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AIDS AND PRIVATE HEALTH INSURANCE: A CRISIS OF RISK SHARING

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INTRODUCTION

The American health care financing system is in crisis; it requires total reconstruction, or at least major alterations. The AIDS epidemic has compounded this crisis by magnifying all of the faults of the health care financing system. Ironically, these very faults have rendered attempts to provide care for persons with HIV and AIDS far more difficult than they might otherwise have been.

The weak and increasingly inadequate risk-sharing arrangements at the heart of employer-sponsored private health insurance are an important link between the crises of AIDS and the health care financing system. These arrangements not only fail to facilitate the wide sharing of health care costs — and, therefore, broad access to health care itself — but act directly to exclude from insurance coverage those with the greatest medical needs, among them persons with HIV and AIDS.

This Article explores the nature of American risk-sharing arrangements and the problems generated by them, as exemplified by the dual crisis of health financing and AIDS. It then discusses more satisfactory risk-sharing arrangements which could serve as the basis of a reformed health care financing system. These arrangements illustrate the principles upon which workable health care reforms must be based. Finally, the Article uses the health care reform principles as the foundation for a critique of the major health care reform proposals now before our nation.

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I. THE INTERSECTION OF THE AIDS EPIDEMIC AND THE CRISIS OF HEALTH CARE FINANCING

The AIDS epidemic came to public notice in the early 1980s, at a time when America's health care insurers found themselves in a crisis of constantly increasing health care costs. Commercial insurers, as well as the public, were persuaded by early cost estimates which inaccurately calculated the costs of treating AIDS and firmly established AIDS as a disease with unacceptably high costs.[1]

When AIDS met an already-strained health insurance system, commercial insurers declared that they had to protect themselves from what they perceived as a risk of financial ruin from HIV and AIDS.[2] Years of narrowing their risk pools weakened insurers' ability to absorb AIDS treatment costs. Consequently, insurers took aggressive steps to stave off further financial difficulties by attempting to exclude victims of the new epidemic from their risk pools. Since that time, persons with AIDS have faced a constant threat of exclusion from health insurance and, accordingly, a constant threat of exclusion from health care itself.[3]

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[1] *See* Jesse Green et al., *The $147,000 Misunderstanding: Overstating the Costs of AIDS*, 19 J. HEALTH POL., POL'Y & L. (forthcoming Spring 1994) [hereinafter *The $147,000 Misunderstanding*] (giving an account of the inaccuracies of one highly influential 1986 AIDS cost study). For more accurate estimates of the costs of AIDS, see Jon Eisenhandler, *AIDS: Update and Reserving*, 18 REC. SOC'Y ACTUARIES 673, 673-93 (1993); Daniel M. Fox & Emily H. Thomas, *The Cost of AIDS: Exaggeration, Entitlement, and Economics*, *in* AIDS AND THE HEALTH CARE SYSTEM 197-210 (Larry O. Gostin ed., 1990); Fred J. Hellinger, *The Lifetime Cost of Treating a Person with HIV*, 270 JAMA 474, 474-78 (1993); discussion *infra* part II.

[2] For early articles on AIDS and insurance, see AIDS:ONE: LEGAL, SOCIAL & ETHICAL ISSUES FACING THE INSURANCE INDUSTRY (James Vculek ed., 1988) [hereinafter AIDS:ONE]; *see also* Norman Daniels, *Insurability and the HIV Epidemic: Ethical Issues in Underwriting*, 68 MILBANK Q. 497 (1990) (rejecting the argument that actuarial determinations of insurability are the only just means of distributing health care); Gerald M. Oppenheimer & Robert A. Padgug, *AIDS: The Risks to Insurers, the Threat to Equity*, HASTINGS CENTER REP., Oct. 1986, at 18 (proposing state-sponsored solutions to the problems of insuring persons with AIDS through private health insurance).

[3] For works documenting the personal and societal effects of the exclusion of persons with AIDS from private insurance, including the loss of all coverage or the necessity of relying on Medicaid, see Daniel Fife & James McAnaney, *Private Medical Insurance Among Philadelphia Residents Diagnosed with AIDS*, 6 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 512,

Many self-insured employers, fearing the financial consequences of insuring persons with AIDS, have also taken actions to remove them from their health insurance plans. These actions include administering HIV antibody tests and setting exceptionally low per-occurrence, lifetime, or yearly caps on — or even the complete elimination of — reimbursement for AIDS.[4] Attempts to exclude persons with HIV infection have generally been successful, in spite of the efforts of some states to prevent them.[5] These discriminatory practices have been upheld by a number of courts, including the Fifth Circuit Court of Appeals, on the ground that the federal legislation regulating self-insurance plans[6] does not forbid them and, in fact, preempts state legislation prohibiting discrimination of this sort.[7]

515-517 (1993); Jesse Green & Peter S. Arno, *The 'Medicaidization' of AIDS: Trends in the Financing of HIV-Related Medical Care*, 264 JAMA 1261, 1261 (1990) [hereinafter *The 'Medicaidization' of AIDS*]; Nancy E. Kass et al., *Loss of Private Health Insurance Among Homosexual Men with AIDS*, 28 INQUIRY 249, 253-54 (1991); Donna Minkowitz, *Redlining the Arts, Insurers Brand Artists AIDS-Prone*, VILLAGE VOICE, Aug. 22, 1989, at 19; *cf.* John A. Fleishman & Vincent Mor, *Insurance Status Among People with AIDS: Relationships with Sociodemographic Characteristics and Service Use*, 30 INQUIRY 180, 187 (1993) (explaining that while there is a large increase in the number of people with AIDS covered by Medicaid in states with generous eligibility criteria, other states with more restrictive eligibility criteria are experiencing smaller increases).

[4] *See* Health Ins. Ass'n of Am., *State Financing for AIDS: Options and Trends*, 3 INTERGOVERNMENTAL AIDS REP. 1, 1-8, 12 (1990) (describing the exclusion of persons with HIV/AIDS from insurance coverage). Of the insurers responding to this 1987 survey taken by the HIA, 100% considered applicants with AIDS uninsurable, 99% considered applicants with less advanced stages of the illness uninsurable, and 91% considered asymptomatic persons affected with HIV uninsurable. *Id.*; *see also* OFF. OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, MEDICAL TESTING AND HEALTH INSURANCE 80 (1988) (finding that most insurers had already begun or planned to screen individual and group applicants for HIV infection, and that 77% of commercial and Blue Cross/Blue Shield carriers who insured small groups and more than 50% of those who covered large groups either already screened for HIV infection or would soon do so). *See generally* sources cited *supra* note 3 (documenting some of the results of the exclusion of persons with HIV infection or AIDS from coverage).

[5] *See* Donald H.J. Hermann, *AIDS and the Law*, *in* AIDS AND ETHICS 277, 291 (Frederic G. Reamer ed., 1991).

[6] Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461 (Supp. IV 1992).

[7] McGann v. H&H Music Co., 946 F.2d 401 (5th Cir. 1991), *cert. denied sub nom.* Greenberg v. H&H Music Co., 113 S. Ct. 482 (1992). *See generally*

Moreover, employers have increasingly resorted to self-financing of employee health benefits so as to take advantage of ERISA's protection of their treatment of persons with AIDS or HIV infection.[8] Whether the recent implementation of the Americans with Disability Act[9] ("ADA") will alter this situation remains uncertain at the present time.[10]

Mark H. Jackson, *Health Insurance: The Battle over Limits on Coverage, in* AIDS AGENDA: EMERGING ISSUES IN CIVIL RIGHTS 147 (Nan D. Hunter & William B. Rubenstein eds., 1992) (examining insurance practices that limit coverage for HIV but not for other diseases, focusing on available legal remedies and gaps in the law that permit those practices to continue). For further discussion of the implications of AIDS caps and the problem of ERISA, see generally Mark Scherzer, *After McGann: Policy Implications of the Decision Authorizing Discriminatory Benefit Caps for Treatment of AIDS*, 7 AIDS & PUB. POL'Y J. 96 (1992); Edward F. Shay, *Discrimination in Health Benefits: ERISA and Beyond*, 7 AIDS & PUB. POL'Y J. 92 (1992); Ronald Turner, *ERISA and Employer Capping of Medical Benefits for Treatment of AIDS and Related Illnesses*, 7 AIDS & PUB. POL'Y J. 89 (1992); Steve Taravella, *Self-Insured Employers Limit AIDS Benefits*, MODERN HEALTHCARE, Feb. 19, 1990, at 52.

[8] *See generally* Steven DiCarlo & Jon R. Gabel, *Conventional Health Insurance: A Decade Later*, HEALTH CARE FINANCING REV., Spring 1989, at 77, 81 (noting the rise of self-administered health care plans among employers); Gail A. Jensen & Jon R. Gabel, *The Erosion of Purchased Health Insurance*, 25 INQUIRY 328, 328-30 (1988) (examining reasons for the rapid growth of self-insurance); Dale A. Rublee, *Self-Funded Health Benefit Plans*, 255 JAMA 787 (1986) (providing a history of self-funding); Eric Zicklin, *More Employers Self-Insure Their Medical Plans, Survey Finds*, BUS. & HEALTH, Apr. 1992, at 74-75 (summarizing survey of health care benefits revealing clear trend toward self-funding).

[9] 42 U.S.C. §§ 12101-12213 (Supp. III 1991).

[10] The Equal Employment Opportunity Commission ("EEOC") has issued regulations for the ADA which would appear to make caps on AIDS reimbursement difficult to defend. 29 C.F.R. § 1630 (1993). Several cases involving health insurance plans that have eliminated or limited coverage for AIDS patients have recently been filed with the EEOC. Milt Friedman, *Patients Cite Bias in AIDS Coverage by Health Plans*, N.Y. TIMES, June 1, 1993, at A1, D2. In Donaghey v. Mason Tenders Dist. Council Trust Fund, EEOC Charge No. 160-93-0419 (Jan. 28, 1993), the hearing officer ruled that Mason Tender's exclusion of coverage for HIV and AIDS was discriminatory and therefore in violation of the ADA. Federal courts are now entering this arena. The EEOC filed suit in the United States District Court in the Southern District of New York on June 10, 1993, to enforce the *Donaghey* ruling. Colleen Mulcahy, *ADA Law Could Smash Health Plan Caps on AIDS*, NAT'L UNDERWRITER, Apr. 19, 1993 at 23, 33; Mary E. Pflum, *EEOC Seeks to Compel Plan to Cover AIDS*, BUS. INS., June 14, 1993, at 20. For general overviews of the potential impact of the ADA on employer-sponsored health insurance, see Joseph A. Brislin, *The Effect of the Americans with Disabilities*

Attempts to exclude persons with HIV infection from insurance coverage have thus become common and, to a large degree, successful. Many persons with AIDS are forced to rely upon Medicaid, which has many shortcomings as a catastrophic health coverage program, including low reimbursement levels, inconsistent coverage policies, inconsistent and cumbersome eligibility requirements, and the refusal of many providers to care for those covered by the program.[11] Additionally, many persons with AIDS who lack adequate coverage belong to socially marginal groups (including the poor, intravenous drug users, and gay men) who have traditionally been underserved by the health care system.[12]

With time we have come to realize that reports of the health insurance industry's impending death were greatly exaggerated.[13] However, we are only beginning to appreciate

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Act upon Medical Insurance and Employee Benefits, EMPLOYEE BENEFITS J., Mar. 1992, at 9, 9-13; Paul M. Heylman et al., *Employee Benefits and ADA: Nondiscrimination or Mandated Benefits?*, BENEFITS Q., Fourth Quarter 1992, at 50. In addition to the ADA, various bills have been introduced into Congress that would specifically prohibit the kind of discrimination represented by caps on AIDS reimbursement. *See, e.g.*, S. 765, 103d Cong., 1st Sess. (1993) (California Senator Boxer's Health Insurance Protection Act); H.R. 975, 103d Cong., 1st Sess. (1993) (The Group Health Plan Nondiscrimination Act of 1993).

[11] For problems with Medicaid coverage, reimbursement, and eligibility requirements, see JOHN F. HOLAHAN & JOEL W. COHEN, MEDICAID: THE TRADE-OFF BETWEEN COST CONTAINMENT AND ACCESS TO CARE 99-110 (1986); MICHAEL T. ISBELL, HEALTH CARE REFORM: LESSONS FROM THE HIV EPIDEMIC 103-07, 111-18, 125-29 (1993); *The 'Medicaidization' of AIDS*, *supra* note 3, at 1263-65; *cf.* Henry Grabowski, *Medicaid Patients' Access to New Drugs*, HEALTH AFF., Winter 1988, at 102-114 (discussing the negative impact of state formularies on the availablity of new drugs to Medicaid recipients).

[12] For the effect of exclusion from insurance on particular groups of persons with AIDS, see *supra* note 3. Generally, access to health care is correlated with socioeconomic class and other demographic characteristics. *See, e.g.*, Nancy Adler et al., *Socioeconomic Inequalities in Health: No Easy Solution*, 269 JAMA 3140 (1993); Marcia Angell, *Privilege and Health — What Is the Connection?*, 329 NEW ENG. J. MED. 126 (1993); Paula Braveman et al., *Women Without Health Insurance: Links Between Access, Poverty, Ethnicity, and Health*, 149 W. J. MED. 708 (1988); Karyn Davis, *Inequality and Access to Health Care*, 69 MILBANK Q. 253 (1991); Jonathan S. Feinstein, *The Relationship Between Socioeconomic Status and Health: A Review of the Literature*, 71 MILBANK Q. 279 (1993); Gregory Pappas et. al., *The Increasing Disparity in Mortality Between Socioeconomic Groups in the United States, 1960 and 1986*, 329 NEW ENG. J. MED. 103 (1993).

[13] Although the cost of AIDS remains relatively high, early estimates have proven to be inaccurately high. *See* Fox & Thomas, *supra* note 1, at 198;

that while AIDS represents only a minor threat to insurance, the insurance system represents a mortal threat to persons with AIDS.[14] Without health insurance, persons with AIDS are ill-equipped to fight their long and sometimes expensive battle with the formidable disease. The next part deals specifically with why our present health care financing system has failed.

II. SHATTERING THE MYTH OF THE UNMANAGEABLE COSTS OF AIDS TREATMENT: EMPIRE BLUE CROSS AND BLUE SHIELD

As noted, both the public and insurance professionals have been convinced from the outset of the epidemic that the costs of AIDS treatment are too high to be managed effectively by the insurance industry. Given such a misconception, some have concluded that the system's failure to meet the health insurance needs of persons with AIDS is the result of the nature of the need itself, rather than the result of shortcomings of the insurance system. The experience of at least one community-oriented insurer, Empire Blue Cross and Blue Shield, however, demonstrates that the costs of treating AIDS are not necessarily unmanageable. The true cause of the failure to provide adequate health care insurance to persons with AIDS is, in reality, the structure of our health care financing system.

Empire Blue Cross and Blue Shield ("Empire") is a private, not-for-profit insurance company located in the epicenter of the AIDS epidemic.[15] Empire provides health coverage to almost eight million persons in the eastern portion of New York State. As one might expect, given its size, location, and underwriting policies, Empire has covered a very large number of persons

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The $147,000 Misunderstanding, *supra* note 1; Hellinger, *supra* note 1, at 474-78; *see also* Eisenhandler, *supra* note 1, at 675 (explaining the reasons for the increase in HIV-related medical costs); discussion *infra* part III.

[14] *Cf.* Gerald M. Oppenheimer & Robert A. Padgug, *AIDS and the Crisis of Health Insurance*, *in* AIDS AND ETHICS 105, 106 (Frederic G. Reamer ed., 1991) [hereinafter *AIDS and the Crisis*] (claiming that among the millions being excluded from health care coverage are persons with the greatest needs).

[15] All Empire data cited in the following pages, as well as additional data and analysis, are available in periodically-updated form from Jon Eisenhandler at Empire Blue Cross and Blue Shield, 622 Third Avenue, New York, NY 10017. The entire section on Empire is based on long-standing personal acquaintance with the company on the part of two of the authors, Eisenhandler and Padgug, who are employed there.

with AIDS and other HIV-related conditions (Table 1). The company has identified almost 19,000 cases of full-blown AIDS among its subscribers through the end of 1992.

TABLE 1
Empire Blue Cross and Blue Shield
AIDS Cases

Cohort	Cases
1982	96
1983	309
1984	577
1985	943
1986	1,357
1987	1,838
1988	2,923
1989	2,848
1990	2,918
1991	2,963
1992*	2,041
Total	18,814

* Incomplete data

For research purposes, persons with AIDS covered by Empire have been divided into cohorts; they have been grouped by the year in which they were identified in the company's claims system as having been diagnosed with AIDS. By grouping cases into cohorts, Empire can monitor trends in cost and utilization associated with AIDS. Based on these trends, Empire can then make projections of the lifetime treatment costs of different cohorts.

All services incurred beginning three years prior to diagnosis or identification and all services incurred after diagnosis or identification until death (or the cessation of coverage) are considered to be HIV-related. Data beginning three years prior to an AIDS diagnosis or identification are included in order to incorporate the medical care and costs of treating the early HIV-symptomatic stage, in which substantial increases in hospital utilization and other services tend to begin.

The average payments per person with AIDS for Empire customers with both hospital and major medical coverage are substantial, and are projected to reach about $190,000 for the cohort of 1993 (Table 2). The projections include estimates for future health care inflation, increasing life expectancies for persons with AIDS, and new and more costly treatment

modalities. The total cost of treatment is, of course, higher than the payments made by Empire, since the data in Table 2 does not include costs of treatment borne by the patient for uncovered services, deductibles and coinsurance, or provider balance billing beyond plan payment allowances.

TABLE 2
Empire Blue Cross and Blue Shield
Projected Lifetime Insurance Payments by Cohort*

Cohort	Cases
1986	$52,000
1987	$65,000
1988	$82,000
1989	$100,000
1990	$115,000
1991	$140,000
1992	$175,000
1993	$190,000

* Paid data, net of patient cost-sharing for patients with both hospital and major medical coverage; includes hospital, physician, home care, and pharmaceutical costs.

While the data clearly demonstrates that lifetime treatment costs of persons with AIDS are substantial, they are not unlike treatment costs incurred by persons with other serious diseases typically covered by health insurance policies. For example, lifetime treatment costs for a person diagnosed with AIDS in 1991 are about the same as the costs associated with an episode of care for a bone marrow transplant in the same year — about $150,000. The average lifetime costs of a person with AIDS somewhat less than those for a person receiving a kidney transplant ($90,000 per transplant in 1991, with total lifetime costs two to three times higher).

It is important to note, however, that individual cases of AIDS diverge considerably from the mean. Some are relatively inexpensive and others cost from two to three times as much as the average. In addition, the actual incidence of AIDS in particular populations varies widely and is essentially unpredictable for all but the very largest employer groups, whose risk is spread among a large population.

Finally, costs associated with AIDS treatment during the first twelve years of the epidemic have reached almost $900 million dollars (Table 3). Yet AIDS accounts for little more than *2 percent* of Empire's total expenditure for all illnesses during

that same period. In the most recent years, that figure has not exceeded 3 to 3½ percent and is not expected to increase.

TABLE 3
Empire Blue Cross and Blue Shield
Total AIDS Payments by Year ($ thousands)

Cohort	Cases	Medical**	Total
1982	$3.1	n/a	n/a
1983	9.7	n/a	n/a
1984	17.9	$1.3	$19.2
1985	31.3	2.3	33.6
1986	47.6	3.5	51.1
1987	61.7	6.3	68.0
1988	92.0	10.5	102.5
1989	118.1	15.3	133.4
1990	134.3	20.2	154.5
1991*	151.2	25.6	176.8
1992*	104.8	23.1	127.9
Total	$771.5	$108.1	$879.6

* Incomplete data. Each year is projected to reach about $185 million.

** A majority of customers with AIDS only have hospital coverage through Empire, which accounts for the great discrepancy between the total corporate expenditures for hospital and for medical care.

This brief analysis suggests not only that the costs of AIDS are relatively manageable in absolute terms, but also that for various reasons, a third-party payer can, given appropriate underwriting policies, successfully deal with the costs of treating the disease. The problems commercial insurers and some self-insured employers are having with managing AIDS treatment costs are products of their own underwriting policies.

III. THE FRAGMENTATION OF RISK POOLS IN THE UNITED STATES

Clearly, the problem is not that AIDS treatment costs are too high, but that the majority of the insurance industry and large self-insuring employers are unable to manage the costs of AIDS through their risk-spreading mechanisms. The insurance industry has weakened its own ability to share risk broadly. In order to see how this has occurred, it is helpful to understand the historical development of the mechanism that is at the heart of health insurance: risk pooling. Health insurers attempt to

spread the losses of the few who use significant amounts of health care among a larger pool of persons, most of whom require relatively little or no care in any given year.[16]

The actual methods of spreading risk and the specific makeup of the pools within which risk is spread have varied considerably over the decades. There is, and always has been, much controversy over the policy choices made in determining just how risk will be spread, notwithstanding the insistence of actuaries and underwriters in the employ of insurance companies that their current methods are firmly anchored in science and reason. A bit of history at this point will be instructive.[17]

In the 1930s, when the Blue Cross companies created the policies which served as the prototypes for our current health insurance system, insurance premiums were based on what is known as community rating. In this community rating system, the costs of health care were spread among the entire population covered by a particular type of policy, and premiums were set at the same level for everyone in the community.[18] This system represented a broad spreading of the risks, and thus of the costs, of health care utilization over a relatively large population.

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[16] On the general nature of health insurance as protection against, and the sharing of, risk, see STAFF OF SENATE COMM. ON AGING, HOUSE COMM. ON EDUCATION AND LABOR, AND HOUSE COMM. ON ENERGY AND COMMERCE, 100TH CONG., 2ND SESS., INSURING THE UNINSURED: OPTIONS AND ANALYSIS 12-26 (Comm. Print 1988) [hereinafter INSURING THE UNINSURED].

[17] For general histories of health insurance and underwriting methodologies in the United States, see INSURING THE UNINSURED, *supra* note 16, at 29; INSTITUTE OF MEDICINE, EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK 49-86 (Marilyn J. Field & Harold J. Shapiro eds., 1993) [hereinafter CONNECTION AT RISK]; Ronald L. Numbers, *The Third Party: Health Insurance in America*, *in* SICKNESS AND HEALTH IN AMERICA: READINGS IN THE HISTORY OF MEDICINE AND PUBLIC HEALTH 233, 233 (Judith W. Leavitt & Ronald L. Numbers eds., 1985).

[18] For more on community rating and the early underwriting and rating principles utilized by Blue Cross, see Robert A. Padgug, *Looking Backward: Empire Blue Cross and Blue Shield as an Object of Historical Analysis*, 16 J. HEALTH POL., POL'Y & L. 793, 798 (1991) [hereinafter *Looking Backward*]; J.T. RICHARDSON, THE ORIGIN AND DEVELOPMENT OF GROUP HOSPITALIZATION IN THE UNITED STATES, 1890-1940, at 14 (1945); Thomas A. Fitzpatrick, *Types of Health Risk Bearers: Blue Cross and Blue Shield Plans*, *in* GROUP INS. HANDBOOK 244, 254 (Robert D. Eilers & Robert M. Crowe eds., 1965).

As a result of the shift to an employment-centered health insurance system,[19] experience rating substantially replaced community rating.[20] Employers began to provide their employees with health insurance during the 1940s and 1950s, and insisted, in the interest of minimizing costs, that their premiums be based only on the actual health care utilization of their individual employee groups. These employee groups were normally comprised of younger and healthier persons than the population in general. Commercial insurers, anxious to be more competitive, complied willingly; eventually most Blue Cross and Blue Shield plans were forced to follow suit in order to survive. Insurance risks were thus spread among a relatively small base, with the elderly, the unemployed, the chronically ill, and the poor largely excluded from the system. Even small groups and individual purchasers of insurance, who continued to be lumped together in somewhat larger pools, felt the effects of this development, as adjustments were made to their premiums based on factors closely correlated with health care utilization, such as age, sex, industry, and geographical location.

By the 1970s, in order to reduce costs further and to escape from state legislation and regulation, large employers instituted what is called self-funding or self-insurance, paying the health care costs of their employees directly from their own funds and relegating the insurance companies to the limited task of performing certain administrative functions.[21] The effect of this trend is that the risks of health care, which even in the days of

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[19] On the centrality of employers to our system of health insurance financing and provision and how their role evolved, see CONNECTION AT RISK, *supra* note 17, at 27; PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 294 (1982).

[20] *See* DUNCAN R. MACINTYRE, VOLUNTARY HEALTH INSURANCE AND RATE MAKING 219-47 (1962); ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH 260-62 (1989); RAY E. TRUSSELL, PREPAYMENT FOR HOSPITAL CARE IN NEW YORK STATE: A REPORT ON THE EIGHT BLUE CROSS PLANS SERVING NEW YORK RESIDENTS 92-107 (1960).

[21] A current and rapid trend has been for smaller sized companies to "self-fund" as well. *See generally* DiCarlo & Gabel, *supra* note 8, at 81-88 (discussing the incentives to self-fund and comparing health plan characteristics by size of employer); Jensen & Gabel, *supra* note 8, at 328-43 (tracing the decline of purchased health insurance and examining the reasons for the rapid growth of self-insurance); Rublee, *supra* note 8 (providing the history of self-funding and the percentage and numbers of groups that self-fund); Zicklin, *supra* note 8, at 74-75 (summarizing survey of health care benefits revealing clear trend toward self-funding).

experience rating were at least shared between employer and insurer, are now spread even more narrowly. Today, a self-insured employer with any significant number of sick persons will be in danger of undesirable cost increases at best and fiscal insolvency at worst. An employer may, of course, deal with some of the risk by "reinsuring" itself with a reinsurance company, which will reimburse the company for health care costs above specified amounts. The efficacy of reinsurance is, however, reduced by its additional cost and by limits on its availability.[22]

The system thus constructed entered a period of serious crisis in the late 1970s and early 1980s. Since that time, it has been confronted with substantial and continuing increases in the costs of health care.[23] These increases have threatened the system's stability, built as it is on the narrowest of risk-sharing bases. The crisis of escalating costs has led insurers to tighten their underwriting rules even further in an effort to exclude those persons who pose the greatest risk of using health services. Among the hardest hit have been small groups and individuals, for whom obtaining health insurance has become extremely difficult and expensive.[24]

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[22] *See* sources cited *supra* note 19 (illustrating the use of reinsurance by self-insured employer-sponsored plans).

[23] *See also* Daniel R. Waldo et al., *Health Spending Through 2030: Three Scenarios*, HEALTH AFF., Winter 1991, at 231 (projecting health cost trends into the near and distant future). *See generally* CONGRESS OF THE U.S., CONG. BUDGET OFF., ECONOMIC IMPLICATIONS OF RISING HEALTH CARE COSTS: CAUSES, IMPLICATIONS, AND STRATEGIES (Apr. 1991); U.S. GEN. ACCT. OFF., U.S. HEALTH CARE SPENDING: TRENDS, CONTRIBUTING FACTORS, AND PROPOSALS FOR REFORM (1991) (Report to the Chairman, House Comm. on Ways and Means).

[24] On the increasing exclusion from health insurance of certain individuals and occupational groups and the resulting difficulties to small business, see U.S. GEN. ACCT. OFF., PRIVATE HEALTH INSURANCE: PROBLEMS CAUSED BY A SEGMENTED MARKET 10-11 (1991); U.S. GEN. ACCT. OFF., WORKERS AT RISK: INCREASED NUMBERS OF WORKERS IN CONTINGENT EMPLOYMENT LACK INSURANCE, OTHER BENEFITS (1991); Roger A. Formisano et al., *Barriers to Group Health Insurance Faced by Small Employers: A Case Study*, BENEFITS Q., First Quarter, 1991, at 6, 11-13; Milt Freudenheim, *Health Insurers to Reduce Losses, Blacklist Dozens of Occupations*, N.Y. TIMES, Feb. 5, 1990, at A1, D5; Julie Kosterlitz, *Sick About Health*, 5 NAT'L J. 270, 272 (1990). *See generally* Richard Kronick, *Health Insurance 1979-1989: The Frayed Connection Between Employment and Insurance*, 28 INQUIRY 318, 323 (1991) (asserting stricter underwriting standards as one of several possible explanations for decreased insurance coverage of low-income employees).

Thus the private employment-based insurance system had by the 1980s, reached a serious impasse which left a significant proportion of the population uninsured or underinsured.[25] Unfortunately, this problem developed at a time when government, both at the state and federal levels, was also retrenching, and the entitlement programs implemented during the 1960s to cover those left out of the employment-centered system were ill-prepared to extend their protection to those who were forced out of the private insurance system.[26]

Today there is little doubt that both commercial insurers and self-insured employers are structurally incapable of spreading the costs of AIDS treatment widely enough to render them more manageable — the risk pools they have established are simply too narrow and fragile. It would be foolish, however, to assume that these serious problems can be overcome by a mere change of heart on the part of either insurers or employers, because the problems that must be overcome are not the result of simple ill will, but are, rather, built into the very nature of the American health care financing system.

IV. PRINCIPLES AND VALUES UNDERLYING AMERICA'S HEALTH CARE FINANCE SYSTEM

The health care insurance system did not develop its present structure by chance. Instead, the structure of the system is a direct result of the way Americans view the very nature of health care itself.

Most modern industrialized societies view health care as a social need, a basic right, and a byproduct of citizenship. Their

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[25] On trends in the numbers of the uninsured, see Employee Benefit Research Inst., *Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1992 Current Population Survey*, 1993 EBRI SPECIAL REPORT AND ISSUE BRIEF NO. 123; OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, DOES HEALTH INSURANCE MAKE A DIFFERENCE — BACKGROUND PAPER (1992); U.S. GEN. ACCT. OFF., HEALTH INSURANCE COVERAGE: A PROFILE OF THE UNINSURED IN SELECTED STATES (1991); Thomas Bodenheimer, *Underinsurance in America*, 327 NEW ENG. J. MED. 274, 274-78 (1992); Howard E. Freeman et al., *Uninsured Working-Age Adults: Characteristics and Consequences*, 24 HEALTH SERVICES RES. 811, 813 (1990); Peter Ries, *Characteristics of Persons With and Without Health Care Coverage: United States, 1989*, ADVANCE DATA FROM VITAL AND HEALTH STAT. OF THE NAT'L CENTER FOR HEALTH STAT., June 19, 1991, at 1, 1-6.

[26] *See* Fox & Thomas, *supra* note 1, at 199; HOLAHAN & COHEN, *supra* note 11, at 9-13.

health care systems are founded on the principle of "social solidarity."[27] Their governments accept the idea that government ought to provide health care to their citizens and believe that all citizens ought to share the costs of providing it, just as they would with any other general social need, such as education. Health care is treated as one of those welfare goods which the government must guarantee to all, and which all must bear an equitable share in financing.[28]

In the United States health care is a commodity distributed in the private market. This view of health care makes the American system distinct from health care systems abroad in a number of ways. First, providing health insurance is left up to the private market. In such a system, only those who have the ability to pay for it will be able to enjoy its benefits.[29] Second, the American health care financing system is not universal; it excludes millions of persons from coverage, many of those with the greatest health needs among them.[30] Third, access to health coverage depends mainly on one's employment relationship; in 1990, 64 percent of all Americans under age sixty-five held employer-purchased health insurance.[31] Finally, the U.S. health

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[27] On the concept of social solidarity, see generally WILLIAM A. GLASER, HEALTH INSURANCE IN PRACTICE: INTERNATIONAL VARIATIONS IN FINANCING, BENEFITS, AND PROBLEMS (1991) (describing the health care financing systems of key European nations with largely private insurance systems as well as the lessons those systems bear for the reform of the American health care financing system).

[28] On the concept of health care as a right in most industrialized nations, see generally ODIN W. ANDERSON, THE HEALTH SERVICES CONTINUUM IN DEMOCRATIC STATES: AN INQUIRY INTO SOLVABLE PROBLEMS (1989) (on the relationship between a nation's medical delivery system and its cultural values); WILLIAM A. GLASER, HEALTH INSURANCE IN PRACTICE: INTERNATIONAL VARIATIONS IN FINANCING, BENEFITS, AND PROBLEMS (1991) (describing how other industrialized nations have transformed voluntary and private health insurance systems into publicly-funded programs that protect their entire populations); MILTON ROEMER, NATIONAL HEALTH SYSTEMS OF THE WORLD (1991) (for a survey and analysis of health care systems in industrialized and developing nations); VICTOR W. SIDEL & RUTH SIDEL, A HEALTHY STATE (2d ed. 1983) (describing universal, publicly-funded health care systems abroad); Bradford L. Kirkman-Liff, *Health Insurance Values and Implementation in the Netherlands and the Federal Republic of Germany: An Alternative Path to Universal Coverage*, 265 JAMA 2496, 2496-2502 (1991).

[29] Marcia Angell, *How Much Will Health Care Reform Cost?*, 328 NEW ENG. J. MED. 1778, 1778 (1993).

[30] *AIDS and the Crisis*, *supra* note 14, at 108.

[31] CONNECTION AT RISK, *supra* note 17, at 28.

care system is not in any real sense democratic: decisions are not made by the population as a whole either directly or through elected representatives, but by employers, insurers, and bureaucrats — groups whose interests do not necessarily coincide with those of society as a whole.

The present health care financing system possesses features which virtually force participants to act in particular ways. Rather than operating according to socially-determined rules to which all must conform for the common good, each party within the system acts to avoid costs that can be passed to others.

Avoiding treatment costs involves not only avoiding risk-taking, but shunning wide risk-sharing as well. Insurers are pressured to divide risk pools as finely as possible, distributing risk among pools with similar members rather than sharing risk among pools with a more diverse membership. Insurers claim that risk groups with unacceptably high patterns of utilization, such as those comprised of persons infected with the HIV virus, must be identified and eliminated from coverage pursuant to sound underwriting policies.[32] Otherwise, they argue, insurance would become financially unsound, and persons with average patterns of utilization would unfairly be subsidizing those with higher ones. Thus, the system virtually forces those who provide financing for health care to take measures to ensure that their own pools do not attract undue numbers of those at high risk for incurring large health care expenses.

Insurers, driven to maximize profits by market forces, sometimes make decisions that are in their own best interests, but not in society's best interests. These insurers have never admitted that the present financial instability of their groups is in large measure their own fault due to the narrow manner in which they have constructed their risk pools, but it is increasingly clear that the effects of the narrowing of risk pools must be overcome.

A reformation of the present system may be accomplished directly through the reestablishment of very large pools, open to all who apply, and capable of spreading the risk of the higher utilizers of health care among a much greater population of lower utilizers. This reform may also be accomplished indirectly

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[32] *See generally* Benjamin Schatz, *The AIDS Insurance Crisis: Underwriting or Overreaching?*, AIDS: ONE: LEGAL, SOCIAL AND ETHICAL ISSUES FACING THE INSURANCE INDUSTRY 1 (James Vculek ed., 1988) (analyzing the legal and public policy implications of underwriting on the basis of sexual orientation).

through the creation of "interplan transfers" that require payers with lower-risk populations to contribute to the financial stability of those with higher-risk populations. Either way, such reform must create conditions under which risk pools no longer include only the individuals covered by a single employer or insurer. Of course, such change cannot occur as long as the system is based on the same set of principles that guided its development. Instead, we must adopt a new set of principles which will provide the basis for a system capable of meeting the health care needs of all members of society.

V. EXTRAPOLATING A NEW SET OF PRINCIPLES FROM THE EXPERIENCE OF EMPIRE BLUE CROSS AND BLUE SHIELD

As discussed, Empire Blue Cross and Blue Shield's practices differ significantly from those of most private insurers in America; in fact, Empire's practices are inconsistent with the values and assumptions that underlie the present, ailing health insurance system. Instead, these practices suggest a new set of principles upon which a restructured system should be based. While these principles remain somewhat untested, their alternatives have been tested and found wanting, as we are reminded by the very existence of the health insurance crisis.

Empire Blue Cross and Blue Shield offers coverage to all who are able to pay the premiums for it, regardless of health status, and spreads risk by placing small employer groups and individuals who purchase their own coverage in large community pools. Medium and large employer groups are either fully experience-rated or are what Empire terms "incentive-rated" — their premiums are based on a combination of an individual group's experience and that of the entire pool of incentive-rated groups. Both incentive-rated and experience-rated groups are assessed an additional premium charge, which is used to subsidize the premiums of the community pools. Through this and other policies of cross-subsidization, Empire, although forced to compete with numerous commercial insurers, is, in effect, able to create a kind of single large risk pool made up of all of its customers.

Empire's policies and experience in providing health insurance for persons with AIDS are important as illustrations of a system of wide risk-sharing. To suggest that they offer a model of an ideal health financing system would over-simplify both the problems of the current system and the means at our

disposal to solve them. The creation, for example, of a new group of not-for-profit insurers like Empire is not a viable answer to our health insurance problems because such insurers would be unable to compete with private insurers. Because the current system requires those who provide financing for health care to ensure that their own pools do not attract undue numbers of those at high risk for large health care expenditures, any third-party payer that acts according to different principles will find itself covering a far larger proportion of the high-risk population than would otherwise be the case.

In order to survive, such an insurer must have sources of revenue that allow it to offset the higher-than-average costs its particular customers will naturally incur.[33] In Empire's case, the offsetting conditions include tax-free status and a state-imposed inpatient reimbursement system that includes a "payment differential" for socially-useful insurers. The latter provides Empire with a competitive advantage, since its competitors pay higher rates for hospital care than it does. This advantage allows Empire to retain much of the business of larger groups and the lower-risk groups and individuals in its community pools. Without this advantage, Empire's policy of cross-subsidizing small groups and individuals would long ago have withered away, no matter how much social goodwill existed at Empire itself. The time when individual not-for-profit, socially-oriented insurers could play a unique role as "insurers of last resort" is almost certainly at an end.[34]

The preceding analysis gives rise to several principles that must be embodied in any health care reform plan. This section presents those elements that deal with issues of risk sharing

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[33] For a fuller account of Empire's offsetting financial advantages and its recent vicissitudes, see generally *Looking Backward*, *supra* note 18.

[34] There are a few regions, however, in which such insurance providers continue to demonstrate considerable vitality. In Rochester, New York, for example, the local Blue Cross and Blue Shield Plan dominates the market and continues to offer community rating and open enrollment to all applicants; the major local employers have remained community rated and there is considerable cooperation among insurers, employers, and providers. U.S. GEN. ACCT. OFF., ROCHESTER'S COMMUNITY APPROACH YIELDS BETTER ACCESS, LOWER COSTS (1993) (applauding Rochester's unique approach to health care); *see also* Robert Leitman et al., *Rochester, New York: A Model for Health Reform*, 2 J. AM. HEALTH POL'Y 49; Theresa Defino, *Rochester Health System: A National Model*, MANAGED HEALTHCARE NEWS, Jan. 1993, at 13-15.

and equity in financing and without which any reform effort is doomed to failure.

A. UNIVERSALITY

Any system of health financing must be universal if the costs and benefits of the system are to be spread as widely as possible and if proper control of the system is to be possible. Omitting large numbers of people from the system will undermine both equity in the distribution of medical services and the ability to control costs.

B. BROAD RISK SHARING

The system must be based on the broadest possible risk sharing arrangements. This does not necessarily require that all residents of the United States be in a single pool, or even that the residents of every state form their own pools, as long as the pools are broad enough to ensure that the costs of medical care are spread widely and equitably. Only in this way can care be provided in a manner fair to both those with the greatest needs — including the chronically ill and those with "catastrophic" medical costs in any given year — and those who are at substantially lower risk.

Many foreign countries finance health care using private insurance that treats all insurers as if they were part of a single risk pool.[35] Great Britain, for example, created a system in which the entire population forms a single risk pool and the government plays a substantial role in the actual delivery of care.[36] Canada has created single risk pools for each of its provinces, but retains private delivery of care.[37] And many of

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[35] *See generally* Glaser, *supra* note 27. One important example of a nation that has used interplan transfers is the Netherlands. *See* Joyce Frieden, *Is Dutch Health Care a Model for the U.S. Health Care System?*, 10 BUS. & HEALTH 34 (1992); Bradford L. Kirkman-Liff, *Health Insurance Values and Implementation in the Netherlands and the Federal Republic of Germany: An Alternative Path to Universal Coverage*, 265 JAMA 2496 (1991). In Germany, a new risk adjustment system is being implemented during 1993. *See* Jeremy W. Hurst, *Reform of Health Care in Germany*, HEALTH CARE FINANCING REV., Spring 1991, at 73.

[36] *See* J. ROGERS HOLLINGSWORTH, A POLITICAL ECONOMY OF MEDICINE: GREAT BRITAIN AND THE UNITED STATES 52-64 (1986).

[37] *See* MALCOLM G. TAYLOR, INSURING NATIONAL HEALTH CARE: THE

the nations of continental Europe (including France, Germany, and the Netherlands) have implemented systems that achieve universal coverage with largely private delivery of care through the use of wide networks of mutual (not-for-profit) health care funds.[38]

All of these systems have made important achievements and are basically popular with the populations they cover.[39] Although all of them have cost containment, service delivery, and quality problems that their sponsors are attempting to remedy,[40] they offer valuable lessons for American reformers.

CANADIAN EXPERIENCE 169 (1990); *see also* JANE FULTON, CANADA'S HEALTH CARE SYSTEM: BORDERING ON THE POSSIBLE 35 (1993); LOOKING NORTH FOR HEALTH: WHAT WE CAN LEARN FROM CANADA'S HEALTH CARE SYSTEM (Arnold Bennett & Orvill Adams eds., 1993); MEDICARE AT MATURITY: ACHIEVEMENTS, LESSONS & CHALLENGES 32 (Robert G. Evans & Greg L. Stoddart eds., 1986).

[38] *See* ROBERT G. EVANS, WHAT SEEMS TO BE THE PROBLEM? THE INTERNATIONAL MOVEMENT TO RESTRUCTURE HEALTH CARE SYSTEMS (1992) (summarizing problems within and efforts to reform health financing systems in other nations). On specific reform efforts, see BRIAN ABEL-SMITH, COST CONTAINMENT AND NEW PRIORITIES IN HEALTH CARE: A STUDY OF THE EUROPEAN COMMUNITY (1992); ORGANIZATION FOR ECON. COOPERATION AND DEV., THE REFORM OF HEALTH CARE: A COMPARATIVE ANALYSIS OF SEVEN OECD COUNTRIES (1992); Patricia Day & Rudolph Klein, *Britain's Health Care Experiment*, HEALTH AFF., Fall 1991, at 39-59; Jeremy W. Hurst, *Reforming Health Care in Seven European Nations*, HEALTH AFF., Fall 1991, at 7-21; Thomas A. Madden, *The Reform of the British National Health Service*, J. PUB. HEALTH POL'Y Autumn 1991, at 378-96; Richard B. Saltman, *Competition and Reform in the Swedish Health System*, 68 MILBANK Q. 597 (1990); W. Van de Van, *Peristroijka in the Dutch Health Care System: a Demonstration Project for Other Countries*, 35 EUROPEAN ECON. REV. 430 (1991); sources cited *supra* note 35 regarding the Netherlands and Germany.

[39] With respect to popular satisfaction with national health financing and provision systems, see Robert J. Blendon et al., *Satisfaction with Health Systems in Ten Nations*, HEALTH AFF., Summer 1990, at 185; Robert J. Blendon & Humphrey Taylor, *Views on Health Care: Public Opinion in Three Nations*, HEALTH AFF., Spring 1989, at 149.

[40] *See* Jonathan E. Fielding & Pierre-Jean Lancry, *Lessons from France — 'Vive la Difference': The French Health Care System and U.S. Health Care System Reform*, 270 JAMA 748, 749-51 (1993); Frieden, *supra* note 35 (describing the health care system of the Netherlands); Kirkman-Liff, *supra* note 35 (same); John K. Iglehart, *Health Policy Report: Germany's Health Care System* (pts. 1 & 2), 324 NEW ENG. J. MED. 503, 1750 (1991).

C. RISK ADJUSTMENT

If there are multiple pools (as there inevitably will be in any system — public, private, or a mixture of the two — that spreads risk on a basis less broad than the entire American population), then there must be some method of "risk adjustment" to ensure that the pools are relatively equal in risk status and fiscal soundness.

Due to differences in the risk status of populations by geographical area, social class, gender, race and ethnicity, employment status, and other demographic characteristics, multiple pools will tend to attract a different mix of high- and low-risk persons. Risk adjustment systems (either "front-end" systems that provide revenues to pools adjusted for the risk status of their members or "back-end" systems that shift funds from one pool to another at the end of a benefit period when actual medical utilization is known and can be evaluated) prevent pools from growing apart in ways that allow premiums charged or benefits given to vary excessively among pools. This consistency is especially necessary for any type of systemic reform based on competition among health plans, under which plans will certainly be tempted to reduce costs (and thereby lower prices) by avoiding enrollment of high-risk persons.

D. OPEN ENROLLMENT

All pools must be open to enrollment by all persons in the geographical areas covered by them without medical underwriting or other attempts to discriminate among risk groups; only in this manner can we even begin to ensure that pools attract a more or less random selection of health risks.

E. EQUITABLE FINANCING

Any reformed system must be financed in a fair and equitable manner that puts no undue burdens on those with greater need for medical services. Ideally, an equitable financing system would be based on the principle of community rating (equal premiums or other types of payments for equivalent or substantially similar benefit packages), adjusted by income to ensure that the wealthy pay more than the less affluent. People with less than a defined income level should either (1) not have to contribute at all (in a tax-based system), or (2) should have their coverage subsidized by public funds (in

a premium-based system). This approach to cost spreading is simply a version of the general principle upon which progressive tax systems are based in modern industrialized nations: those who have more should pay more for services that all receive. It also avoids one of the perceived problems of pure community rating: that often in such a system the low-risk but poor will be unfairly subsidizing the high-risk but well-off.[41]

F. UNIFORM BENEFITS

All residents of this country should have access to the same, standard benefit package. Standardized coverage is not only a question of equity in the provision of care, but would prevent health plans in a multi-pool environment from (1) reducing benefits for everyone, (2) reducing benefits for selected populations in order to ensure that they attract only better risks, or (3) reducing their costs directly by reducing utilization. Such a standardized benefit package must include not only the typical acute care coverage that employer-sponsored plans currently include, but also preventive care services and those long-term care services that the chronically ill require.[42]

G. ELIMINATION OF EMPLOYER POWER

The power that employers have to determine whether to provide benefits at all, the nature of the benefits to be provided, the size and type of risk pools, and the financing arrangements underlying those pools must be eliminated. Since it is the unique power of employer-established risk pools in our current financing system that has caused our present predicament in the arena of health care financing, the elimination of employer power is the essential principle around which all of the others must be structured.

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[41] *Cf.* William R. Jones et al., *Pure Community Rating: A Quick Fix to Avoid*, 3 J. AM. HEALTH POL'Y 29, 31 (1993) (arguing that younger, healthier, and less well paid employees would subsidize older, less healthy, better paid employees in a pure community rating system).

[42] *See generally* Judith K. Barr & Robert A. Padgug, *Employers and AIDS: Meeting the Health Benefit Needs of People with HIV/AIDS*, 3 CORNELL J. L. & PUB. POL'Y 83 (discussing employer responses to HIV/AIDS care); Sara D. Watson, *Reality Ignored: Health Reform and People with Disabilities*, 3 J. AM. HEALTH POL'Y 49 (1993) (discussing the needs of the chronically ill and the services required by them).

VI. IMPLEMENTING NEW HEALTH REFORM PRINCIPLES IN AMERICA

It does not follow from our analysis that only one type of health care finance system can embody the principles outlined above. Still, individual employers and insurers in a reformed American system *will* perforce lose much of their direct power over the health care financing system. Above all, employers will lose their centrality to the system — and their continued ability to further narrow risk pools — except to provide necessary sources of funds. They will become, as in the case of Empire's customer base, merely pieces of a more complicated, interconnected set of larger risk pools that should be capable of handling even the most expensive patterns of illness.

There are a number of approaches to health care financing reform which make implementation of these principles possible. Until now, however, no satisfactory health care reform proposal has been proposed. In the United States, reform proposals tend to fall into one of three categories: (1) market-based universal coverage plans; (2) universal, single payer plans; and (3) plans to incrementally reform the present system. Brief analyses of these general approaches will show that while all have progressive elements, each of the current proposals fall short of meeting at least some of the criteria.

A. MANAGED COMPETITION

Currently, there is rapid movement toward using of market reform to solve the current health care finance crisis.[43] These market reform plans are primarily built on the concept of "managed competition," a term coined by Stanford professor Alain Enthoven. The essence (and advantage) of managed competition, according to Enthoven, is that it promotes "cost-conscious consumer choice among health plans in the pursuit of equity and efficiency in health care financing and delivery."[44]

Under Enthoven's proposed system of managed competition, employees would be able to choose among competing health

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[43] Colloquy, *Managed Competition: Health Reform American Style*, HEALTH AFF., Supp. 1993.

[44] ALAIN C. ENTHOVEN, MANAGED COMPETITION OF ALTERNATIVE DELIVERY SYSTEMS, IN COMPETITION IN THE HEALTH CARE CENTER: TEN YEARS LATER 83, 85 (1988).

plans offered by their employer. These health plans would be comprised of provider networks integrating doctors, hospitals, and insurance providers. Proponents of such a managed competition scheme claim that improved quality and reduced costs follow as the necessary by-product of network competition for patient enrollment.

In addition to competing on the basis of quality care and price, such a managed competition scheme attempts to promote cost-consciousness through tax disincentives. Under the plan, the maximum amount of employer-paid premiums that an individual would be allowed to exclude from their taxable income would be equivalent to the price of the lowest-cost plan then available to that individual.[45] Thus, individuals who opted to join more expensive health plans would bear the additional cost.[46]

Under Enthoven's proposal, "the federal government would enact legislation giving each state powerful incentives to create a 'public sponsor' agency to act as a sponsor for people otherwise unsponsored."[47] Thus individuals or families not covered through employment would have the option to register with a public sponsor, provided that they agree to abide by the conditions of participation. Once such groups are formed, the public sponsors aggregate the buying power of those small employers and individuals in order to contract on their behalf for a wide variety of managed care plans.

Unfortunately, the health care reform principles reveal that Enthoven's system of managed competition fails to measure up. While such a plan may satisfy the principles of universality and open enrollment, Enthoven's version of managed competition leaves employers (in particular, large employers) in control of the system.

Like Enthoven's plan, President Clinton's new health care proposal (released in draft form in September, 1993),[48] similarly

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[45] This maximum deduction will not always be equivalent to the cost of the lowest-priced plan; rather, it will vary based upon the framework of the specific managed competition plan. For instance, the maximum deduction might be set at an average cost of all then available plans.

[46] Elaine Lu, *The Potential Effect of Managed Competition in Health Care on Provider Liability and Patient Autonomy*, 30 HARV. J. ON LEGIS. 519 (1993).

[47] Alain C. Enthoven & Richard Kronick, *A Consumer Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy* (pt. 1), 320 NEW ENG. J. MED. 29, 31 (1989).

[48] WHITE HOUSE DOMESTIC POL'Y COUNCIL, THE PRESIDENT'S HEALTH

rests upon managed competition. Unlike Enthoven's plan, the Clinton proposal substantially decreases employer power over benefit structures and financing methodologies. Therefore, at first glance, the proposal seems to take active steps to reduce the risk pooling problems created by the current employer-sponsored system. For instance, the Clinton Proposal would create very large "community" pools that would include all employer groups with fewer than 5,000 members, as well as all individual purchasers, Medicaid recipients, and government employees. Further, the plan creates front-end risk adjustment mechanisms to balance projected utilization experience.

Nevertheless, the Clinton Proposal falls short of satisfying other health reform principles that are an essential part of any truly effective and equitable health reform. The Clinton Proposal allows large employers (those with more than 5,000 employees) to decide whether to enter the risk sharing pools or to remain autonomous. The practical effect of permitting such a choice will be to ensure that employers whose employees have greater-than-average health care needs will join the newly created pools, while employers whose employees pose lower-than-average health risks will not join. Such a system removes large numbers of the "best risks" from the community pools, and therefore clearly violates the principles of broad risk sharing and employer power.

We do not mean to imply that no plan under the rubric of managed competition can measure up to all of the necessary principles for health reform. However, no such plan has yet been proposed, nor does one appear likely to be proposed given the current political environment in the United States.

B. SINGLE PAYER PLANS

Universal, single payer plans make up the second common category of health reform proposals. Best exemplified by the proposed American Health Security Act of 1993,[49] introduced by Senator Paul D. Wellstone (D-Minn.), single payer plans most completely embody the seven reform principles enunciated above.[50] Under the "Wellstone Bill," as it is called, the federal

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SECURITY PLAN: THE CLINTON BLUEPRINT (1993).

[49] S. 491, 103d Cong., 1st Sess. (1993).

[50] For an example of another proposed single payer plan, see David U. Himmelstein et al., *A National Health Program for the United States: A*

government, as the single payer of health insurance benefits, would be responsible for collecting and distributing to the states all funds necessary for the nation's health care coverage.[51] Equitable, progressive financing would be achieved through increases in marginal federal income tax rates, payroll taxes on employers, and the elimination of certain tax loopholes.[52]

The Wellstone bill provides for uniform, comprehensive benefits, while disallowing duplicative coverage outside the system for included benefits.[53] While its main focus would be primary and preventive care, inpatient services and long-term care would also be covered.[54] A national "Quality Council" would assure the quality of these services through a system of guidelines, incentives, and peer reviews.[55]

The proposal's most effective feature is its separation of health care coverage from the employment setting.[56] The removal of employer control furthers the goals of universality and open enrollment. With coverage based on state residency rather than employment status, employers would lose the power to determine their employees' coverage. The unemployed and self-employed would no longer be excluded, and medical underwriting would be eliminated, ensuring that high-risk individuals would not be denied coverage.

Insurance pools based on state population would be larger and more random than employment-based pools in which employers are able to opt out of the system, making broader risk sharing possible.[57] The proposal does not, however, address ways of dealing with the potential differences in risk status by geographical area, although the establishment of such large risk pools might eliminate the need for regional risk adjustment.

Despite its embodiment of our health reform principles, implementation of the Wellington bill or any single payer plan seems unlikely. Fear of tax increases, even if unfounded, may

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Physician's Proposal, 320 NEW ENG. J. MED. 102 (1989) (advocating a single comprehensive insurance program to cover all Americans).

[51] *See* Paul D. Wellstone & Ellen Shaffer, *The American Health Security Act: A Single Payer Proposal*, 328 NEW ENG. J. MED. 1489, 1489 (1993).

[52] *Id.* at 1492.

[53] *Id.* at 1491.

[54] *Id.*

[55] *Id.*

[56] *Id.*

[57] *Id.* at 1492.

hinder public support, and many medical care providers will oppose the plan because it could lower their fees.[58] Private health care insurers will also be strong opponents because, by restricting duplicative outside coverage, the plan limits the private coverage they can offer.[59] Moreover, most recent proposals appear to favor managed competition over single payer plans,[60] despite the fact that managed competition proposals less perfectly embody the reform principles outlined above.

C. INCREMENTAL REFORM PROPOSALS

Finally, a wide variety of health care financing reform proposals can best be described as "incremental" reform proposals.[61] Short of advocating the creation of an entirely new system, these proposals address less drastic changes that can be made to the present system. Examples of incremental reform proposals include the expansion of Medicaid,[62] state mandating of employer-sponsored health insurance,[63] state subsidization of individuals, businesses, or both,[64] and the establishment of risk pools for medically uninsurable persons.[65]

While these proposals aim to improve access to health insurance for individuals and small groups, they ignore the underlying problems of our present system, and address neither the rising costs of insurance nor the importance of broader risk sharing. Finally, many such proposals maintain employer power over access to health care.

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[58] *Id.* at 1490.

[59] *Id.* at 1491.

[60] *Id.* at 1492.

[61] An example of the incremental approach being discussed in Congress is the "Affordable Health Care Now Act of 1993," put forward by a large number of Republicans in the House of Representatives. *See* H.R. 3080, 103d Cong., 1st Sess. (1993).

[62] *See* John F. Holahan & Sheila Zedlewski, *Expanding Medicaid to Cover Uninsured Americans*, HEALTH AFF., Spring 1991, at 45.

[63] *See* Michael S. Dukakis, *The States and Health Care Reform*, 327 NEW ENG. J. MED. 1090, 1090-92 (1992).

[64] *See* Thomas Bodenheimer, *Private Insurance Reform in the 1990s: Can It Solve the Health Care Crisis?*, 22 INT'L J. HEALTH SERVICES 197, 200 (1992).

[65] *See id.* at 200-01.

Despite their shortcomings, however, these incremental reforms may perform an important stopgap function until such time as a reformed health care system embodying all of our reform principles can be adopted.

CONCLUSION

Clearly, we as a nation have much work to do before we can implement an effective and equitable health care financing reform plan. However we finally accomplish this, it remains clear that any reformed system must seriously confront and reverse the deleterious effects of the narrowing of insurance risk pools. None of the various approaches to health reform will succeed unless the costs of health care can be spread equitably among all Americans. Persons with AIDS and others with chronic illnesses must be relieved of the disproportionate burdens of higher costs and reduced access to health insurance and care they are now forced to bear. Successfully reforming our health care finance system will first require us to discover for ourselves what has long been made a matter of policy elsewhere in the world: in the sphere of health care, the only principle upon which a workable and fair system of health care financing can be constructed is that of "social solidarity," whereby we all help each other (and ourselves) by sharing equitably in the risks of incurring health care expenses.