data reflects that the cities with the largest increases in the unsubsidized second-lowest silver plan, the most popular plan in the marketplace, “were Phoenix, AZ (up 145% from \$207 to \$507 per month for a 40-year-old non-smoker), Birmingham, AL (up 71% from \$288 to \$492) and Oklahoma City, OK (up 67% from \$295 to \$493).”<sup>206</sup> Again, not all states experienced premium increases, however, those that did point to some instability in the market both in terms of choice of provider and cost.

The design of the ACA was a well-intentioned attempt to reform healthcare in a partnership with the private insurance industry and the states. The economic strategies essential to the success of the plan were thwarted by court battles lost and the unexpected non-compliance with the individual mandate. The ambitious blueprint simply lost essential parts that have made real healthcare reform under the ACA illusory. As observed by the Court in *Sibelius*, Congress did not build in a backup plan to cover these contingencies despite the pre-passage debates that hearkened possible

---

203. *Id.*

204. Cynthia Cox et al., *2017 Premium Changes and Insurer Participation in the Affordable Act's Health Insurance Marketplaces*, KFF (Nov. 1, 2016), <https://www.kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordabl-e-care-acts-health-insurance-marketplaces/> [https://perma.cc/267S-48JB].

205. *Id.*

206. *Id.*

opposition after passage of the Act.<sup>207</sup>

While the Act has not been totally repealed, arguably because there is no better policy solution being offered in its place, it has also not been mended. Another solution might be the regulatory vision of a single payer system with basic core coverage for all. The U.S. has not harbored an aversion to learning from other industrialized nations as our current fragmented system suggests. Unquestionably, future congressional action will be necessary to achieve reform.

## VII. THE FAILURE OF FREE MARKETS: WHAT OTHER DEVELOPED COUNTRIES DO

Currently, under its fragmented healthcare system, the U.S. maintains separate but unequal systems of healthcare access for separate classes of people. The above data shows that the U.S. pays more healthcare subsidies per capita than other national healthcare single payer systems spend per capita and achieves lesser health outcomes; that the uninsured place a greater economic burden on the healthcare system than if the uninsured were simply covered by a national health plan; and, that the bureaucratic inefficiencies of the system contribute to waste. So, why not change?

### A. *The Fear of Rationing*

Change is never easy and resistance to change is motivated in part by the thinking that with all of the flaws of the current system, “the devil we know may be far superior to the devil we don’t know.” Indeed, many Americans are concerned that UHC means that health care will somehow be rationed, and that access will be hindered for those who are willing to pay for it.<sup>208</sup> Is there some guarantee that the other global systems are really going to be “better” than the U.S. system?

Professor Reinhardt overcomes the objection that UHC means rationing care for Americans who will not tolerate limits on available healthcare. Newsweek staff observes:

In our current debate on health care, many have warned that universal

---

207. See Nat’l. Fed’n. Of Indep. Bus. v. Sebelius, 567 U.S. 519, 686 (2012) (Scalia, J., Kennedy, J., Thomas, J., and Alito, J., dissenting) (“If Congress had thought that States might actually refuse to go along with the expansion of Medicaid, Congress would surely have devised a backup scheme so that the most vulnerable groups in our society, those previously eligible for Medicaid, would not be left out in the cold. But nowhere in the over 900-page Act is such a scheme to be found.”) *Id.*

208. Newsweek Staff, *supra* note 18.

coverage will inevitably lead to “rationing” of health care. The argument overlooks a basic fact: the United States already rations health care. Indeed, every country rations health care, because no system can afford to pay for everything. The key distinction is the way rationing happens.<sup>209</sup>

The question of which system is “better” is perhaps a misnomer regarding health care. There is no perfect system. However, other countries may ration health care more efficiently and with less bureaucratic expense and reap better health care outcomes than the U.S.

*B. The Global Perspective: System Comparisons*

Table VII titled “Healthcare System Financing and Coverage in 18 Countries” is compiled of data collected by the OECD to provide a basis for comparison of the healthcare systems in 18 developed countries including the U.S.<sup>210</sup>

In summary, the various healthcare systems in other developed countries share major commonalities despite many details that vary between systems. All have crafted one healthcare system that applies to everybody and everyone is covered by a single set of rules. This requires the adoption of a plan that provides equal access to care at some level of coverage. A single system is easier to administer and serves as a powerful influence for cost control. Price transparency is another key component guaranteeing one price for the same service.<sup>211</sup> Dr. David Himmelstein, an Associate Professor of Medicine at Harvard Medical School and a primary care doctor at Cambridge Hospital in Cambridge, Massachusetts, told the House Subcommittee on Health, Employment, Labor and Pensions that a publicly financed, single-payer program similar to Medicare, will effectively control costs while guaranteeing universal, comprehensive coverage.<sup>212</sup> He stated:

A single-payer reform would make care affordable through vast savings on bureaucracy and profits. As my colleagues and I have shown in research published in the *New England Journal of*

---

209. *Id.*

210. ELIAS MOSSIALOS ET AL., COMMONWEALTH FUND, INTERNATIONAL PROFILES OF HEALTHCARE SYSTEMS, (Jan. 2016), [http://www.commonwealthfund.org/~media/files/publications/fund-report/2016/jan/1857\\_mossialos\\_intl\\_profiles\\_2015\\_v7.pdf](http://www.commonwealthfund.org/~media/files/publications/fund-report/2016/jan/1857_mossialos_intl_profiles_2015_v7.pdf) [https://perma.cc/F7NV-HYGT].

211. *Ways to Reduce the Cost of Health Insurance for Employers, Employees, and their Families: Hearing Before the Health, Employment, Labor and Pensions Subcommittee of the House Committee on Education and Labor*, (2009), available at [http://www.pnhp.org/news/2009/april/testimony\\_of\\_david\\_u.php](http://www.pnhp.org/news/2009/april/testimony_of_david_u.php) [https://perma.cc/87PC-NRCC].

212. *Id.*

Medicine, administration consumes 31 percent of health spending in the U.S., nearly double what Canada spends. In other words, if we cut our bureaucratic costs to Canadian levels, we'd save nearly \$400 billion annually - more than enough to cover the uninsured and to eliminate co-payments and deductibles for all Americans.<sup>213</sup>

Not every universal healthcare system utilizes a single payer system. Countries such as Germany, Japan and Canada, utilizing the Bismark Model, do have multipayer systems.<sup>214</sup> However, all providers fees must adhere to government regulated unified payment schedules and so, cost shifting is eliminated.<sup>215</sup>

Additionally, each system provides some variation of standardized care offering a set of core services provided to all. For example, in France:

Lists of covered procedures, drugs, and medical devices are defined at the national level and apply to all regions of the country. The Ministry of Health, a pricing committee within the ministry, and SHI [State Health Insurance] funds all play roles in setting these lists, rates of coverage, and prices.

SHI covers the following: hospital care and treatment in public or private rehabilitation or physiotherapy institutions; outpatient care provided by general practitioners, specialists, dentists, and midwives; diagnostic services prescribed by doctors and carried out by laboratories and paramedical professionals; prescription drugs, medical appliances, and prostheses that have been approved for reimbursement; and prescribed health care-related transportation and home care. It also partially covers long-term hospice and mental health care and provides only minimal coverage of outpatient vision and dental care.<sup>216</sup>

Total health expenditures constituted 11 percent of GDP in 2013, of which 76 percent was publicly financed.

SHI is financed by employer and employee payroll taxes (64%); a national earmarked income tax (16%); taxes levied on tobacco and alcohol, the pharmaceutical industry, and voluntary health insurance companies (12%); state subsidies (2%); and transfers from other branches of Social Security (6%).

Coverage is universal and compulsory, provided to all residents by noncompetitive SHI.<sup>217</sup>

---

213. *Id.*

214. Reid, *supra* note 17, at 236.

215. *Id.* at 235-6.

216. Mossialos et al., *supra* note 210, at 60.

217. *Id.* at 59.

In Britain, the statutory duty of the Secretary for Health is to ensure comprehensive coverage.<sup>218</sup> In practice, the National Health System (NHS):

[P]rovides or pays for preventive services, including screening, immunization, and vaccination programs; inpatient and outpatient hospital care; physician services; inpatient and outpatient drugs; clinically necessary dental care; some eye care; mental health care, including some care for those with learning disabilities; palliative care; some long-term care; rehabilitation, including physiotherapy (e.g., after-stroke care); and home visits by community-based nurses.<sup>219</sup>

The volume and scope of these services are generally a matter for local decision-making, but the NHS Constitution also states that patients have a right to drugs or treatment approved in technology appraisals carried out by the National Institute of Health and Clinical Excellence (NICE), if recommended by their clinician. . . . For drugs or treatments that have not been appraised by NICE, the NHS Constitution states that agencies shall make rational, evidence-based decisions. . . .<sup>220</sup>

“Primary care is delivered mainly through general practitioners (GPs), who act as gatekeepers for secondary care.”<sup>221</sup> Rather than using patient cost-sharing or imposing direct constraints on supply, costs in the NHS are constrained by a global budget that cannot be exceeded. NHS budgets are set at the national level, usually on a three-year cycle. “Coverage is universal. All those ‘ordinarily resident’ in England are automatically entitled to NHS care, largely free at the point of use, as are nonresidents with a European Health Insurance Card.”<sup>222</sup> “In 2013, the U.K. spent 8.8 percent of GDP on health care, of which public expenditure, mainly on the NHS, accounted for 83.3 percent.”<sup>223</sup> Most of the “funding for the NHS comes from general taxation, and a smaller proportion from national insurance (a payroll tax).”<sup>224</sup>

In each of these examples, the systems continue to experience increased demand for limited services as in the U.S. Cost control remains a universal challenge. Each system utilizes different cost control measures to

---

218. *Id.* at 49.

219. *Id.* at 49-50.

220. *Id.* at 50

221. *Id.*

222. *Id.* at 49.

223. *Id.*

224. *Id.*

limit per capita expenditures. For example, some systems use capitation.<sup>225</sup> Capitation provides a fixed per-patient reimbursement for each patient serviced by a physician. The capitation amount is paid whether there is over or under utilization of services. The point is that a unified single payor system does not have to “break the bank” and would result in cost savings in the US given high per capita expenditures.

These unified systems also do not prevent the rich segment of the population from purchasing private supplemental insurance. In fact, in Germany, rich people are given the option of opting out of the health insurance system at their own peril.<sup>226</sup> Most do not opt out. In Britain, “only about three percent of medical costs are paid by private insurance.”<sup>227</sup> In any case, there are many countries that allow private sector companies to participate in the system of unified healthcare.<sup>228</sup>

These UHC systems are primarily financed through general tax revenues and/or contributions by employer/employee to healthcare accounts. Each system offers some variation of low-income protection for the poor through government subsidies. Singapore, widely regarded as one of the most successful, efficient, and high performing health systems in the world has a somewhat different financing model, one which has allowed Singapore to achieve high quality healthcare while limiting its health spending to just 4.25 percent of its GDP.<sup>229</sup>

The government system, outlined in the 1993 White Paper, “Affordable Health Care”<sup>230</sup> concludes that medical services should not be provided for free.<sup>231</sup> The Singaporean system is hardly a welfare system. Medisave was first implemented in 1984 as a tax exempt, interest yielding savings plan much like the U.S. social security system.<sup>232</sup> The program includes employer-employee matching contributions and is designed to cover medical costs. It is designed as a savings account and any used

---

225. *Id.* at 6-9.

226. BACCHUS BARUA & NADEEM ESMAIL, FOR-PROFIT HOSPITAL AND INSURERS: IN UNIVERSAL HEALTH CARE COUNTRIES 14-15 (2015), <https://www.fraserinstitute.org/sites/default/files/for-profit-hospitals-and-insurers-in-universal-health-care-countries.pdf> [<https://perma.cc/JW7J-CLLL>].

227. Reid, *supra* note 17, at 238.

228. Barua & Esmail, *supra* note 226, at iii.

229. *Current health expenditure (% of GDP)*, WORLD BANK, <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS> [<https://perma.cc/9GQX-92HL>]

230. SINGAPORE MINISTRY OF PUBLIC HEALTH, AFFORDABLE HEALTH CARE: A WHITE PAPER, 7 (1993).

231. Lim Meng-Kin, *Health care systems in transition II. Singapore, part I An overview of health care systems in Singapore*, 20 J. PUB. HEALTH MED. 16, 18 (1998).

232. *Id.* at 18-19.



portion remits to the contributor.<sup>233</sup> Medisave was complimented in 1990 by a low-cost premium plan Medishield.<sup>234</sup> Medishield is a “catastrophic illness” plan for individuals up to the age of seventy.<sup>235</sup> There is a co-pay and co-insurance deductible of twenty percent.<sup>236</sup> Medisave is mandatory while Medishield is voluntary. Finally, Medifund is a state funded safety net for those without the ability to pay for care. The fund is an endowment fund created by the government and the earned interest is used to cover medical costs.<sup>237</sup>

Another commonality among developed nations is the principle that paying for or financing healthcare must be a non-profit economic activity. As noted above, free market enterprise and for-profit entities may be used in some systems to provide healthcare but not to pay for it. Again, the U.S. is the only developed nation that allows insurance companies to make a profit from basic health coverage. The non-profit financing decision eliminates the conflict of interest between providing needed care and the profit motive to deny payment.

Finally, every country enforces an individual mandate which guarantees enough income to pay claims. While a profit cannot be made on basic coverage, insurance companies do sell for-profit policies covering services not included in the core set of services in the unified plan.

## VIII. THE REGULATORY SOLUTION: SINGLE PAYER SYSTEM AND UNIVERSAL HEALTHCARE

### A. *Guidance for a Blueprint*

A blueprint for the provision of a unified single payer healthcare system is a complicated task requiring an understanding of the factors essential to efficiency and fairness. Guidance is imperative to ensure a system that makes legal, economic, and political sense.

Hsiao and Heller provide a normative baseline for designing the single payer system.<sup>238</sup> They postulate that:

Health resources should be allocated to achieve three objectives: (i) an optimal level of health status distributed equitably; (ii) an adequate degree of risk protection for all; and (iii) the highest

---

233. *Id.*

234. *Id.* at 19.

235. *Id.*

236. *Id.*

237. *Id.*

238. Hsiao & Heller, *supra* note 47, at 8.

possible level of public satisfaction for the entire population.<sup>239</sup> Achieving these objectives will require making difficult decisions about trade-offs, especially between equity and efficiency.<sup>240</sup>

They further observe that governments should establish institutions to finance health care and pool risk, rather than relying only on the free market.<sup>241</sup> At the same time recognizing that because market competition is capable of addressing only the efficiency issue, the government has to be responsible for the equitable financing and distribution of essential health goods.

In conjunction, guidance for designing a UHC system is provided by the OECD.<sup>242</sup> The OECD observes, “UHC consists of three dimensions: (i) the range of health services according to need; (ii) a level of financial protection; and (iii) coverage for the entire population.”<sup>243</sup>

Tracking the progress towards UHC requires the development of a set of suitable indicators which in turn should be part of an overall framework of monitoring health system performance. Discussions have focused on the need for two discrete components of health system performance: the levels of coverage for health interventions, and financial risk protection, with a focus on equity.<sup>244</sup>

### *B. Regulatory Vision*

The regulatory vision of UHC proposed by this paper is based on a single payer system for a core set of basic coverage services made available to all Americans. The blueprint guidance combined with the global lessons outlined above offer a starting point for drafting the plan:

First, the goal is to craft one healthcare system that applies to everybody where everyone is covered by a single set of rules providing equal access to core care services at some level of coverage. No American should ever file bankruptcy again due to the inability to cover medical bills.

Second, a single system is easier administer, cheaper, and serves as a powerful influence for cost control.

Third, that paying for or financing healthcare must be a non-profit

---

239. *Id.*

240. *Id.*

241. *Id.*

242. OECD, MEASURING FINANCIAL PROTECTION AND ACCESS TO SERVICES IN THE UHC AGENDA (2014).

243. *Id.* at 2.

244. *Id.*

economic activity.

Fourth, while a profit cannot be made on basic coverage, insurance companies can participate and sell for-profit policies covering services not included in the basic coverage core set of services in the unified plan.

Fifth, meaningful enforcement of an individual mandate which guarantees a large enough risk pool to pay for claims.

Sixth, the importance of price transparency and uniform pricing for services.

Seventh, the recognition that free market enterprise may not be a suitable model for healthcare. That does not mean that the U.S. should adopt a system of socialism. In fact, U.S. healthcare subsidies currently exceed the per capita expenditures of socialist governments. A single payer system simply provides better efficiencies and healthcare results.

Finally, there must be a national decision to define health care policy rather than continually skirt the issues of fairness and efficiency to satisfy influential private political interests. Political access is overshadowing healthcare access. It is, therefore, not surprising that the U.S. healthcare system is costly, inefficient and without equal access to basic services. It is a seminal example of doing the wrong thing for all the wrong reasons.

### *C. Selecting the Core Set of Services*

Despite the demonstrated global consensus that UHC is critical to meaningful access to healthcare on a population-wide basis, there is little consensus on the conceptual definition, meaning, and scope of UHC. Likewise, there is “no consensus [] on whether UHC is achievable” or what common metrics should be used for measuring progress.<sup>245</sup> Hsiao has previously attempted to fashion “some broad parameters” to evaluate a country’s health policy and performance but principally from a microeconomic perspective and not a cost feasibility perspective.<sup>246</sup> Starting from a feasibility view-point, this proposal follows the recommendations of some scholars, who observe that the focus of any UHC system should be on the provision of a minimum basic package to cover priority health needs for which there are effective low-cost interventions.<sup>247</sup> The core services selected in this plan reflect that

---

245. G. ABIIRO & M. DE ALLEGRI, UNIVERSAL HEALTH COVERAGE FROM MULTIPLE PERSPECTIVES: A SYNTHESIS OF CONCEPTUAL LITERATURE AND GLOBAL DEBATES 2 (2015).

246. William Hsiao, *What Should Macroeconomists Know About Health Care Policy? A Primer* (IMF Working Paper No. 00/136, 2000), 4.

247. Jeffrey D. Sachs, *Achieving universal health coverage in low-income settings*, 380 THE LANCET 944, 944 (2012).

philosophy.

In selecting a core set of services to define the parameters of universal healthcare coverage, reference was made to several sources and compiled using these recommendations. The first source is the United States Preventative Services Task Force (USPSTF).<sup>248</sup> One of the most important missions of the USPSTF is to make “evidence-based recommendations about clinical preventative services” included in primary care and disease prevention.<sup>249</sup> The USPSTF serves as an “independent, volunteer panel of national experts in [disease] prevention and evidence-based medicine.”<sup>250</sup> The recommendations are based on a four-step process:<sup>251</sup>

*D. Step 1. Topic Nomination*

The Task Force prioritizes topics based on several criteria, including the topic’s relevance to prevention and primary care, importance for public health, potential impact of the recommendation, and whether there is new evidence that may change a current recommendation.

*E. Step 2. Draft and Final Research Plans*

Once a topic is selected, the Task Force and researchers from an Evidence-based Practice Center (EPC) develop a draft research plan for the topic. This plan includes key questions to be answered and target populations to be considered.

---

248. *About the USPSTF*, U.S. Preventative Task Force (Jan. 2019), <https://www.uspreventiveservicestaskforce.org/Page/Name/about-the-uspstf> [<https://perma.cc/V5M2-XKGL>]. As noted in its website: “Created in 1984, the U.S. Preventive Services Task Force is an independent, volunteer panel of national experts in prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications. All recommendations are published on the Task Force’s Web site and/or in a peer-reviewed journal.” *Id.*

249. *Id.*

250. *Id.*

251. U.S. PREVENTIVE SERVICES TASK FORCE, UNDERSTANDING HOW THE USPSTF WORKS: USPSTF 101 7, <https://www.uspreventiveservicestaskforce.org/Page/Name/understanding-how-the-uspstf-works> [<https://perma.cc/D24S-3QYN>].

*F. Step 3. Draft Evidence Review and Draft Recommendation Statement*

Using the final research plan as a guide, EPC researchers gather, review, and analyze evidence on the topic from studies published in peer-reviewed scientific journals. The EPC then develops one or more draft evidence reviews summarizing the evidence on the topic. Members discuss the evidence reviews and use the information to determine the effectiveness of a service by weighing the potential benefits and harms. Members then develop a draft recommendation statement based on this discussion.

*G. Step 4. Final Evidence Review and Final Recommendation Statement*

The Task Force and EPC consider all comments on draft evidence reviews and the Task Force considers all comments on the draft recommendation statement. The EPC revises and finalizes the evidence reviews and the Task Force finalizes the recommendation statement based on both the final evidence review and the public comments.

The final recommendation statement and a final evidence summary, a document that outlines the evidence it reviewed, are also published in a peer-reviewed scientific journal.<sup>252</sup>

The second source referenced includes the immunization recommendations of the Center for Disease and Control Prevention (CDC).<sup>253</sup> As the nation's primary government run health protection agency, its mission is to save lives and protect people from health threats.<sup>254</sup> It conducts critical science and provides health information in response to the rise of a health threat. CDC prepares an immunization schedule which is a set of recommendations available to all health professionals nationally.<sup>255</sup> The recommendations include the Advisory Committee on Immunization Practices (ACIP) Vaccine Recommendations and Guidelines. The ACIP is a committee of the CDC selected by the Secretary of U.S. Department of Health and Human Services and comprised of medical and public health experts who develop recommendations on the

---

252. *Id.* at 8–11.

253. *Immunization Schedules*, CDC, <https://www.cdc.gov/vaccines/schedules/index.html> [<https://perma.cc/6VYD-N47L>] (last reviewed Feb. 5, 2019).

254. *About CDC 24-7: Mission, Role, and Pledge*, CDC, <https://www.cdc.gov/about/organization/mission.htm> [<https://perma.cc/9BVX-ZADF>].

255. *Immunization Schedules*, *supra* note 253.

use of vaccines in the civilian population of the United States.<sup>256</sup> The recommendations stand as public health guidance for safe use of vaccines and related biological products.<sup>257</sup>

The third source referenced includes the Center for Medicare and Medicaid (CMS) guidelines for coverage of catastrophic care and tier 1 drugs. CMS is part of the Department for Health and Human Services. It administers the Medicare program and works in partnership with state governments to administer Medicaid. It also publishes covered services, fee schedules and reimbursement rates to providers.<sup>258</sup> Parenthetically, drug tiers are how “prescription drugs are divided into different levels of cost.”<sup>259</sup> Drugs in Tier 1 are the cheapest options.<sup>260</sup> Drugs in tier 5 are the most expensive.<sup>261</sup>

Finally, the medical data studies recommending Tier 1 and Tier 2 drugs were reviewed independently from the USPSTF conclusions to confirm medical findings.<sup>262</sup> This included a review of approximately 32 independent drug studies. The aforementioned sources were reviewed and a resulting sample of the core services selection for UHC is attached in Table VIII.<sup>263</sup> This formulary is designed to meet the requirement of the importance of price transparency and uniform pricing for services included in a workable blueprint design for an UHC plan.

#### *H. Financing: Lessons Learned*

Based on the data analysis above, there are four lessons that may be learned from the global experience. First, the private insurance market does not offer effective cost control. A single payer system offers

---

256. *ACIP Charter*, CDC, <https://www.cdc.gov/vaccines/acip/committee/charter.html> [<https://perma.cc/V27B-2A64>].

257. *ACIP Vaccine Recommendations and Guidelines*, CDC, <https://www.cdc.gov/vaccines/hcp/acip-recs/index.html> [<https://perma.cc/3EKU-9SKY>] (last updated Feb. 14, 2019).

258. *CY 2019 Physician Fee Schedule*, Center for Medicare and Medicaid (Nov. 1, 2018 3:51 PM), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/> [<https://perma.cc/NU9Z-CUA3>].

259. *How Do Drug Tiers Work?*, BLUE CROSS BLUE SHIELD BLUE CARE NETWORK OF MICHIGAN, <https://www.bcbsm.com/medicare/help/understanding-plans/pharmacy-prescription-drugs/tiers.html> [<https://perma.cc/4UZC-VQMJ>] (last updated Aug. 9, 2018).

260. *Id.*

261. *Id.*

262. *See Grade Definitions After 2012*, U.S. PREVENTATIVE TASK FORCE (June 2018), <https://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions> [<https://perma.cc/R6J4-5YZM>] (“This new definition applies to USPSTF recommendations voted on after July 2012.”).

263. *See infra* Table VIII.

substantial administrative savings.<sup>264</sup> Those savings alone could pay for much of the expense. The U.S. Government Accountability Office found that if the U.S. could reduce its administrative costs for healthcare, which are also the highest in the world, to the costs incurred by its neighboring Canada, the amount saved could pay for healthcare for all uninsured Americans.<sup>265</sup> Himmelstein stated:

A single-payer reform would make care affordable through vast savings on bureaucracy and profits. As my colleagues and I have shown in research published in the *New England Journal of Medicine*, administration consumes 31 percent of health spending in the U.S., nearly double what Canada spends. In other words, if we cut our bureaucratic costs to Canadian levels, we'd save nearly \$400 billion annually - more than enough to cover the uninsured and to eliminate co-payments and deductibles for all Americans.<sup>266</sup>

Second, health care should not be free for those who can afford to pay for it. UHC is not the equivalent of welfare. "International experience shows that government-managed 'free' public health services tend to be inefficient and nonresponsive to patients' needs."<sup>267</sup> Singapore provides guidance in the form of its Medisave plan like the U.S. social security system.<sup>268</sup> Any investment type system which includes employer-employee contributions is suitable. Thus, the regulatory vision must be one suitably designed to find a solution to the failures that characterize the voluntary private insurance market and the historical inefficiencies in the mismanaged government welfare systems.

Third, price transparency and a government regulated cost structure for services will eliminate unnecessary and costly inflation for healthcare services and cost shifting.

Finally, a government funded safety net system for those unable to pay for coverage either due to poverty or unanticipated life events should be implemented. The current Medicaid gap contributing to over 25 million uninsured Americans is unacceptable.<sup>269</sup> The uninsured create more cost in

---

264. Reid, *supra* note 17, at 42-43.

265. *Id.* at 44.

266. *Ways to Reduce the Cost of Health Insurance*, *supra* note 211.

267. Hsiao & Heller, *supra* note 47, at 9.

268. Benedict S. K. Koh, *Singapore's Social Security Savings System: A Review and Some Lessons for the United States*, 5-7 (The Wharton Sch., Univ. of Pa., Pension Research Council, WP2014-18, 2014), <http://pensionresearchcouncil.wharton.upenn.edu/wp-content/uploads/2015/09/WP2014-18-Koh.pdf> [<https://perma.cc/L2TY-SUFH>].

269. "In 2013, one year before the ACA went into full effect, roughly 15% of the population was uninsured, and as many as 32 million U.S. residents were unable to obtain

the system than if the government would simply fund a basic coverage plan for the uninsured.

#### IX. THE CONCLUSION: THE NEW SOCIAL CONTRACT

In 2009, a study conducted at Harvard Medical School and Cambridge Health Alliance found that uninsured, working-age Americans have a 40% higher risk of death than their privately insured counterparts, up from a 25% excess death rate found in 1993.<sup>270</sup> The study concludes, based upon the data, that “uninsurance is associated with mortality.”<sup>271</sup> The debate over UHC has been assiduously devoid of the real life and death challenges faced by Americans who are uninsured and underinsured. Yet, that data may be the most critical of all. These Americans face death, bankruptcy and a degree of hopelessness.

As Reinhardt observes: The fundamental truth about healthcare in every country is . . . that national values, national character, determine how each system works.<sup>272</sup> Therefore, “[o]nce a nation decides that it has a moral obligation to provide healthcare for everybody” and every day, then and only then, does it begin to build the infrastructure necessary to implement that healthcare system.<sup>273</sup> The regulatory vision of healthcare must consider the national values recognized in this country, whether articulated in the Constitution or simply left to the development of our ideals as a democratic nation.

---

coverage for different reasons (such as pre-existing conditions). The ACA became effective January 2014; by the end of 2016, the rate of uninsured Americans had dropped to 10.9%. The Congressional Budget Office (CBO) estimated that the ACA would help reduce the national deficit by as much as \$100 billion over the next decade.” *Understanding the Affordable Care Act*, MED. BILLING & CODING CERTIFICATION (2018), <https://www.medicalbillingandcoding.org/health-insurance-guide/affordable-care-act/> [<https://perma.cc/FR2R-2ZHP>].

270. Andrew P. Wilper et al., *Health Insurance and Mortality in U.S. Adults*, 99 AMERICAN J. OF PUB. HEALTH, 2289, 2289 (2009), <http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2008.157685> [<https://perma.cc/A3UT-FQ2Z>].

271. *Id.*

272. Newsweek Staff, *supra* note 18.

273. Reid *supra* note 17, at 269-70.



## APPENDICES

## Table I:

Chart 1: Healthcare Spending By Sources of Healthcare Funds  
(CMS, 2015)

Chart 2: Health Spending By Type of Service or Products  
(CMS, 2015)

Table II: Healthcare Spending as a Percentage of GDP, 1980-2013  
(Commonwealth Fund, 2015)

Table III: Healthcare Resources (OECD, 2015)

Table IV: Select Population Health Outcomes and Risk Factors  
(OECD Health Data, 2015)

Table V: Access to Care (OECD, 2015)

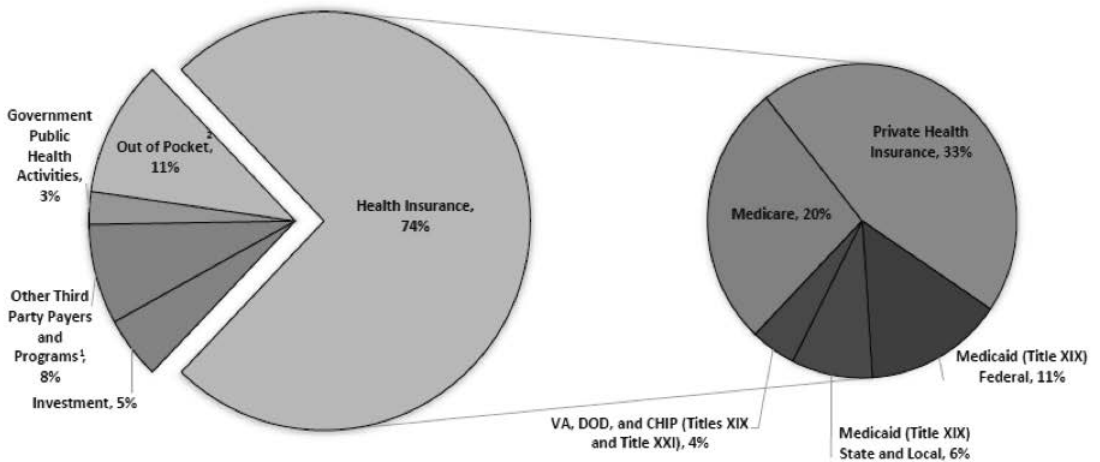
Table VI: Quality of Care (OECD, 2015)

Table VII: Healthcare System Financing and Coverage in 18  
Countries (OECD, 2015)

Table VIII: Sample/Core Services Selection

TABLE I  
 Chart 1. Healthcare Spending By Sources of Healthcare Funds

THE NATION'S HEALTH DOLLAR (\$3.2 TRILLION), CALENDAR YEAR 2015:  
 WHERE IT CAME FROM

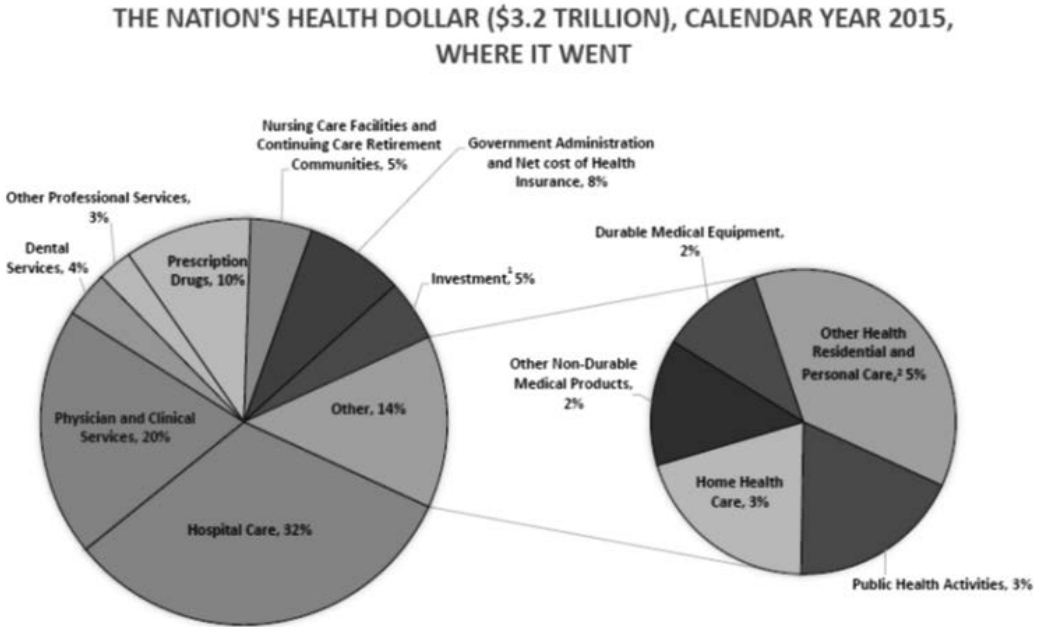


<sup>1</sup>Includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services Administration, school health, and other federal and state local programs.

<sup>2</sup>Includes co-payments, deductibles, and any amounts not covered by health insurance.

Note: Sum of pieces may not equal 100% due to rounding.

Chart 2. Health Spending By Type of Service or Products (CMS, 2015)



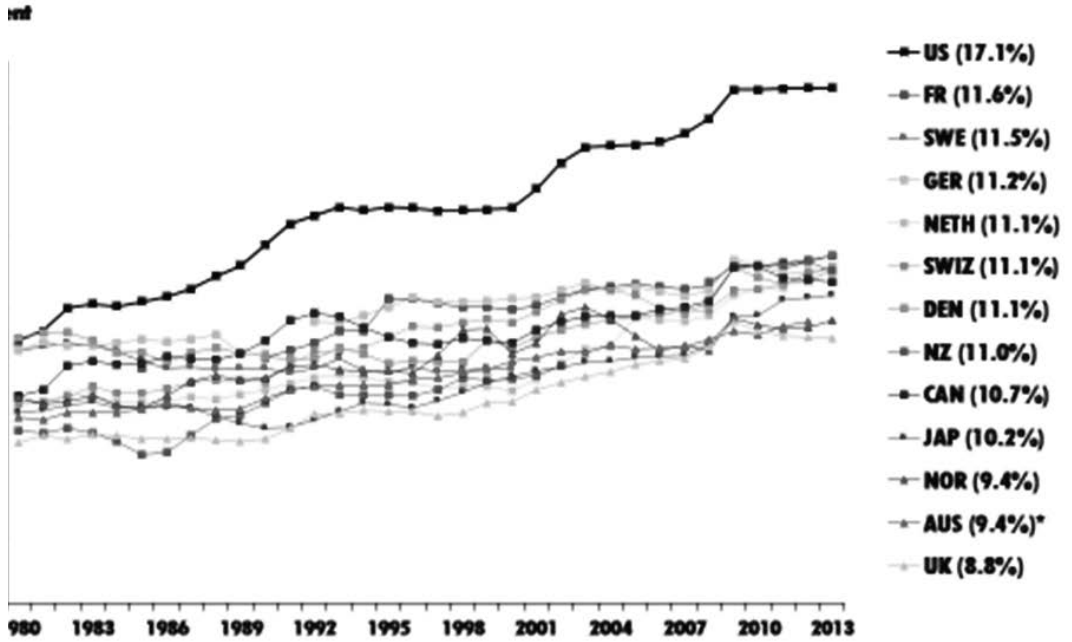
<sup>1</sup> Includes Noncommercial Research (2%) and Structures and Equipment (3%).

<sup>2</sup> Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid. Note: Sum of pieces may not equal 100% due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

TABLE II  
Healthcare Spending as a Percentage of GDP, 1980-2013

**Health Care Spending as a Percentage of GDP, 1980-2013**



\*GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude capital formation of health care providers. OECD Health Data 2015.



The COMMONWEALTH FUND

TABLE III  
Healthcare Resources  
(OECD, 2015)

1. DASHBOARDS OF HEALTH INDICATORS

Table 1.5. Health care resources

Top third in health spending or resources  
Middle third in health spending or resources  
Bottom third in health spending or resources

Note: Countries are listed in alphabetical order. The number in the cell indicates the position of each country among all countries for which data is available. Although countries are ranked from highest health spending or availability of resources to lowest, this does not necessarily mean better performance.

Indicator	Health expenditure per capita	Doctors per capita (active)	Nurses per capita (active)	Hospital beds per capita	MRI units per capita*	CT scanners per capita*
Australia	13	14	10	18	12*	2*
Austria	8	2	21	4	9	10
Belgium	11	21	15	9	19*	11*
Canada	10	28	16	29	22	23
Chile	30	33	27	32	26	26
Czech Rep.	27	10	20	7	24	22
Denmark	7	11	3	23	10	5
Estonia	31	18	23	12	17	15
Finland	17	20	5	13	6	13
France	12	16	17	8	21	24
Germany	6	5	6	3	15*	16*
Greece	25	1	32	14	5	8
Hungary	29	19	22	5	31*	31*
Iceland	15	11	4	21	7	4
Ireland	16	25	7	26	13	17
Israel	24	13	31	22	30	29
Italy	20	8	24	19	3	9
Japan	14	29	13	1	1	1
Korea	26	31	29	2	4	6
Luxembourg	9	22	9	11	14	12
Mexico	33	32	33	33	32	32
Netherlands	4	17	8	n.a.	16	28
New Zealand	18	22	14	26	18	20
Norway	3	3	2	17	n.a.	n.a.
Poland	32	30	28	6	28	19
Portugal	22	4	25	20	27*	14*
Slovak Rep.	28	14	26	10	25	21
Slovenia	23	26	18	16	23	27
Spain	21	9	30	24	11	18
Sweden	5	7	11	31	n.a.	n.a.
Switzerland	2	6	1	15	8*	7
Turkey	34	34	34	30	20	25
United Kingdom	19	24	19	26	29	30
United States	1	27	12	25	2	3

\* Data for most countries marked with an \* do not include MRI units and CT scanners installed outside hospitals, leading to an under-estimation. In Australia and Hungary, the data only include MRI units and CT scanners eligible for public reimbursement, also leading to an under-estimation.

Source: Health at a Glance 2015.


StatLink  <http://dx.doi.org/10.1787/888933281500>

TABLE IV  
Select Population Health Outcomes and Risk Factors

### Exhibit 9. Select Population Health Outcomes and Risk Factors

	Life exp. at birth, 2013 <sup>a</sup>	Infant mortality, per 1,000 live births, 2013 <sup>a</sup>	Percent of pop. age 65+ with two or more chronic conditions, 2014 <sup>b</sup>	Obesity rate (BMI>30), 2013 <sup>a,c</sup>	Percent of pop. (age 15+) who are daily smokers, 2013 <sup>a</sup>	Percent of pop. age 65+
Australia	82.2	3.6	54	28.3 <sup>e</sup>	12.8	14.4
Canada	81.5 <sup>a</sup>	4.8 <sup>a</sup>	56	25.8	14.9	15.2
Denmark	80.4	3.5	–	14.2	17.0	17.8
France	82.3	3.6	43	14.5 <sup>d</sup>	24.1 <sup>d</sup>	17.7
Germany	80.9	3.3	49	23.6	20.9	21.1
Japan	83.4	2.1	–	3.7	19.3	25.1
Netherlands	81.4	3.8	46	11.8	18.5	16.8
New Zealand	81.4	5.2 <sup>a</sup>	37	30.6	15.5	14.2
Norway	81.8	2.4	43	10.0 <sup>d</sup>	15.0	15.6
Sweden	82.0	2.7	42	11.7	10.7	19.0
Switzerland	82.9	3.9	44	10.3 <sup>d</sup>	20.4 <sup>d</sup>	17.3
United Kingdom	81.1	3.8	33	24.9	20.0 <sup>d</sup>	17.1
United States	78.8	6.1 <sup>a</sup>	68	35.3 <sup>d</sup>	13.7	14.1
OECD median	81.2	3.5	–	28.3	18.9	17.0

Source: OECD Health Data 2015.

Notes: <sup>a</sup>includes hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, joint pain/arthritis. Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014.

TABLE V  
Access to Care

1. DASHBOARDS OF HEALTH INDICATORS

Table 1.3. Access to care

■ Top third performers (or between 95% and 100% for health care coverage)  
 ■ Middle third performers (or between 90% and 95% for health care coverage)  
 ■ Bottom third performers (or less than 90% for health care coverage)

*Note:* Countries are listed in alphabetical order. The number in the cell indicates the position of each country among all countries for which data is available. For out-of-pocket medical expenditure, unmet care needs and the waiting times indicators, the top performers in terms of access are countries with the lowest expenditure as a share of household consumption, the lowest unmet care needs or lowest waiting times.

Indicator	Health care coverage	Share of out of pocket medical expenditure in household consumption	Unmet medical care needs*	Unmet dental care needs*	Waiting times for cataract surgery - median	Waiting times for knee replacement - median
Australia	1	22	n.a.	n.a.	8	12
Austria	1	18	1	2	n.a.	n.a.
Belgium	1	20	11	8	n.a.	n.a.
Canada	1	11	n.a.	n.a.	2	4
Chile	1	28	n.a.	n.a.	13	8
Czech Rep.	1	7	5	4	n.a.	n.a.
Denmark	1	14	7	10	4	1
Estonia	2	12	21	19	9	13
Finland	1	18	19	11	10	7
France	1	3	15	15	n.a.	n.a.
Germany	1	5	9	5	n.a.	n.a.
Greece	3	32	23	20	n.a.	n.a.
Hungary	1	30	14	9	1	6
Iceland	1	21	18	22	n.a.	n.a.
Ireland	1	22	17	17	n.a.	n.a.
Israel	1	16	n.a.	n.a.	3	3
Italy	1	22	20	21	n.a.	n.a.
Japan	1	9	n.a.	n.a.	n.a.	n.a.
Korea	1	34	n.a.	n.a.	n.a.	n.a.
Luxembourg	1	5	4	3	n.a.	n.a.
Mexico	1	30	n.a.	n.a.	n.a.	n.a.
Netherlands	1	2**	1	1	n.a.	n.a.
New Zealand	1	9	n.a.	n.a.	7	5
Norway	1	16	8	15	12	10
Poland	2	13	22	13	14	14
Portugal	1	29	16	23	6	11
Slovak Rep.	2	22	11	6	n.a.	n.a.
Slovenia	1	7	n.a.	n.a.	n.a.	n.a.
Spain	1	26	3	18	11	9
Sweden	1	26	11	14	n.a.	n.a.
Switzerland	1	33	6	12	n.a.	n.a.
Turkey	1	1	n.a.	n.a.	n.a.	n.a.
United Kingdom	1	3	9	7	4	2
United States	3	14	n.a.	n.a.	n.a.	n.a.

\* Unmet medical or dental care needs may be for financial reasons, waiting times or long distance to travel to get access to services. The data only cover European countries because they are based on the EU-SILC survey.

\*\* The ranking for the Netherlands is overrated as it excludes compulsory co-payments to health insurers (if these were included, this would move the Netherlands in the middle third category).

Source: Health at a Glance 2015.

StatLink  <http://dx.doi.org/10.1787/888933281483>

TABLE VI  
Quality of Care

## DASHBOARDS OF HEALTH INDICATORS

Table 1.4. Quality of care

Top third performers  
Middle third performers  
Bottom third performers

Note: Countries are listed in alphabetical order. The number in the cell indicates the position of each country among all countries for which data is available. For the indicators of avoidable hospital admissions and case-fatality rates, the top performers are countries with the lowest rates.

Indicator	Asthma and COPD hospital admission	Diabetes hospital admission	Case-fatality for AMI (admission-based)	Case-fatality for ischemic stroke (admission-based)	Cervical cancer survival	Breast cancer survival	Colorectal cancer survival
Australia	29	17	1	20	11	5	3
Austria	28	29	27	8	19	19	7
Belgium	16	20	19	20	16	12	4
Canada	18	10	11	26	12	8	13
Chile	6	27	31	16	25	23	n.a.
Czech Rep.	12	23	11	22	13	22	21
Denmark	26	14	7	17	5	11	18
Estonia	27	n.a.	28	29	8	25	22
Finland	10	15	9	4	6	4	7
France	7	21	17	13	n.a.	n.a.	n.a.
Germany	21	25	25	8	15	15	10
Greece	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Hungary	31	11	30	22	n.a.	n.a.	n.a.
Iceland	14	4	15	14	7	10	n.a.
Ireland	32	16	8	24	20	20	19
Israel	19	9	11	6	10	7	2
Italy	2	1	5	7	3	15	12
Japan	1	18	29	1	4	9	4
Korea	24	30	24	2	2	14	1
Luxembourg	9	19	16	17	n.a.	n.a.	n.a.
Mexico	5	31	32	31	n.a.	n.a.	n.a.
Netherlands	11	6	20	12	16	16	11
New Zealand	30	22	10	14	14	12	15
Norway	17	7	11	5	1	2	13
Poland	20	28	3	n.a.	24	24	23
Portugal	3	8	26	27	18	6	16
Slovak Rep.	23	26	17	28	n.a.	n.a.	n.a.
Slovenia	8	13	4	30	23	18	17
Spain	15	3	23	24	n.a.	n.a.	n.a.
Sweden	13	12	2	8	9	1	6
Switzerland	4	2	22	11	n.a.	n.a.	n.a.
Turkey	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
United Kingdom	22	5	20	19	22	21	20
United States	25	24	5	3	21	2	9

Source: Health at a Glance 2015.

StatLink  <http://dx.doi.org/10.1787/888933281494>



TABLE VII  
Healthcare System Financing and Coverage in 18 Countries  
(OECD, 2015)

Table 1. Health Care System Financing and Coverage in 18 Countries

HEALTH SYSTEM AND PUBLIC/PRIVATE INSURANCE ROLE			
	Government role	Public system financing	Private insurance role (core benefits; cost-sharing; noncovered benefits; private facilities or amenities; substitute for public insurance)
Australia	Regionally administered, joint (national & state) public hospital funding; universal public medical insurance program (Medicare)	General tax revenue; earmarked income tax	~47.3% buy complementary (e.g., private hospital and dental care, optometry) and supplementary coverage (increased choice, faster access for nonemergency services, rebates for selected services)
Canada	Regionally administered universal public insurance program that plans and funds (mainly private) provision	Provincial/federal general tax revenue	~67% buy complementary coverage for noncovered benefits (e.g., private rooms in hospitals, drugs, dental care, optometry)
China	Supervision by health authorities (Health and Family Planning Commissions) at the national, provincial and local levels; some direct provision through public ownership of hospitals	There are three main publicly financed health insurance types with local-area risk-pooling: urban employer-based (mainly payroll taxes, for formally employed urban residents), urban resident basic (mainly government funded, for urban nonemployed residents), and rural cooperative medical scheme (government-funded, for rural residents)	Complementary to cover cost-sharing and gaps, as well as better health care quality and/or higher reimbursements. No data on coverage, but growth has been rapid.
Denmark	National health care system. Regulation, central planning, and funding by national government; provision by regional and municipal authorities.	Earmarked income tax	~39% have complementary coverage (cost-sharing, noncovered benefits such as physiotherapy), ~26% have supplementary coverage (access to private providers)
England	National health service (NHS)	General tax revenue (includes employment-related insurance contributions)	~11% buy supplementary coverage for more rapid and convenient access (including to elective treatment in private hospitals)
France	Statutory health insurance system, with all SHI insurers incorporated into a single national exchange	Employer/employee earmarked income and payroll tax; general tax revenue, earmarked taxes	~95% buy or receive government vouchers for complementary coverage (mainly cost-sharing, some noncovered benefits); limited supplementary insurance
Germany	Statutory health insurance (SHI) system, with 124 competing SHI insurers ("sickness funds" in a national exchange); high income can opt out for private coverage	Employer/employee earmarked payroll tax; general tax revenue	~11% opt out from statutory insurance and buy substitutive coverage. Some complementary (minor benefit exclusions from statutory scheme, copayments) and supplementary coverage (improved amenities).
India	Children and adolescents <18 years of age are exempt	General tax revenue	Limited role (<5% of total expenditure) providing substitutive coverage for the upper class urban population
Israel	National Health Insurance (NHI) system with four competing, nonprofit health plans. Government distributes the NHI budget among the health plans primarily through capitation.	Earmarked income-related tax and general government revenues	Complementary (for benefits such as dental care, drugs, or long-term care) and supplementary coverage (for quicker access and superior service) provided by two types of voluntary insurance: VHI offered by statutory health plans (HP-VHI) (~87% of adult population coverage); commercial VHI (C-VHI) (~53% coverage); C-VHI tend to be more comprehensive and more expensive.
Italy	National health care system. Funding and definition of minimum benefit package by national government; planning, regulation and provision by regional governments.	National earmarked corporate and value-added taxes; general tax revenue and regional tax revenue	~15% buy complementary (services excluded from statutory benefits) or supplementary coverage (more amenities in hospitals, wider provider choice)

			U-VHI tend to be more comprehensive and more expensive.
Italy	National health care system. Funding and definition of minimum benefit package by national government; planning, regulation and provision by regional governments.	National earmarked corporate and value-added taxes; general tax revenue and regional tax revenue	~15% buy complementary (services excluded from statutory benefits) or supplementary coverage (more amenities in hospitals, wider provider choice)
Japan	Statutory health insurance system, with >3,400 noncompeting public, quasi-public, and employer-based insurers. National government sets provider fees, subsidizes local governments, insurers, and providers and supervises insurers and providers.	General tax revenue; insurance contributions	Majority of population have coverage for cash benefits in case of sickness, usually together with life insurance. Limited role of complementary and supplementary insurance offered separately from life insurance.
Netherlands	Statutory health insurance system, with universally-mandated private insurance (national exchange); government regulates and subsidizes insurance	Earmarked payroll tax; community-rated insurance premiums; general tax revenue	Private plans provide statutory benefits; 84% buy complementary coverage for benefits excluded from statutory package such as dental care, alternative medicine, physiotherapy, eyeglasses, contraceptives and copayments
New Zealand	National health care system. Responsibility for planning, purchasing, and provision devolved to geographically defined District Health Boards.	General tax revenue	~33% buy complementary coverage (for cost-sharing, specialist fees, and elective surgery in private hospitals) and supplementary coverage for faster access to nonurgent treatment
Norway	National health care system. Some direct funding and provision roles for national government and some responsibilities devolved to Regional Health Care Authorities and municipalities.	General tax revenue, national and municipal taxes	~8% holds supplementary VHI, mainly bought by employers for providing employees quicker access to publicly covered elective services and choice among private providers.
Singapore	Government subsidies at public health care institutions and some providers; Medisave: mandatory medical savings program for routine expenses; MediShield: catastrophic health insurance; Medifund: government endowment fund to subsidize health care for low-income and those with large bills. Government regulation of private insurance, central planning and financing of infrastructure and some direct provision through public hospitals and clinics.	General tax revenue	Medisave-approved Integrated Shield Plans (private insurance plans) supplement MediShield coverage to provide catastrophic health coverage for additional ward classes. Other types of private insurance are also available, including private insurance provided by employers.
Sweden	National health care system. Regulation, supervision, and some funding by national government; responsibility for most financing and purchasing/provision devolved to county councils.	Mainly general tax revenue raised by county councils; some national tax revenue	~10% of all employed individuals ages 15-74 get supplementary coverage from employers for quicker access to a specialists and elective treatment
Switzerland	Statutory health insurance system, with universally mandated private insurance (regional exchanges); some federal legislation, with cantonal (state) government responsible for provider supervision, capacity planning, and financing through subsidies	Community-rated insurance premiums; general tax revenue	Private plans provide universal core benefits; some people buy complementary (services not covered by statutory insurance) and supplementary (improved amenities and access); no coverage data available
United States	Medicare: age 65 and older, some disabled; Medicaid: some low-income; for those without employer coverage, state-level insurance exchanges with income-based subsidies; insurance coverage mandated, with some exemptions (10.4% of adults uninsured)	Medicare: payroll tax, premiums, federal tax revenue; Medicaid: federal, state tax revenue	Primary private voluntary insurance covers ~66% of population (employer-based and individual); supplementary for Medicare

TABLE VIII  
Sample/Core Set of Services Selection

**USPTF Grade A and B Recommendations**

Demographic	Treatment	CPT	CPT Notes	CMS Rate
Children/ Adolescents	Congenital Hypothyroidism	84443	TSH	\$20.75
	Gonococcal Neonatorium	87075	Gram Stain	\$11.69
	Hepatitis C	80074		\$58.81
	HIV	86703	HIV 1&2	\$16.92
	Phenyleketonuria	84030	PKU	\$6.79
	Sickle Cell Disease	83020	HGB Electrophoresis	\$15.89
Male	AAA	76706		\$130.00
	Colon Cancer Screening Colonoscopy	45378	Professional Fees + Facility + Anesthesia + Lab + Path	\$950.31
	DM	82947	Fasting Glucose	\$4.85
	DM	83036	HGB A1C	\$11.99
	Hepatitis Panel	80074		\$58.81
	HIV	86703		\$16.92
	Lipid Panel	80061		\$16.53
	Lung Cancer Counseling	G0296		\$36.00
Lung Cancer Low Dose CT	G0297		\$249.00	
Pregnancy	Bacteriuria	81001		\$3.92
	Pap Smear	88164		\$14.65
	Chlamydia	87110		\$24.19
	Gestational DM	82947	Fasting Glucose	\$4.85
	Hepatitis Panel	80074		\$58.81
	HIV	86703		\$16.92
	Iron Deficiency Anemia (CBC)	85025		\$9.59
	Syphilis	86780		\$16.34
Obstetrical Panel	80081	CBC, ABO, Antibodies, RPR, Hepatitis B, HIV, Rubella	\$92.42	
Female	Breast Cancer	77066	Bilateral Screening Mammogram	\$179.14
	Colon Cancer	44388	Professional Fees + Facility + Lab + Path	\$950.31
	Pap Smear	88164		\$14.65
	Chlamydia	87110		\$24.19
	DM	82947; 83036		\$16.84
	Gonorrhea	87491		\$43.31
	Hepatitis Panel	80074		\$58.81
	HIV	86703		\$16.92
	Lipid Panel	80061		\$16.53
	Lung Cancer Counseling	G0296		\$36.00
	Lung Cancer Low Dose CT	G0297		\$249.00
Osteoporosis	77080	Dexa SCA		