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THE HEALTH SECURITY ACT: COERCION AND DISTRUST FOR THE MARKET

H. Richard Beresford†

At the center of current deliberations over health care reform are debates about the proper role of government. Much of the controversy focuses on the allocation of power among state and federal governments and private actors. For example, some critics of the Clinton Administration's Health Security Act (HSA),[1] the starter for today's drive towards reform, have cast it as extravagant and intrusive "socialized medicine" that will erode the high quality of American health care.

Less ideologically-driven criticisms rest on concerns that some employers will shed workers if they are subject to a federal mandate to fund employee heath benefits,[2] that reliance on a regulated market to contain health care costs is misplaced,[3] and that requiring universal coverage will lead to a reduction in quality of care for many citizens.[4] The scope and complexity of the regulatory bureaucracy the HSA contemplates are also problematic, and the provision for federal price controls in the form of contingent caps on health insurance premiums is sure to attract determined opposition from health insurers and those who have little faith in price controls as a solution to the problem of rising costs.

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1 H.R. 3600, 103d Cong., 1st Sess. (1993).

2 *See* Jacob A. Klerman & Dana P. Goldman, *Job Loss Due to Health Insurance Mandates*, 272 JAMA 552, 555-56 (1994) (estimating, based on past responses by employers to minimum wage legislation, that approximately 100,000 jobs would be lost due to the employer mandate of the HSA.).

3 *See* John K. Iglehart, *Managed Care*, 327 NEW ENG. J. MED. 742, 745 (1992) (citing data casting doubt on cost-containing potential of managed care); Thomas Rice et al., *Holes in the Jackson Hole Approach to Health Care Reform*, 270 JAMA 1357, 1358-59 (1993) (arguing that managed competition will not control heath care expenditures because wealthy consumers will continue to buy insurance with rich benefits, enrollees in HMOs will increase their utilization of services, and providers will continue to exercise their strong bargaining powers).

4 *See* Robert J. Blendon et al., *Physician's Perspectives on Caring for Patients in the United States, Canada, and West Germany*, 328 NEW ENG. J. MED. 1011, 1014-15 (1993) (data suggesting that the trade-off citizens of Canada and West Germany incur for universal coverage is reduced access to advanced medical technology and a lower quality of some medical services than in the United States).

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The critics of enlarging the governmental role in health care cannot deny that the federal government is already a major player. Under the Medicare statute,[5] the federal government operates a national single payer system for a burgeoning population of persons over sixty-five and for many younger disabled persons.[6] Through the Medicaid program, it oversees and substantially funds efforts by state and local governments to assure health care for millions of needy citizens.[7] Additionally, the federal government directs and finances a broad array of specialized prevention and treatment programs, generously supports the world's most productive biomedical research, and heavily subsidizes undergraduate and graduate medical education.[8]

Although popular enthusiasm for these programs varies, there is no evident public outcry for eliminating or trimming them. Moreover, many state governments have increased their regulation of health care providers and health insurers, and initiated a wide range of programs aimed at controlling costs and improving access to care.[9] Therefore, the question is not whether the government ought to play a major role in the delivery and financing of health care: it is already extensively involved at various levels and will remain so, apparently with the public's blessing.

More pertinent are the narrower questions of whether the HSA's elaborate strategies for involving government are necessary and, if they are, whether methodologies for implementing these strategies are framed so as to avoid debilitating legal and political challenges. The gist of my answer to the first question is that less complex and intrusive approaches than those of the HSA are preferable.

This is not because I believe that reform is unnecessary or undesirable. Considerations of social justice, economics and politics underscore the importance of addressing major shortcomings in our system of health care. Too many people, including many of the most vulnerable, lack health insurance or adequate access to medical care; escalating costs impose heavy and sometimes unsustainable financial

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5 42 U.S.C. § 1395 (1988).

6 *See* John K. Iglehart, *The American Health Care System: Medicare*, 327 NEW ENG. J. MED. 1467 (1992).

7 *See* John K. Iglehart, *The American Health Care System: Medicaid*, 328 NEW ENG. J. MED. 896 (1993).

8 *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 335-419 (1982) (describing the dramatic expansion of the role of federal government in regulating and financing health care, medical education and biomedical research since World War II).

9 *See* Marilyn Moon & John Holahan, *Can States Take the Lead in Health Care Reform*, 268 JAMA 468 (1992); John K. Iglehart, *Health Care Reform: The States*, 330 NEW ENG. J. MED. 75 (1993).

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burdens on public and private payers; and there is a pervasive sense of insecurity about the reliability of existing health insurance coverage.[10]

In this Article, I delineate major elements of the HSA in order to critique what I see as its most troubling features. I then offer a less elaborate approach that preserves a stronger role for nonfederal actors in the sensitive, complicated task of achieving a decent level of health care for all the public. I argue that the HSA is unduly coercive and distrustful of the market forces it purports to unleash. Although I concede that new regulatory efforts and subsidies are needed, I propose a version of "managed competition"[11] that emphasizes assuring universal access to health insurance, attacks some of the current system's more egregious abuses and perverse incentives, and forthrightly recognizes that a more just system of health care will require widespread sharing of the necessary added costs.

This alternative version would hardly be painless. However, I believe it would be less onerous than the HSA and its variants, leaving largely intact a system that, for all its imperfections, delivers technically excellent care, is capable of nuanced allocative decisions, and responds quickly to calls for scientific and technical innovation.

I
THE HEALTH SECURITY ACT

A. Central Features of the HSA

The HSA is grand in design. It seeks to remedy fundamental shortcomings of the American health care system: the millions who lack health insurance, the insecurity of benefits for those who are insured, and escalating costs that neither regulation nor market forces have much dampened. The HSA's dominant strategy is to recast the medical marketplace to assure that members of the public have the

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10 Lack of health insurance may cause more than financial problems. Recent empirical studies demonstrate a direct correlation between lack of adequate health insurance and mortality and morbidity. *See* Peter Franks et al., *Health Insurance and Mortality: Evidenee from a National Cohort*, 270 JAMA 737 (1993) (empirical study revealing that lack of health insurance associated with increased mortality in all sociodemographic groups examined); Helen R. Burstin et al., *Socioeconomic Status and Risk for Substandard Medical Care*, 268 JAMA 2383 (1992). *See generally* Troyen A. Brennan, *An Ethical Perspective on Health Care Insurance Reform*, 19 AM. J.L. & MED. 38 (1993) (proposing that "ethical" health care reform would provide universal coverage, would assure the same broad benefits for everyone, would not commit to either competitive or single payer modes of financing, would assure informed consent in managed care, would segregate ethics of medical care to individual patients from ethics of health care delivery to populations, and would contemplate limits on providers' incomes).

11 *See generally* Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFF. 23 (Supp. 1993) (defining managed competition and supporting the proposition that managed competition is workable); John K. Iglehart, *Health Policy Report: Managed Competition*, 328 NEW ENG. J. MED. 1208 (1993) (explaining principles of managed competition).

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power to bargain effectively with insurers and providers over prices for services.

To implement this strategy, the HSA offers a mix of coercion, regulation, and constraints on pricing. It requires that everyone buy health insurance,[12] that health plans provide comprehensive benefits,[13] and that employers pay a heavy share of health insurance costs.[14] It would reshape the medical workforce to limit new entrants and produce more general practitioners and fewer specialists.[15] Cost containment would flow from a more competitive market, administrative efficiencies,[16] attacks on fraud and abuse,[17] and reform of malpractice laws.[18] If market forces fail to control costs, caps on health insurance premiums would be imposed to induce payers to force providers to lower prices.[19] Funding for subsidies needed to assure universal coverage would come from a tax on tobacco products and savings from the operation of Medicare.[20]

Beyond these core elements, the HSA addresses several other aspects of American health care. Although some of these are of great interest, the focus of discussion here will be on the methods for attaining and financing universal coverage.

B. Attaining Universal Coverage

1. *Mandatory Enrollment in Alliances*

The HSA requires states to establish one or more regional alliances that all must join.[21] The alliances may be state agencies, nonprofit corporations, or entities that contract with state agencies and are subject to regulations by states under standards provided in the HSA.[22] Directors of the regional alliances must include representatives of the employers required to buy health insurance for employees who have enrolled in the alliances.[23] Corporations with more than 5000 employees have the option to form their own corporate alliances,[24] enabling them to continue their own self-insurance programs subject to constraints applicable to the regional alliances.

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12 H.R. 3600, 103d Cong., 1st Sess. § 1002 (1993).
13 *Id.* §§ 1101(a), 1111-1123.
14 *Id.* § 6122.
15 *Id.* § 3012.
16 *Id.* § 1410.
17 *Id.* §§ 5432-5441.
18 *Id.* §§ 5301-5310.
19 *Id.* § 6011.
20 *Id.* § 7111.
21 *Id.* § 1002(a).
22 *Id.* § 1301.
23 *Id.* § 1301(b).
24 *Id.* § 1311.

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The regional alliances must negotiate contracts with state-approved health plans to provide health services for their enrollees.[25] These contracts must provide comprehensive benefits and a menu of options for enrollees,[26] including at least one "fee for service" option.[27] Part of the negotiation with health plans would be to establish premiums payable under the various options. Alliances, however, could refuse to negotiate with any health plan whose proposed premium exceeds 120 percent of the weighted average of premiums proposed by all other health plans in the alliance.[28] Once alliances complete their negotiations with health plans, they must determine and publish the premiums to be charged enrollees or their employers.[29] Enrollees would then elect a particular contract under which they or their employers would be responsible for payment of premiums.

After enrollees have chosen an insurance contract, alliances would collect the premiums and distribute them to the health plans on an adjusted per capita basis.[30] The adjustments would take into account differences in insurance risk profiles among enrollees in different plans, recognizing that some plans might, for example, have a disproportionately large number of high risk enrollees such as elders and HIV-positive persons. Premium distributions to health plans would be subject to set asides for administrative costs and a 1.5 percent subsidy to academic medical centers for graduate medical education in programs approved under the workforce provisions of the HSA.[31]

2. *Guaranteed Issue by Health Plans*

To secure the state approval specified by the HSA and to qualify for bargaining with alliances, health plans must agree to offer comprehensive benefits and to accept important constraints on how they operate.[32] They must, for example, forego actuarial underwriting ("experience rating"); cover persons with preexisting medical conditions; eschew use of waiting periods before coverage becomes effective and the practice of canceling coverage after large claims are made; and utilize community rating in calculating premiums.[33]

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25 *Id.* § 1321.
26 *Id.* § 1322(a).
27 *Id.* § 1322(b)(1).
28 *Id.* § 1321(b)(1).
29 *Id.* §§ 1342-1344.
30 *Id.* § 1351.
31 *Id.* §§ 1351-1353, 3031-3032.
32 *Id.* §§ 1402-1403.
33 *Id.*

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These constraints would not only force health insurers to issue contracts to applicants whom they once rejected or abandoned as prohibitive actuarial risks; they would also compel insurers to equalize premiums among all their insureds. For younger persons and other low-risk enrollees who can now obtain relatively low cost coverage in the small group or individual health insurance markets, the result could be a substantial increase in health insurance costs.

Health plans that are part of an employer's self-insurance program would be subject to the same constraints as insurer-operated plans.[34] Large self-insuring employers could, however, soften the impact of a community rating methodology for setting premiums by creating large risk pools and by implementing hiring policies that account for health insurance risks posed by potential employees. Selective hiring policies are of course limited to the extent that employers can lawfully discern these risks without violating antidiscrimination laws.

Health care providers that form entities coupling delivery of services with prepayment or other insurance-like mechanisms are bound by the same constraints as health plans formed by insurers. Finally, all plans that issue health insurance contracts must, in order to promote financial stability, competence, and fair administration, meet specified capital and solvency requirements, verify credentialing of providers, monitor quality of care, and provide mechanisms for resolving disputes among providers and plan enrollees.[35]

3. *Defined Benefits*

The HSA specifies a benefit package that is truly comprehensive. It provides coverage for physician and hospital care, preventive services, mental health and substance abuse services, family planning, hospice and home health care, prescription drugs, and outpatient diagnostic testing and rehabilitation services.[36] It also covers durable medical equipment and devices, vision and dental care, and investigational treatments that are part of an approved research protocol.[37] Coverage is subject to cost-sharing requirements and other adjustments.[38]

The oversight body created by the HSA, the National Health Board,[39] is empowered to expand the benefit package to the extent expansion would not cause a regional alliance to exceed its per capita

34 *Id.*
35 *Id.* § 1410.
36 *Id.* §§ 1101(a), 1111-1123.
37 *Id.* §§ 1101(a), 1124-1128.
38 *Id.* §§ 1342-1344.
39 *Id.* § 1151.

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premium target[40] and to specify the preventive services to be covered.[41] The Board is also responsible for writing regulations that set standards for determining when ostensibly covered services are "medically necessary or appropriate."[42] Services that fail this test are not reimbursable, and providers are barred from seeking payment for such excluded services from health plans or enrollees.

4. *Sources of Payment for Universal Coverage*

Accurately projecting the costs of achieving universal coverage is a daunting task. Nevertheless, it is obvious these costs will be large and that additional public expenditures will be necessary. Added public burdens may be direct and easily appreciated, such as sharp increases in income or sales taxes, or indirect and obfuscated, such as cost shifting from private third-party payers to public payers. Cost-shifting will in turn cause widespread inflation in private insurance premiums, higher costs of goods and services when sellers pass on their higher health care costs, and selective manipulations of income tax rules. The HSA offers a mix of direct and indirect burdens, emphasizing the indirect.

a. *Employer Mandate*

The HSA would require most employers to pay about eighty percent of the costs of health insurance coverage for employees and their families.[43] For all but the smallest employers, an employer's obligation would be capped at 7.9 percent of adjusted payroll.[44] For employers with fewer than seventy-five full-time employees the cap could be as low as 3.5 percent of adjusted payroll.[45]

b. *Self-Employed Individuals*

Self-employed enrollees would pay for their own health insurance, as would unemployed enrollees who do not qualify for federal programs or subsidies. However, they would be entitled to deduct from gross taxable income the cost of premiums paid to purchase the comprehensive benefits package specified in the HSA, capped at a sum equal to their earned income.[46]

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40 *Id.* § 1152.
41 *Id.* § 1153.
42 *Id.* § 1154.
43 *Id.* § 6122.
44 *Id.* § 6123(b)(1).
45 *Id.* § 6123(b)(2).
46 *Id.* § 7203.

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c. *Public Funds*

The HSA would impose an additional federal excise tax on tobacco[47] and a one percent annual payroll tax on large employers electing to form corporate alliances.[48] After the year 2004, the value of employer-paid premiums for health insurance coverage beyond that of the comprehensive benefit package would be includible in an employee's gross taxable income.[49] Employer contributions towards the comprehensive benefit package would remain tax free.

C. Lowering Health Care Costs

1. *Managed Competition*

The policy choice of the HSA is to retain private health insurance as the predominant payment mechanism and to rely heavily on a restructured, intensely competitive medical marketplace to achieve the economies needed to sustain universal coverage. The components of this new medical market are the alliances as informed buyers, the various providers of health services and products as sellers, and the regulated health plans as intermediaries between the alliances and the providers. While the HSA does not formally require physicians and hospitals to band together to negotiate with purchasing alliances, anticipation of the HSA or something like it has apparently fueled movement towards integration or joint ventures among providers as a way to maximize bargaining power.[50] The new domain is thus one that emphasizes large size and great efficiency.

In keeping with this shift to what Professor Blumstein describes as a countervailing power model of health market economics,[51] the HSA contains provisions desigued to maximize the ability of some major players—but not physicians—to exercise economic power. One such provision is a broad preemption of state laws that inhibit certain cost-containing practices of HMOs and health insurers that rely on reimbursement methodologies other than fee-for-service. Among the preempted laws are those that require health plans to accept all willing providers, that limit the power of plans to require use of designated providers in nonemergency situations, that prevent plans from limiting access to nonparticipating providers, that bar creating incentives

47 *Id.* § 7111.

48 *Id.* § 7121(a).

49 *Id.* § 7201(b).

50 *See* Kevin E. Grady, *A Framework for Antitrust Analysis of Health Care Joint Ventures*, 61 ANTITRUST LAW J. 765, 766-67 (1993) (describing recent tendencies of medical providers to form joint ventures to achieve efficiencies in health care delivery).

51 *See* James F. Blumstein, *Health Care Reform: The Policy Context*, 29 WAKE FOREST L. REV. 15, 28-29 (1994).

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to using participating providers, and that bar corporations from conducting medical practice.[52]

The obvious rationale for this preemption is to remove impediments that states have erected to some of the more aggressive strategies which HMOs and third party payers have employed in their efforts to contain health care costs. Although the preempted laws may represent public concerns about the adverse effects on the quality of care resulting from certain cost-containing strategies, the HSA drafters may have concluded that regulatory constraints on health plans and the professionalism of most providers furnish adequate counterweights to overly crass attempts at cost containment. On the other hand, they may simply have discounted the possibility that the preempted laws could have any positive impact on the quality of health care.

The HSA would also remove the umbrella protection from antitrust prosecution that the McCarran-Ferguson Act[53] affords for actions by health insurers that are part of the business of insurance.[54] The HSA thus increases the risk of antitrust prosecutions for certain actions by health insurers that were once immune, such as coerced discounts by insurers with substantial market power.[55]

On the other hand, the HSA contains a provision that would retain federal antitrust immunity for negotiations between providers and alliances that culminate in a fee scale,[56] effectively incorporating a version of "state action" immunity for these negotiations.[57] It would, however, bar providers from threatening or engaging in a boycott as part of the process,[58] thereby limiting their ability to exercise whatever market power they possess with respect to monolithic regional alliances.

2. *Targeted Cost Containment Measures*

Alongside the cost-restraining pressures of an efficient market, the HSA would attack certain problems that contribute to the escalating costs of health care.

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52 H.R. 3600, 103d Cong., 1st Sess. § 1407 (1993).

53 McCarran-Ferguson Act, ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011-1015 (1988)).

54 *See, e.g.*, Health Care Equalization Comm. v. Iowa Medical Soc'y, 851 F.2d 1020 (8th Cir. 1988) (construing McCarran-Ferguson Act to immunize conduct in business of insurance from antitrust scrutiny). *Cf.* H.R. 3600, 103d Cong., 1st Sess. § 5501 (1993) (repealing McCarran-Ferguson exemption).

55 *See, e.g.*, Group Life and Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979).

56 H.R. 3600, 103d Cong., 1st Sess. § 1322(c)(5) (1993).

57 *See* Patrick v. Burget, 486 U.S. 94 (1988).

58 H.R. 3600, 103d Cong., 1st Sess. § 1322(c)(6) (1993).

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a. *Fraud and Abuse*

The HSA would amend federal criminal laws to include a new offense of health care fraud,[59] and would provide for expanded enforcement and penalties under existing laws against fraud and abuse (including self-referrals by medical providers).[60]

b. *Workforce Reform*

Although the HSA would continue a federal subsidy for graduate medical education,[61] it would form a national council on graduate medical education to oversee and administer the subsidy.[62] The council would ensure that the total number of training slots approved for funding each year would bear a relationship to the number of United States medical graduates in the preceding year.[63] The council would also be required to ensure that by the year 2002 no fewer than fifty-five percent of medical graduates enter graduate training programs in primary care. The fiscal goal of these provisions is to contain those portions of rising health care costs attributed to a perceived glut of physicians and to overutilization of the services of specialists and subspecialists.

c. *Malpractice reform*

The HSA includes several provisions designed to reduce medical liability costs.[64] These provisions would preempt any conflicting state laws except those that afford stronger defenses to providers or greater cost-reducing potential than those of the HSA.[65] Included in the HSA reforms are mandatory use of alternative dispute resolution prior to filing suit,[66] mandatory inclusion of a certificate of merit in any filing of a malpractice suit,[67] limitations on contingency fees,[68] a collateral payment offset,[69] and provision for periodic payment of damage awards.[70] One assumption that seems to underlie these reforms is that medical liability costs, including those attributable to "defensive medicine," are significant contributors to the overall escalation in health care costs.

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59 *Id.* § 5431.
60 *Id.* §§ 5432-5441.
61 *Id.* § 3031.
62 *Id.* § 3001.
63 *Id.* § 3012(d)(3)(A).
64 *Id.* §§ 5301-5310.
65 *Id.* § 5301(a)(2).
66 *Id.* § 5302.
67 *Id.* § 5303.
68 *Id.* § 5304.
69 *Id.* § 5305.
70 *Id.* § 5306.

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3. *Price Controls*

Under the HSA, the national health board is required to determine a regional alliance inflation factor, a general health care inflation factor (limited to the Consumer Price Index after 1998), and a national per capita baseline premium target derived from current national average per capita expenditures on covered services and adjusted for inflation.[71] If regional alliance health plans exceed their per capita targets in any given year, the premiums payable in the succeeding year are reduced proportionally to the excess.[72] The predictable downstream effect of this would be to force providers under the health plans to accept reduced prices for their services.

II
CRITIQUE OF THE HSA

A. The HSA in Context

If the drafters of the HSA believed they were beginning with a blank slate, they had options ranging from a federalized single payer system to a totally deregulated health care market. However, political realities apparently intruded early.

The conceptually simplest plan, a national single payer plan, was promptly rejected. This was true despite its potential for quick achievement of universal coverage, large savings in administrative costs, and preservation of existing relationships between patients and providers.[73] An explicit federal takeover of health care financing and the attendant need for broad-based tax increases to fund the new program are features that may have made the single-payer option seem politically untenable. Ironically, the HSA would permit states to create their own single payer plans, either statewide or on a regional basis.[74] Its designers may thus have concluded that the political climate in at least some places is conducive to a government-run program.

At the opposite pole from a single payer plan is a plan that removes much of the existing regulation of health care delivery, retaining some sort of public safety net for the uninsurable and those who incur medical catastrophes. Such a plan would abolish laws that permit governments to regulate prices charged by providers and in-

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71 *Id.* §§ 6001-6002.

72 *Id.* § 6011.

73 *See, e.g.*, David U. Himmelstein et al., *A National Health Program for the United States*, 320 NEW ENG. J. MED. 102, 106-110 (1989) (argument for Canadian style single payer system with a single set of benefits); Steffie Woolhandler & David U. Himmelstein, *The Deteriorating Administrative Efficiency of the U.S. Health Care System*, 324 NEW ENG. J. MED. 1253, 1256-57 (1991) (demonstrating the high administrative costs of the United States' health care system as compared to those in Canada).

74 H.R. 3600, 103d Cong., 1st Sess. § 1221 (1993).

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surers, laws that restrict health insurers' ability to utilize actuarial underwriting, and laws that limit capital expenditures by hospitals or other corporate providers. To remove incentives to overutilize health care, such a deregulatory plan might also remove the tax preference for employment-based health insurance benefits. The safety net could be a tax-funded program such as Medicaid or a redesigned Medicare.

A deregulatory plan might improve marketplace efficiency though reduced regulatory costs and better matching of health insurance costs to rationally determined needs for medical services. But it would rather overtly create a dual-track system of health care, one for those with means to purchase adequate health insurance and one for those relegated to marginally funded public programs in which quality of care may be suspect.[75] The perceived inequity of such a system could evoke enough opposition to derail an overt move to deregulate, even though the American public has long tolerated huge numbers of medically uninsured persons and differential access to health care services based on ability to pay.

B. Coercive Dimensions of the HSA

The HSA would refashion the health care market through regulation so that virtually everyone would become entitled to private health insurance. This approach is coercive in several respects.

The HSA would force everyone to buy insurance through large alliances that could only negotiate with health plans that meet stringent regulatory requirements. It would compel employers to pay most of the costs of insurance for employees and their families. It would compel insurers to cover persons they would otherwise exclude according to traditional actuarial principles. By virtue of the default power to control premiums payable to health plans, the HSA would bar insurers and providers from charging prices they could ordinarily command in a competitive market, even if their services are of exceptional quality. The workforce provisions would enable regulators to constrain both the number of physicians entering the market and their choice of activity in that market.

What would remain after enactment of the HSA would be a "market" in which corporate purchasers bargain with corporate sellers under ground rules that specify what products sellers can offer and that limit the prices they can charge. The actual providers of most of the services, physicians and hospitals, can obtain effective entry into the bargaining process only by banding together into entities large enough to capture the attention of alliances and health plans. Bar-

75 *See* Katherine L. Kahn et al., *Health Care for Black and Poor Hospitalized Medicare Patients*, 271 JAMA 1169 (1994) (poor and minority patients received lower quality of care than other patients despite Medicare coverage).

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gaining will occur only in the shadow of price controls, amended federal antitrust laws that limit exercises of whatever market power physicians collectively possess, and bureaucratic controls on the number of new physician entrants into either the broad market or the limited markets for specialty services. This would be indeed a strange marketplace.

C. Illusory Commitment to Competition

1. *Contrived Bargaining*

The ideal of "managed competition" is that informed and empowered buyers of health insurance and services can lever competitive insurers and providers into offering cost-efficient products. In this paradigm, neither purchasers nor sellers should have enough economic power to force unreasonably high or low prices on the other through either monopoly or monopsony.

To protect against an imbalance of power, the HSA attempts through regulation to allocate appropriate amounts of economic power to buyers and sellers so that appropriate prices will emerge. Whether the allocations of the HSA are rational in an economic sense is far beyond my competence to assess. But I am profoundly skeptical about the assumption that legislators or regulators can determine in advance what is the proper amount of power economic actors should have to arrive at socially desirable pricing of health services. It is hard enough to make such judgments retrospectively when large amounts of empirical and other data are available.

2. *Hiding True Costs*

From a political perspective, major health care reform is a hard sell. A commanding majority of the public have health insurance, and most of them are apparently satisfied with the quality of health care they receive. However, fears about loss of health insurance and rising out-of-pocket payments for health care are realistic concerns for many who are insured,[76] and there is apparently broad support for the idea of universal, noncancellable coverage.[77] When it comes to paying for

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76 *See* Robert J. Blendon et al., *Paying Medical Bills in the United States*, 271 JAMA 949, 950-51 (1994) (survey of 1897 households revealing that three of four Americans with health insurance have problems paying medical bills, that worries about costs of medical care coincide with concerns about job loss, and that these worries strike those who are most vulnerable).

77 *See* Robert J. Blendon et al., *Bridging the Gap Between Expert and Public Views on Health Care Reform*, 269 JAMA 2573, 2574 (1993) (as a health system reform strategy, the public overwhelmingly prefers universal health insurance coverage to attempts to control medical costs); Lawrence R. Jacobs, *Health Reform Impasse: The Politics of American Ambivalence Toward Government*, 18 J. HEALTH POL., POL'Y & L. 629, 631-37 (1993) (summarizing opinion poll data indicating public support for universal health insurance coverage); Mark Schlesinger

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universal coverage, there is little public support for tax increases but more enthusiasm for employment-based insurance in which employers pay most or all of the costs.[78] In this context, the HSA heeds the public mood with its call for universal coverage, narrowly targeted taxes, and a mandate to employers to pay most of the incremental costs.

Despite these perceived benefits, it makes no sense to suggest that an employer mandate somehow allows the public to avoid paying for universal coverage. If they can, employers will pass on their raised insurance costs to the public in the form of higher prices. If they cannot, they are likely to reduce wages and salaries of their employees or reduce their workforce by firing or limiting hiring.

In these ways, costs of reform are shifted to the public, albeit unevenly and often unrecognizably. Nevertheless, the financial impact is equivalent to a tax. Much of the public may not recognize this effect or, if they do, may find it less objectionable than a higher tax bill that is directly traceable to health care reform. Yet to the extent that the HSA plays into the illusion that an employer mandate allows employees (and therefore the bulk of the United States population) to avoid paying for universal coverage, it may dampen the incentives of employees to make prudent choices about consuming health care and run counter to other measures designed to promote cost containment.

3. *Perverse Tax Incentives*

In addition to requiring employers to pay for employees' health insurance the HSA would allow employees to exclude from taxable income employer payments for the comprehensive benefits package.[79] The negative effects of this exclusion on federal tax revenues are obvious and quite considerable.[80]

Even more controversial is the impact of favorable tax treatment of health benefits on consumption of health care. Some commentators argne that the exclusion encourages covered employees to seek marginally useful or unnecessary care.[81] Moreover, even if care meets

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& Tae-ku Lee, *Is Health Care Different? Popular Support of Federal Health and Social Policies*, 18 J. HEALTH POL., POL'Y AND L. 551, 557-78 (1993) (data from regression analyses suggest growing public support for federal intervention in health care relative to other social programs).

78 Blendon et al., *supra* note 77, at 2575-76.

79 H.R. 3600, 103d Cong. 1st Sess. § 7201 (1993).

80 *See* M. Susan Marquis & Joan L. Buchanan, *How Will Changes in Health Insurance Tax Policy and Employer Health Plan Contributions Affect Access to Health Care and Health Care Costs*, 271 JAMA 939, 944 (1994) (economic simulation indicating that removal of tax subsidy for employer paid premiums would have small impact on total health spending but raise annual tax revenues by $35.6 billion).

81 *See* Blumstein, *supra* note 51, at 21-25.

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a lax standard of medical necessity, employees who are taxed on the value of employer-provided health benefits might forego care that translates into higher costs for their employer and a higher valuation of their taxable health benefits.[82]

Undoubtedly, the utility of some care that individuals purchase is negligible. But whether the availability of health insurance actually influences an individual's decision to seek such care is hard to measure. Indeed, empirical studies involving Medicare beneficiaries have revealed wide geographic variations in expenditures for comparable medical services,[83] suggesting a lack of consensus among physicians and patients about how much care is appropriate even when patients are insured. The decision may be influenced by factors other than the availability of insurance. For example, visiting a physician or hospital may be an uncomfortable, unpleasant experience, no matter who pays the bill, and in this sense may never be cost free. On the other hand, once care is initiated there is some evidence that decisions about how much care to consume are influenced by what insurance is available.[84]

Regardless of the effect of health insurance on consumption decisions, the choice to perpetuate tax breaks for employer-paid insurance seems primarily political in character. Inclusion of the value of health insurance benefits in taxable income would be widely and accurately perceived as a dreaded tax, as would removing deductibility of health insurance premiums paid by the self-employed. It might matter little to the public that resultant increases in federal tax collections might be enough to largely fund subsidies for the needy uninsured and underinsured.[85] Nevertheless, the decision by architects of the HSA to retain the tax preference for employee health benefits further displays the highly provisional quality of their commitment to market forces as a vehicle for driving down consumption of marginally useful services.

4. *Workforce Controls*

The HSA would limit both the total number of training slots available for medical graduates and the number of opportunities for training in medical specialties.[86] The rationale is that an excess of physicians, and especially an excess of specialists, fuels inflation in

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82 *Id.*

83 *See* W. Pete Welch et al., *Geographic Variation in Expenditures for Physicians' Services in the United States*, 328 NEW ENG. J. MED. 621 (1993).

84 *See* Willard G. Manning, *Health Insurance and the Demand for Medical Care*, 77 AM. ECON. REV. 251, 252 (1986) (evidence that first dollar health insurance coverage increased utilization of health services).

85 *See* Marquis & Buchanan, *supra* note 80.

86 H.R. 3600, 103d Cong. 1st Sess. §§ 3012-3013 (1993).

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health care costs.[87] It is further assumed that physicians can create markets for their services, some of which are unnecessary, and that specialists in particular cause excessive consumption of medical services because of their tendency to order high-cost diagnostic or therapeutic measures.[88]

While there are empirical data to support these assumptions,[89] there is no generally accepted approach to forecasting how many physicians will be needed at any given time.[90] Moreover, the notion that reducing the number of physicians or specialists will in itself affect total health care costs may be only wishful thinking. A smaller number of physicians may increase the volume of reimbursable services they provide, and continuing advances in medical technology will assure that ever more costly—and effective—diagnostic and therapeutic modalities will be available to physicians[91] regardless of their shrinking number. Thus, a "top down" attempt to control and redistribute the physician workforce, with the additional regulatory effort this would entail and its potentially demoralizing effects on new physicians and medical students, is at best problematic. To avoid this sort of regulatory solution, medical educators have recently shown increased interest in proposals to redress the existing imbalance between specialists and primary care physicians.[92]

The idea that reducing the supply of physicians will contain health care costs in a competitive market is counterintuitive. Health plans ought to have greater bargaining power to secure favorable prices for physician services if numerous physicians are competing for contracts with them. If the number of new physicians entering a particular market for primary care or specialty services declines, the remaining physicians will be positioned to command higher prices from health plans than if they were facing competition from new market entrants. Moreover, if managed competition works as it is supposed to, new entrants would be unable to create a demand for "unnecessary" or overpriced services. Health plans would presumably negotiate

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87 *See* Anne Schwartz et al., *Reforming Graduate Medical Education*, 270 JAMA 1079 (1993).

88 *See generally* Physician Payment Reform Commission, Annual Report to Congress, Medicare & Medicaid Guide (CCH) No. 694, extra ed. (Apr. 23, 1992) (expressing view that the dominance of specialists in the U.S. health care system is an important cause of escalating costs because of their reliance on expensive technology).

89 *Id.*

90 *See* Elizabeth C. Feil et al., *Why Estimates of Physician Supply and Requirements Disagree*, 269 JAMA 2659, 2663 (1993) (describing absence of accepted approach to forecasting physician requirements and wide discrepancies in forecasts).

91 *See* Eli Ginzburg, *High-Tech Medicine and Rising Health Care Costs*, 263 JAMA 1820 (1990).

92 *See* John K. Iglehart, *Health Care Reform and Graduate Medical Education*, 330 NEW ENG. J. MED. 1167, 1169-70 (1994).

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only for those services its subscribers need and that are cost effective. Physicians trying to offer marginally useful or overly costly services would therefore be unlikely to secure contracts with the health plans. In this context, a flood of new physicians would not generate higher health care costs in a particular region unless health plans determined their services were needed.

D. The Threat to Medical Professionalism

1. *Loss of Autonomy*

The HSA does not purport to regulate physicians with respect to fees or modes of practice. Physicians would, in theory, remain free to choose which health plans to join, which patients to serve, and where and how to practice. The reality is, however, that the HSA would reduce their freedom in these respects. All potential patients would be enrolled in approved health plans, and the plans would exert considerable control over the flow of patients. To gain access to these patients, physicians would be forced to contract with health plans directly or to join networks with other providers as a way capturing patients from insurer-controlled plans or HMOs. Once physicians contract with a plan or join a network, they are bound by its fee structure and become subject to the credentialing and monitoring the HSA requires all health plans to implement. A few specialists whose services are in great demand or who enjoy a sort of "natural monopoly"[93] may retain a measure of autonomy for a time, but their number would probably shrink as health plans expanded.

The diminished autonomy for physicians that the HSA envisions would not necessarily erode the quality of care they offer. Quality-oriented oversight activities of health plans might counter the demoralization that could otherwise lead to substandard care. More efficient referrals under a managed care model might allow physicians to make better use of their time with patients. Nevertheless, some—perhaps many—physicians could find that a combination of micromanagement by lay administrators of health plans and cost-driven pressures to process patients so alters their personal relationships with patients as to affect the quality of care they provide.

2. *Loss of Bargaining Power*

In the new market of the HSA, physicians would suffer a marked reduction in their power to set prices for their services. The most

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93 *See generally* Richard Posner, *Natural Monopoly and Its Regulation*, 21 STAN. L. REV. 548 (1969) (describing how natural monopoly may arise when the entire demand in a relevant market can be satisfied at lowest cost by a single firm that possesses particular technology or resources).

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important bargaining would be between alliances and health plans over premiums. Physicians' prices for their services would largely turn on the outcome of these negotiations. An exception would exist where physicians control the health plans, but few physicians are likely to find themselves in this position.

This disempowerment of physicians may be just what the architects of the HSA intended. Physicians as a group have high incomes, the rate of increase in their income has historically exceeded the general rate of inflation, and traditional fee-for-service medicine has been viewed as a major contributor to high health care costs. Reducing physicians' power to set prices by interposing regulated alliances and health plans might therefore be seen as a just way of containing health care costs.

The problem for patients, however, may be that the exclusion of physicians from a central price-setting role may result in excessive concentration on costs by nonphysician administrators and insufficient attention to providing the resources needed to deliver the sort of care patients in the United States have come to expect. How big a problem this might become is impossible to know, but it would seem to be a legitimate concern in an environment where physicians play a limited role in decisions about allocation of medical resources.

III

TOWARD ADEQUATE REFORM: AN ALTERNATIVE TO THE HSA

A. Extent of Consensus on Reform

There is an apparent public consensus that some health care reform is needed,[94] and there is no dearth of ideas about how to accomplish it. But uncertainty surrounds the durability of the consensus and the ability of Congress to produce a plan that will substantially remedy agreed upon problems of inadequate access and high costs.

The HSA is a pastiche of regulation and market-oriented measures that, in one way or another, addresses these problems. Given wise and dedicated regulators, compliant medical providers, and a firm societal commitment to distributive justice, including tolerance for higher public expenditures, the HSA could perhaps achieve its goals. But because I doubt that these elements are now in place or soon realizable, it seems appropriate to consider a less elaborate approach than that of the HSA.

One alternative, of course, is to abandon the struggle for major legislative changes, take solace that American medicine well meets the needs of most citizens, and continue nibbling at the edges of the problems of the uninsured and of others whose access to urgently

94 *See* Blendon et al., *supra* notes 76-77.

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needed care is limited or who face grave financial hardships because of ill health. Because I find this alternative too grim to contemplate and agree that expanded coverage and better cost containment are important social goals, I will suggest elements of an approach that is less coercive and more faithful to a market model of health care than the HSA, and that does not evade the issue of the need for all who can to share the costs of reform.

B. Elements of Adequate Reform

1. *Assured Access to Private Health Insurance*

To approximate the ideal of universal coverage in a polity that has apparently rejected a national single payer system, everyone must have an opportunity to obtain private health insurance. This necessarily includes those in poor health, those who cannot afford to pay for insurance, and those incapable of recognizing the value of insurance, such as children and the legally incompetent.

The solution of the HSA is to compel everyone to join alliances, to compel most employers to pay most of the costs of insurance for employees and their families, to offer tax benefits to the self-employed, and to provide means-tested subsidies for those who cannot buy health insurance. The HSA would thus provide coverage for everyone, making employers pay a large portion of the added costs. While this approach builds upon an existing tradition of tax favored, employment-based insurance and is a convenient way of adding many currently uninsured persons to health insurance rolls, it is very coercive and perpetuates the notion that obtaining, paying for, and utilizing health insurance is the responsibility of someone else.

A less burdensome and more nearly market-oriented approach would guarantee health insurance to all who apply, regardless of health, and establish mechanisms to facilitate application for insurance and to assist those who need help in paying premiums. California, for example, has enacted legislation that enables employees of small businesses and their families, other uninsured employees and families, and persons who represent high actuarial risks for health insurers to join purchasing cooperatives that must take all comers.[95] Like the regional alliances under the HSA, the cooperatives can negotiate discounted benefits for their members in prepaid or fee-for-service health plans. But unlike the alliances of the HSA, these cooperatives have no significant regulatory powers with respect to health plans. The health plans themselves have considerable flexibil-

95 *See* Michelle Quinn, *California's Health Pool: Limits, but Lower Rates*, N.Y. TIMES, Jan. 11, 1994, at A1.

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ity as to how they structure delivery of services, so long as they offer statutorily defined core benefits.

An alternative to assured access to purchasing cooperatives is enrollment in existing or expanded government-sponsored health benefit programs. Eligible individuals could thus enroll in Medicare or the Federal Employee Health Benefits Program. In these programs, enrollees would share costs of insurance to the extent of their financial ability and could qualify for subsidized premiums on proof of financial need. Also, eligible persons could be given access to statewide or regional risk pools or reinsurance programs in which purchase of coverage is partially or fully subsidized through broadly based state taxes, premium taxes or assessments on private health insurers.[96] Needed subsidies in these programs could take the form of direct governmental payments to health insurers, tax credits, or credit cards dedicated for use in buying health insurance. Those with the means to supplement their coverage beyond the core benefit package could purchase additional coverage or receive it as a taxable employment benefit.

There is an obvious risk that these noncoercive alternatives to the HSA might leave an appreciable number of persons uninsured. Some persons may be unwilling to expend *any* money to buy health insurance and will bypass the opportunity to obtain coverage. Others, because of inertia, poor judgment, or mental incapacity, may fail to acquire coverage, even though there is a clear need for it. If the pool of nonparticipants becomes too large, costs of their care would be unsystematically shifted to those who pay for their insurance, as is now the case. Among other consequences, this inefficient allocation of medical resources could greatly complicate efforts to achieve cost containment.

A partial solution to the problem of nonparticipation lies in creating tax-funded special purpose programs.[97] For example, special funds could be established to compensate providers for services to those who have failed to obtain health insurance or who are ineligible for it, such as illegal immigrants. Children and other vulnerable persons could be automatically enrolled in a private health insurance program and subsidized as required. Or they could be assigned to risk pools that would be sources of funding for care they need.

If it became apparent over time that significant numbers of persons were not acquiring health insurance on a voluntary basis, new

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96 *See* Carl J. Schramm, *Health Care Financing for All Americans*, 265 JAMA 3296, 3297 (1991) (advocating targeted insurance reforms, including reinsurance to absorb losses for high-risk individuals and high-risk employer groups, state risk pools for high-risk individuals who cannot obtain coverage through employers, and expanded Medicaid to cover poor and near poor).

97 *See id.* at 3298.

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legislation could require all persons to obtain coverage through their employers, purchasing cooperatives, or available public programs. Unless penalties for ignoring this individual mandate were substantial, a few persons might still forego coverage, as in the case of those who operate cars without auto liability insurance. Anticipating this possibility, an assessment based or tax-funded uncompensated care fund could be created to assure that providers receive minimally adequate payment for services to the uninsured.

A touchy question is whether deferring imposition of an individual mandate to purchase insurance that is assuredly available is wise legislative or social policy. It is uncertain how many persons would actually opt out of coverage. Undoubtedly some would, including younger persons who see no immediate need for health insurance but whose participation is needed to assure that health insurers' risk pools are not disproportionally populated by older and unhealthy persons. On the other hand, awareness of the high costs of medical care and the potentially disastrous financial consequences of not having health insurance seems to be growing. It is thus quite possible that assurance of access to insurance will attract enough good insurance risks into the pool that the overall impact of dropouts will be small.

2. *Scope of Benefits*

Once access to coverage is assured, the question becomes access to what? Here considerations of cost are pivotal. The cheapest coverage would presumably be that which reimburses only for catastrophic illness or injury, or for costs of treatment that exceed a specified monetary threshold.

At the other pole is comprehensive coverage of all medically necessary expenses, comparable to the defined benefit package of the HSA, but without deductibles or copayments. It is obvious that a plan which promises this sort of coverage to everyone would require substantial tax increases, regardless of any savings from enhanced administrative efficiencies, vigorous attack on fraud and abuse, and medical malpractice reforms. If tax increases are unacceptable, options include limiting the range of benefits, creating disincentives to use services (such as higher copayments), and limiting payments to providers directly through fee scales or indirectly through caps on health insurance premiums.

The political volatility of these alternatives is significant. The public would presumably prefer broad coverage, little or no coinsurance, and no tax increases.[98] Providers would vigorously oppose reductions in the price of their goods and services and, like most of the

98 *See* Blendon et al., *supra* notes 76-77.

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public, would probably disfavor significant tax increases. Thus, an important challenge is to design a benefit package that would not increase taxes so much as to invite public rejection but that somehow meets public expectations for health care of decent quality and providers' expectations for decent incomes.

In constructing such a core benefits package, reliable projections of budgetary consequences of particular options are essential. These are hard to come by, and legislators may feel a need to fall back on some organizing principle to guide their deliberations.

Professor Dworkin has offered one such principle, that of "prudent insurance."[99] Applying this principle involves determining what health insurance coverage prudent persons would buy in a truly free market if they had state-of-the-art information about costs and benefits of medical services for which they can anticipate a need. Dworkin suggests that legislators could make such determinations after hearing the views of citizens and the opinions of experts skilled in evaluating the utility of particular health services. This determination would then become the core or basic benefit package to which all would have access through their health insurance. If the resulting package seemed too expensive, legislators could pare it by trying to assess what benefits a prudent but financially strapped person would choose to forego.

Without such an organizing principle, those who construct a core benefit package may be left with a choice between covering general categories of "medically necessary" services such as office visits, hospitalization, diagnostic tests, and drugs, or trying to specify what medical conditions qualify for coverage. The first choice is simpler conceptually but leaves an opportunity for interminable hassling over whether particular items of care are "medically necessary." The second would engage legislators in a lengthy, complex task of cost-benefit analysis,[100] requiring considerable input from medical and scientific experts, and could result in extremely prolix laws or regulations.

Although applying a "prudent insurance" test in developing a core benefit package would not eliminate all problems inherent in either of these options, it would force legislators to look at health insurance in the context of the totality of social needs and to recognize that health care is but one of several goods the public may desire.

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99 Ronald Dworkin, *Will Clinton's Plan Be Fair?*, N.Y. REV. BOOKS, Jan. 13, 1994, at 20, 22.

100 *See* W. John Thomas, *The Oregon Medicaid Proposal: Ethical Paralysis, Tragic Democracy, and the Fate of a Utilitarian Health Care Program*, 72 OR. L. REV. 47, 91-104 (1993) (depicting complex nature of prioritizing by need for health services).

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This might help legislators resist a tendency toward fiscally unsustainable overinclusiveness in the core benefit package.

3. *Permanency of Coverage*

Minimally adequate health care reform requires that all persons be allowed to keep their health insurance, whether or not they are in good health. A striking shortcoming in the current system of health insurance is insecurity of coverage. Insurers often cancel or limit coverage if individual subscribers incur large medical expenses or are thought to represent high risks. Workers who lose their jobs also lose employment-based health insurance or, if continuation coverage is offered, may not be able to afford it. Moreover, a new health insurer may refuse coverage for health problems that developed while covered under the worker's former insurance on the ground they represent preexisting conditions.

Under a reform that assures access to health insurance coverage for all, an applicant's preexisting condition cannot bar coverage. Consequently, health insurers will have higher costs and will need to adjust their premiums. Traditionally, their approach has been to employ some form of experience rating so that individuals or groups who represent higher actuarial risks pay higher premiums. Experience rating can result in very high premiums for some individuals or for small groups with a disproportionate number of high-risk members, so high as to be prohibitive in some instances.

An effective—though hardly uncontroversial—response is to require all insurers to employ community rating of premiums, as under the HSA. Under community rating, all subscribers in broadly defined risk pools pay the same premiums, regardless of whether they have preexisting conditions or are heavy users of medical services. In this way, relatively healthy subscribers subsidize those whose medical needs are greater. While they may then be tempted to try to secure coverage from insurers whose subscriber population generates smaller cross-subsidies of this nature, the effort should be largely fruitless if insurers must accept all comers and use community rating in setting premiums. Moreover, risk-adjustment methodologies could be invoked to equalize premiums charged by insurers in particular locales. To prevent insurers from narrowing risk pools in such a way as to defeat the goals of community rating, laws could limit risk pools to broad age categories (for example, under twenty-one years old, twenty-one to fifty, over fifty) and geographic locale (in recognition of wide regional variations in health care costs).

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4. *Financing and Cost Containment*

Expanding the number of covered persons and ensuring their entitlement to specified core benefits will obviously raise total health care expenditures. The approach outlined above would probably require a mix of tax increases, shifting of costs to those with greater ability to pay, and lower profits for some health insurers and medical providers.

a. *Market Efficiencies*

The magnitude of these effects would be influenced by the degree of efficiency that insurers and providers achieve in the operation of their enterprises. Highly efficient insurers and providers may not only improve their own profitability but could also keep health care costs at levels that dampen the need for substantial tax increases. Conversely, widespread inefficiencies would reduce profit margins and possibly fuel higher taxes.

Market-based competition is intended to maximize efficiency, reducing the need for frankly regnlatory solutions such as premium caps, provider fee scales, hospital rate regnlation, and restraints on capital expenditures for new facilities and technologies. Insurers that are truly competing with one another have a powerful incentive to obtain discounted prices from providers, and providers have incentive to contract with insurers who can assure them a steady supply of insured patients, while keeping their costs low enough to maximize profits in the face of discounted prices.

Whether this idealized version of competition in health care will in fact work is an open question. But the moderation of health care cost inflation that has emerged in the context of voluntary shifts towards a market-oriented delivery system offers some encouragement. To me this is enough to warrant foregoing, for now, resort to price controls or increased regulation of how providers and payors negotiate prices. Some form of global expenditure targets might be appropriate as an aspirational goal and as a benchmark for adjusting benefits, subsidies, and coinsurance requirements. Also helpful would be vigorous efforts to streamline processing of insurance claims; to attack fraud, dubious gaming practices, and self-dealing among providers; and to reduce the more outlandish extravagances of medical malpractice litigation.[101]

101 *See* Robert J. Rubin & David A. Mendelson, *Estimating the Costs of Defensive Medicine*, 10(4) MED. BENEFITS 7 (1993) (estimating annual costs of defensive medical practices at $25 billion, representing about 3% of total health care expenditures).

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b. *Role of Employers*

Despite the linkage between employment and health insurance and the fact that many employers currently pay for their employees' health insurance, a market-based approach does not logically require that employers pay. Many employers may merely act as agents for their employees to obtain coverage at favorable group rates. It is in this role that employers can make the greatest contribution to cost containment. Indeed, the most useful form of an employer mandate might be one that requires employers, particularly large ones, to act as bargaining agents for their employees in the purchase of health insurance, whether or not employers pay the bill.

If employers pay some or all of their employees' health insurance bills, so much the better for the employees. But if employers do not pay, employees are in no worse position than the self-employed. Both could use voluntary purchasing cooperatives to secure coverage that is discounted, permanent, and affords the required core benefits.

c. *Income Tax Considerations*

Where employers pay for employees' health insurance, the value of this benefit ought to be includible in the taxable income of employees. It is clearly part of the employees' compensation and should be treated as such. Moreover, taxing the value of health benefits would give employees a stake in trying to hold down insurance costs.

One great advantage of taxing employee health benefits is the billions of dollars this would yield the federal government to subsidize health insurance for those who cannot afford it.[102] Removal of the tax preference might also encourage some employees to seek cash payments, in lieu of health benefits, to purchase health insurance from a more satisfactory insurer.

If this change in income tax laws proves politically impossible, as it might, one could limit the exclusion from taxable income to the imputed value of the core health benefits, or deny a deduction to employers for payments to purchase extra benefits for employees. This would yield extra tax revenues and might discourage employers and employees from collaborating in overuse of medical services. Alternatively, employers could be subject to a tax with respect to payments made to purchase extra benefits for their employees. In this scenario, employees could continue to receive tax-free health benefits, but employers might be less generous in what they offer.

102 *See* Marquis & Buchanan, *supra* note 80.

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d. *Physician Workforce Reform*

Because of the great difficulty in accurately predicting how many physicians or specialists are needed to make the medical marketplace work,[103] the foundation for regulatory control of the supply of physicians or their choice of specialty is shaky. Moreover, reliance on market forces as a dominant strategy of cost containment would seem to count against attempts to regulate the supply of physicians.

Although medical specialists may indeed contribute to spiraling costs of health care, cost-conscious and competitive health plans ought to be able to influence physicians who overutilize medical resources by limiting referrals to them and denying payment for inappropriate services. Eventually specialists who face competition would be expected either to lower their prices or to decrease the volume of unnecessary or marginal services they provide. Moreover, the degree of competition in various specialties should ultimately influence entry. Thus, if the average income of physicians in currently overpopulated specialties such as ophthalmology or orthopedics begins to decline, the flow of new physicians may shift towards nonspecialty practice or into specialties where the demand for new entrants is greater.

However, eschewing formal workforce controls does not mean ignoring the issue of whether "too many" specialists are being trained. Through the existing Medicare subsidy for graduate medical education and the proposed HSA subsidy, clinical training of medical graduates would continue to enjoy federal support. Most of the trainees are now in specialty programs,[104] and the federal subsidy is equivalent to an entitlement program costing taxpayers several billion dollars a year. To qualify for the subsidy, an academic medical center need only secure approval of its training program by a private accrediting body that assesses whether the program meets prescribed educational standards.[105] The accreditation process does not explicitly address the need for physicians in a specialty or take into account that other programs in that specialty may already be turning out substantial numbers of new trainees. Furthermore, hospitals may opt to engage in specialty training for very parochial reasons, such as a desire for the cheap labor represented by trainees or the desire to market themselves as a "teaching hospital."

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103 *See* Feil et al., *supra* note 90.

104 *See* David A. Kindig & Donald Libby, *How Will Graduate Medical Education Reform Affect Specialties and Geographic Areas?*, 272 JAMA 37, 39 (1994) (current data indicate that the majority of medical residents now in training will enter specialties); Jack M. Colwill, *Where Have All the Primary Care Applicants Gone?*, 326 NEW ENG. J. MED. 387, 388-89 (1992) (describing recent sharp decline in applications for residencies in primary care).

105 *See* Schwartz et al., *supra* note 87, at 1079 (describing how current system of accrediting graduate medical education programs allows academic medical centers to ignore national health needs for more generalists).

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Even if academic medical centers have not captured the accrediting process, there is reason to believe they are training more of some specialists than can be absorbed by the current medical marketplace in those specialties.[106] This suggests a need for a more socially responsive accrediting process, one that takes into account that large amounts of public funds are expended as a result of accrediting decisions. In short, rather than trying to allocate training slots by regulation, a more cogent reform might be to require academic medical centers to inform themselves about societal needs for specialty services and recast their training efforts accordingly.

5. *Considerations of Federalism*

a. *A Federal Law*

Under the version of minimally adequate health care reform sketched out in preceding sections, I envision that Congress would enact federal legislation requiring that all interstate health insurers offer insurance policies to all comers, regardless of health status. The law would also specify a core benefit package based on a "prudent insurance" principle, or at least establish a mechanism by which the package could be defined and adjusted. The law would require that insurers utilize community rating in calculating premiums for the core benefits, adjusting only for age and geographic locale of subscribers, and would forbid cancellation of policies except for nonpayment of premiums or fraud.

The law would also include a methodology for subsidizing persons unable to pay for insurance but would not require employers to pay for their employees' insurance. It would remove the tax preference for employee health benefits to free up funds for subsidies and provide incentives to encourage states to form voluntary purchasing cooperatives or alliances for use by persons who are unemployed or needy, or whose employers have opted not to buy them health insurance.

b. *Role of States*

Under this hypothesized federal law, states would retain their powers under the McCarran-Ferguson Act[107] to regulate health insurers in ways not inconsistent with the new federal law. States could thus set capital requirements and other standards relating to solvency and claims administration. They could monitor insurers to assure compliance with the federal mandate to employ community rating in

106 *See* Marc L. Rivo & David Satcher, *Improving Access to Health Care Through Physician Workplace Reform*, 270 JAMA 1074 (1993).

107 McCarran-Ferguson Act, ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011-1015 (1988)).

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setting premiums and with the statutory bar against cancellation of policies other than for nonpayment of premiums or fraud. States would also retain existing powers to regulate health plans and providers with respect to credentialing and quality of care, to conduct innovative health planning, to regulate supplemental health insurance for excess coverage beyond the core benefit package, and to enforce their own antitrust laws.

This distribution of power among federal and state governments would minimize the need for a new federal bureaucracy, although it would not eliminate the need for a federal role in formulating and adjusting the core benefit package and administering a subsidy program. States, however, could largely administer a subsidy program once basic eligibility criteria were established under federal law, and could also provide more generous subsidies than under federal law if they so chose. Existing federal antitrust laws would remain in place to protect the health care marketplace against anticompetitive conduct by health insurers, provider networks, or other groups that have gained market power.

The hypothesized federal legislation would effectively remove the temptation for employers to self-insure their employee health benefit programs only so they could hide behind ERISA.[108] ERISA preemption of state regulation has been exploited by some employers to escape state insurance laws mandating benefits or limiting insurers' freedom to restrict coverage for preexisting conditions or illnesses deemed too costly to insure.[109] Employees under the new regime would be entitled to obtain coverage for core benefits and protection against cancellations, whether or not employers chose to pay for the coverage. In this context, the ERISA preemption clause would have little significance. The new federal law would itself enable access to specified core benefits and durable coverage for everyone.

CONCLUSION

The complex and ambitious HSA aims for universal coverage and cost containment in health care. To these ends, it would reconfignre the medical marketplace through regulation that includes mandatory purchase of private health insurance, a requirement that employers pay the costs of insuring employees and their families, and standby price controls in the form of premium caps. Its financing relies on

108 Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (1988).

109 *See generally* Wendy K. Mariner, *Problems With Employer-Provided Health Insurance—The Employee Retirement Income Security Act and Health Care Reform*, 327 NEW ENG. J. MED. 1682 (1992) (noting how ERISA preempts states from imposing their own substantive standards for employee health benefits upon self-insuring employers while providing no such standards of its own).

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improved efficiencies in a regulated market, targeted taxes, controls on the supply and distribution of physicians, administrative savings, malpractice liability reforms, and stronger enforcement of expanded fraud and abuse laws.

Success in meeting its goals would likely require conjunction of a high level of bureaucratic competence, compliant providers and insurers, and a public that is willing to share the undoubtedly high costs of the plan. That this blend of conditions now exists or is soon attainable is doubtful.

In my view, moreover, the plan is seriously flawed. It is broadly coercive and its declared commitment to a competitive market is in many respects illusory. The competitive structure it contemplates seems overly contrived, its emphasis on employer financing obfuscates the true costs of the plan, it retains perverse tax incentives, it proposes regulation of the supply of physicians without adequate foundation, and its potentially adverse impact on medical professionalism may disadvantage patients.

Based on a belief that significant health care reform is nonetheless highly desirable, I have sketched a less intrusive path to expanded coverage. It features guaranteed access to noncancellable health insurance, a benefit package incorporating the "prudent insurance" principle of Dworkin, modified community rating of premiums, public subsidies for those of limited means, elimination of some tax benefits, a restrained approach to regulating the physician workforce, and a commitment to preserving an important role for state governments in overseeing delivery of care. While there are many pitfalls in this approach, I believe it offers a useful way of redressing major problems of American health care at a more tolerable social cost than the HSA or its variants would impose.

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