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Keynote Address: Helping the Uninsured: Health Insurance in Ohio and in the Nation

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III. KEYNOTE ADDRESS: HELPING THE UNINSURED: HEALTH INSURANCE IN OHIO AND IN THE NATION

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I. INTRODUCTION: THE EIGHTIES AND THE UNINSURED

Americans who lack private or public health insurance receive less medical care than the insured. During the last decade, the ranks of the uninsured swelled to over 30 million Americans,[1] with over twice that number uninsured at some point during a three-year period,[2] fortunately most for short-term periods.[3] There is some disagreement about the pre-

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[1] The numbers of uninsured have repeatedly been documented, although different methods of estimation yield different estimates, as do different survey data bases. *Compare, e.g.*, K. SWARTZ, THE MEDICALLY UNINSURED: SPECIAL FOCUS ON WORKERS (1989) (The Urban Institute) (37 million non-elderly uninsured for all or part of 1987) with Moyer, *A Revised Look at the Number of Uninsured Americans*, 8 HEALTH AFFAIRS 102, no. 2 (Summer 1989) (31 million in 1987); *see also*, U.S. GENERAL ACCOUNTING OFFICE, A PROFILE OF THE UNINSURED IN MICHIGAN AND THE UNITED STATES (1990) (over 35 million in 1987, commenting on different estimates).

[2] Nelson & Short, *Health Insurance Coverage 1986-88*, BUREAU OF THE CENSUS, CURRENT POPULATION REPORTS, HOUSEHOLD ECONOMIC STUDIES, Series P-70, No. 17 (March 1990) (63 million Americans lacking coverage for at least one month during 1985-87).

[3] Swartz & McBride, *Spells Without Health Insurance: Distributions of Durations and Their Link to Point-in-Time Estimates of the Uninsured*, 27 INQUIRY 281, no. 3 (Fall 1990) (half of all spells without insurance end within 4 months, only 15% last over 24 months).

cise extent of the uninsured, but there is general agreement about the upward trend.[4] Rises occurred at first during the recession of the early 1980s, then Medicaid cutbacks, and then, restructuring in labor and insurance markets reduced the extent of insurance coverage.

At the same time, the uninsureds' health care problems, difficulties in obtaining access to medical services, and the fiscal problems of hospitals that did serve them became ever more prominent.[5] The dimensions of these problems have been discussed in numerous scholarly publications, such as medical journals,[6] law reviews[7] and policy journals,[8] as well as in the popular press.[9] Many approaches to solutions have been put forth. Governments have also taken note. Legislative hearings and commissions' reports have commonly set out the extent of problems and possible solutions.[10] Most remedial legislation has occurred at the state level,[11] but there have been some federal initiatives as well.[12]

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[4] The exact composition of the uninsured is less well understood as are the dynamics of the reasons that they lack coverage at the times they do. *See generally* Swartz & McBride, *supra* note 3.

[5] On the average, the uninsured seems to get about one third as much hospital care and see doctors about two thirds as often as the majority insured population. *See* Long & Rodgers, *Federal Options for Helping the Uninsured* (unpublished conference presentation A. Pub. Analysis and Mgmt., 1990). Given that most of the uninsured are probably healthier than average, this "access gap" is probably less significant when adjusted for health status or "need." Presumably in part because of the gap, hospitals were the early 1980s vocal advocates for the uninsured. On the problems of hospital "uncompensated care," *see generally* F. SLOAN, J. BLUMSTEIN & J. PERRIN, eds., UNCOMPENSATED HOSPITAL CARE (1986).

[6] *E.g.*, Ginzberg, *Health Care Reform – Why So Slow?*, 322 N. ENGL. J. MED. 1464 (1990).

[7] *E.g.*, Bovbjerg & Kopit, *Coverage and Care for the Indigent: Public and Private Options*, 19 IND. L. REV. 857 (1986).

[8] *E.g.*, Johnston & Reinhardt, *Addressing the Health of a Nation: Two Views*, 8 HEALTH AFF. 5, no. 2 (Summer 1989).

[9] *E.g.*, *When Illness Strikes and Health Insurance Won't Pay*, Wash. Post/ Health, June 26, 1990, at 12, col. 1 [hereinafter *Illness*].

[10] At the state level, *see, e.g.*, GOVERNOR'S COMMISSION ON OHIO HEALTH CARE COSTS: FINAL REPORT (July 1984) (suggesting "care or share" program under which licensed hospitals would have to provide 5% of the budget as charity care or contribute the difference to a state fund that would subsidize other institutions providing more than their share which was never enacted); J. LUEHRS & R. DESONIA, A REVIEW OF STATE TASK FORCE AND SPECIAL STUDY RECOMMENDATIONS TO ADDRESS HEALTH CARE FOR THE INDIGENT 37-8 (Nov. 1984) (Intergov'tal Health Pol'y Project). At the federal level, the Pepper Commission has most recently drawn attention to the uninsured. U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE A CALL FOR ACTION, (Sept. 1990) [hereinafter cited as PEPPER REPORT].

[11] *See, e.g.*, R. CURTIS & S. WHITE, eds., ACCESS TO CARE FOR THE MEDICALLY INDIGENT: A RESOURCE DOCUMENT FOR STATE AND LOCAL OFFICIALS (March 1985) (Nat'l Governors Ass'n.).

[12] Congress has addressed Medicaid coverage, the right of employees leaving work to continue group health coverage, and the obligation of hospitals not to "dump" patients seeking emergency services. *See infra* notes 33-36. Congress has also generated information. *E.g.*, CONGRESSIONAL RESEARCH SERVICE, HEALTH INSURANCE AND THE UNINSURED: BACKGROUND DATA AND ANALYSIS, Committee Print (1988). Many state and private analyses rely on government-supplied data from national surveys.

This article briefly discusses five salient issues for decision makers to ponder, in Ohio and in the nation: (1) What, exactly, is the problem? (2) What about National Health Insurance (NHI)? (3) What roles are likely for national, state, and local governments? (4) How can one design solutions and evaluate the trade-offs they pose? (5) What are we willing to pay? A major conclusion is that many ways exist to provide subsidized coverage or other access to care. In other words, many possible solutions exist. They have different emphases, different structural characteristics, different benefits, and different price tags. What does not exist is consensus on the nature of the personal, business, and social obligations that must underlie any possible solution. This lack makes the social-political problems seem intractable, especially at the federal level. States will probably continue to exercise leadership in this area.[13]

II. WHAT IS THE PROBLEM?

In systems design, specificity is important. The first step in designing a "solution," whether it is a state and local approach or a global system run from Washington or Baltimore, is defining *precisely* what problem one is addressing. This point seems straightforward, but is often ignored by advocates.

The first question here is whether one sees a problem of hospital "uncompensated care,"[14] of people with health histories that make them "uninsurable,"[15] of workers who through no fault of their own have lost their

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[13] As will become clear, there is a case to be made for state leadership. *See infra* Section V. There is considerable truth to the common, derogatory assertion that Washingtonians can develop an "inside-the-Beltway" mentality. This mindset can obscure empathy for the state and local perspective. Moreover, markets for health care and for health insurance are predominantly state and local, although payment decisions about Medicare, among other things, are made nationally and considerably affect local medical institutions. Most of what I have learned about health care and especially about coping with the uninsured has come by talking to people in the field, although sometimes the field is D.C.

[14] Clearly, burdens have grown for hospitals that treat uninsured patients (or, by some definitions, also patients whose coverage pays less than the hospitals' costs). *E.g.*, CENTER FOR HEALTH AFFAIRS, GREATER CLEVELAND HOSPITAL A. THE UNCOMPENSATED CARE CRISIS: 10 QUESTIONS FOR NORTHEAST OHIOANS (1986). Most observers count as "uncompensated" only hospital care knowingly given as a matter of charity or, less willingly, after the fact, bills rendered that become a bad debt — with the total being about two thirds charity, one third bad debt. Other "below (average) cost" payments generally are not counted. These include low payment levels from state Medicaid plans, "contractual allowances" given to Blues Plans, and "discounts" given to Preferred Provider entities. It was hospitals that first raised the issues at the state level, prompting a round of state study commissions in the early 1980s.

[15] *See, e.g.*, Bovbjerg & Keller, *State Health Insurance Pools: Current Performance, Future Prospects*, 23 INQUIRY 111, 112 (Summer 1986).

job-related coverage,[16] of welfare mothers who dare not give up Medicaid even for a reasonably good job without health insurance,[17] of young people in good health who do not buy coverage, or of uninsured people generally. Most recently, and from this corner, more properly, attention has moved to the general problems of all those who lack coverage, for whatever reasons. These are all legitimate views of problems, but these different perspectives lead to quite different conclusions and policy recommendations.[18]

Beyond differences in focus lie differences in philosophy, which often vary by state or region, as already noted. There are four basic views of health "rights" which are often invoked in policy discussions.[19] It might be better to refer to fundamental fairness or equity rather than "rights," which connote a legally enforceable duty, but the terminology is well established. Table 1 presents the philosophical spectrum.

Table 1: Competing Views of Rights in Health Care

Right to health	Right to health care	Right to equal floor of medical access	Right of equal opportunity to buy access
Broadest view of all: equal outcomes for all, large public role	Massachusetts view: equal access to care for all, including very high-tech care, publicly guaranteed	President's Commission view: public guarantees adequate access of care for all, subsidizing needy as necessary	People "earn" health coverage, like other goods, little public role

Those deemed outside the workforce, the elderly of traditional retirement age and the long-term disabled, get federal Medicare coverage. The deserving poor who cannot work (parents with dependent children, the aged, blind, and disabled) also get public help, federal-state Medicaid. Everyone else is on their own, possibly helped by public hospitals and an assortment of public health programs.

In between, toward the left end, lies the old liberal vision of a "right to health care." This is essentially a right to health care services, or

[16] At the federal level, attention was early focused on the plight of workers who lost health coverage when laid off in the recession, especially in the "smokestack" industries long accustomed to full coverage, in Ohio and elsewhere. *E.g.*, *Health Insurance For The Unemployed*, HEARING BEFORE THE SUBCOMM. ON HEALTH, COMM. ON FINANCE, U.S. Sen., 98th Cong., 11th Sess., S. Hrg. 980187 (Apr. 21 & 27, 1983).

[17] *See infra* note 75.

[18] On policy choices, *see infra* Section V and accompanying notes 102 *et. seq.*

[19] This discussion is adapted from Bovbjerg, *Human Organ Transplantation: Societal, Medical-Legal, Regulatory, and Reimbursement Issues*, 9 J. LEG. MED. 467-74 (1988).

equality of access. Not necessarily a right to equal outcome, as at the far left, but at least an equal chance to see doctors or enter a hospital. This conception was at the center of most intellectual and policy discussions in the 1970s and retains considerable force today. It is labelled the "Massachusetts" view because of that state's new approach to health coverage.[21] Allied with this view is often one that income or wealth is unfairly distributed, and redress should be a public function, certainly as it affects health care.[22]

The 1980s have moved the philosophical focus toward a right to an *equal floor of medical access*. The idea of a decent minimum of health care was popularized by a presidential commission,[23] and holds consid-

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[20] *Cf.* CONSTITUTION OF THE WORLD HEALTH ORGANIZATION (defines expansive view of health), as cited in Lave & Lave, *Medical Care and Its Delivery: An Economic Appraisal*, 35 LAW & COMTEMP. PROB. 252, 254, n. 5 (1970).

[21] Although not technically a mandate, the law is commonly described as such. The state's employers (other than very small ones) are required to pay a payroll tax unless they provide health care coverage. The state has also set up a "buy-in" to Medicaid for the disabled and is arranging for pooled coverage for those without workplace or public coverage. *See, e.g., Massachusetts' Universal Access Law*, HEALTH CARE FOR THE UNINSURED PROGRAM UPDATE 3 (1988) (The Alpha Center, May). Moreover, a well known Massachusetts Transplantation Task Force successfully urged the state to apply the equal access principle even to high-technology, expensive transplantation services. *See*, e.g., Annas, *Regulating Heart and Liver Transplants in Massachusetts: An Overview of the Report of the Task Force on Organ Transplantation*, 13 J. LAW, MED. & HEALTH CARE 4, no. 1 (Feb. 1985), *discussed in* Bovbjerg, *supra* note 19, at 472-78.

[22] Such a definition of the problem really seeks income redistribution, from one type of person to another and from one type of spending to another. It is common for commentators to slide into such recommendations with little explanation. A standard approach is to decry that "we" are spending X billion dollars on frivolous fidgets (readers can name their own favorite low priority), whereas "we" should be spending it on wonderful widgets (or their own favorite high priority). Properly phrased, such debating points are hard to resist. The conceptual problem is that different "we's" allocate the different dollars, and the allocations have not been made a matter of explicit social choice (not yet, at least). In any case, if one favors a great deal of such redistribution, the ultimate redistributive pot that we have is the federal tax system; there are distinct limits to private cross-subsidies and even to state mandates and funding. Privately, insurance rates and hospital charges effect some cross-subsidies. So do state systems of taxation and benefits. However, competition limits the ability of any non-universal system to cross-subsidize without the consent of the payer. Hospitals and insurers can lose business, and states can lose businesses and population. Federal policy is already redistributive, without explicit acknowledgement, and in the "wrong" direction from the above perspective; the open-ended tax subsidy gives no benefit to the uninsured, poorer population, and higher benefits to higher-income people. One might say that the (largely uninsured) farm workers pay higher taxes so that the (heavily insured) auto workers can pay less. For an argument that a tax credit to all should replace this regressive tax subsidy, *see* Enthoven, *A New Proposal to Reform the Tax Treatment of Health Insurance*, 3 HEALTH AFFAIRS 21, no. 1, (Spring 1984); Enthoven, *Health Tax Policy Mismatch*, 4 HEALTH AFFAIRS 5, no. 4, (Winter 1985).

[23] PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, THE ETHICAL AND LEGAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SUMMING UP, vol. 1 (March 1983).

erable middle-of-the-road appeal to socially responsible conservatives[24] and practical liberals.[25] It emphasizes an achievable sort of equality of access to basic services, not perfect access to everything the medical system can deliver, or learn to deliver. As just noted, standard American practice, as opposed to philosophizing, lies well to the right of even the equal-floor philosophy of fairness.

How one views the dictates of fairness in health care has much to do with one's attitude toward mandating or funding additional insurance. These same views also color how one approaches who should be covered and the content of any additional coverage. Actual implementation of any additional state or federal commitment calls for considerable effort at defining such content. Oregon has sought to spell out what decency requires in its Medicaid program and has been castigated for "rationing."[26] Yet, implementing any of the achievable visions of health care rights calls for innumerable decisions about what is or is not covered.

Fertility services were mentioned at the conference. Are these important enough to cover? This might seem a matter for a case-by-case decision by separate plans because values differ as do resources. Indeed, such choices were traditionally left to doctors and their patients, as private and public plans paid indiscriminately for all "medically necessary" care, with a few exclusions like cosmetic surgery or non-reconstructive dentistry. The scope for explicit exclusions has been narrowed considerably by states' "mandated benefits" legislation applicable to privately insured care.[27] Broader coverage means more expense. Mandates raise the cost of insurance benefits and appear to reduce the extent of voluntary purchase.[28]

An open issue is the extent to which any further expansion of health coverage to the uninsured will be allowed to offer less than the full panoply of benefits available from modern medicine. Presently, some states allow coverage for newly insured people to waive mandated benefits.[29]

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[24] Blumstein, *Financing Uncompensated Care: An Approach to the Issues*, 38 J. LEG. EDUC. 511 (1988).

[25] Some, however, continue to dismiss such approaches as "two-tier medicine," holding that programs for poor people are poor programs, an aphorism that is virtually an article of faith among liberal social insurance congnicenti. *Cf.* K. ERDMAN & S. WOLFE, POOR HEALTH CARE FOR POOR AMERICANS: A RANKING OF STATE MEDICAID PROGRAMS (1987) (Pub. Cit. Hlth Rsch Grp.).

[26] On the misuse of this inflammatory word, *see, e.g.*, Bovbjerg & Held, *Ethics and Money: The Case of Kidney Dialysis and Transplantation*, 1 TOPICS IN HOSP. L. 55 (Sept. 1986).

[27] Such mandates generally call for insurance policies to cover services from particular sorts of providers—psychologists and chiropractors are classic examples—or particular services, such as fertility treatment. Because of federal ERISA pre-emption, they do not apply to self-insured plans, *see* Bovbjerg & Kopit, *supra* note 7, at 906-08. Such uncovered plans now account for the majority of large groups' plans. The Blue Cross and Blue Shield Association, which tracks this matter, counts over 800 mandates as of summer 1990. Personal communication from G. Scandlen, Director of State Studies, Blue Cross and Blue Shield Assoc., Washington, D.C. [hereinafter Scandlen].

[28] Gabel & Jensen, *The Price of State Mandated Benefits*, 26 INQUIRY 419 (1990).

[29] *See* Scandlen, *supra* note 27.

Just as "necessity" or "right" to services can be considered service by service, it can also be judged for each service rendered to an individual patient. Here, consensus is emerging that "managed care," through utilization review and other means, is acceptable. Many different approaches are being tried. How much society can or should want to standardize such choices in any expansion of coverage also remains an open question.

III. "NATIONAL HEALTH INSURANCE": WHAT IS IT? WHEN IS IT?

A. What Is National Health Insurance?

The next topic is National Health Insurance (NHI), which in discussions of paying for medical services always seems on the horizon. What is NHI, anyway? The term means radically different things to different people. The ultimate issue is access to medical services when in need. Many people feel this is a basic human right,[30] although our legal and political systems have never taken this view.[31]

In considering NHI, it is instructive to remember that we actually have a kind of national health insurance now, although this is not generally appreciated.[32] Congress has enacted national access to hospital care; not by providing payment, not for all patients and not by creating a positive mandate for providers to reach out to patients. Rather, 1985 budget legislation created penalties against hospitals that turn away patients needing emergency care.[33] This "COBRA" legislation exemplifies the classic American "safety net" approach to social issues like national health insurance; the public sector assumes only marginal, not fundamental responsibility. It also represents vintage 1980s public-sector thinking: promise them anything, but keep spending "off budget," and try mightily not to raise taxes. COBRA is not without meaning. It helps secure a limited right of access to the most crucial form of care, anywhere in this country. Nonetheless, people can be forgiven for believing that carrying evidence of good insurance coverage will be more beneficial, even in an emergency.

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[30] Both opinion polls and scholarly writing support this statement. *See, e.g.*, Gabel, Cohen & Fink, *Americans' Views of Health Care: Foolish Inconsistencies*, 8 HEALTH AFFAIRS 103, 111, no. 1 (Spring 1989) (42% of Americans surveyed think right to health care is in constitution); PRESIDENT'S COMMISSION FOR THE DISCUSSION OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, THE ETHICAL AND LEGAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE, vols 1-3 (March 1983).

[31] There is no fundamental, constitutional right to health care. There is not even a general statutory right, with specific exceptions like emergency care. *See generally* Bovbjerg & Kopit, *supra* note 7, at 871-91 (1986); Blumstein, *supra* note 24, at 514-17 (1988).

[32] I owe this insight—which seems obvious only in hindsight—to my colleague, Mark V. Pauly, of the University of Pennsylvania.

[33] CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985, Pub. L. No. 99-272, §9121, 100 Stat. 82, 164 et seq. (approved Apr. 7, 1986). Inside the Beltway, the Act is known as "COBRA," in the tradition of its predecessors OBRA and

Beyond emergency care, Congress in recent years also encouraged or required states to expand Medicaid coverage for children. This is the first time Congress went beyond the traditional definition of income eligibility.[34] Even after some limited recent expansions, however, Medicaid still covers less than half of people below the poverty line. COBRA also expanded large employers' obligations to allow laid-off employees to continue to participate in group health insurance.[35]

Such incremental federal efforts as COBRA and targeted Medicaid expansions are certainly not what people have considered to be NHI since the early 1930s when NHI first appeared on the national agenda.[36] Although NHI means different things to different people, at a minimum it means mandatory, universal, prepaid coverage of some sort, probably also with similar if not identical benefits for all. The raison d'etre of NHI has always been expanded access to coverage and care. Most recently, the potential for cost containment has also proved an attraction.

There are many possible models for a national system. Perhaps the largest change would be to move to a national health *service* (NHS). A NHS would mean public ownership of medical facilities or employment of medical personnel on the British or, perhaps, on a Scandinavian model.[37] An NHS is the most interventionist approach and may indeed seem foreign; but smaller-scale U.S. models already exist for direct public

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TEFRA, and its successors like SOBRA. For a discussion of COBRA provisions, *see* Bovbjerg & Kopit, *supra* note 7, at 878-79: Any hospital that participates in Medicare or Medicaid, which includes almost all of the community hospitals in the country, and that has an emergency room, as most do, must treat someone who is an emergency patient or in active labor, or at least stabilize them before referring them to somewhere else that agrees to treat them. Enforcement relies on fines, with an ultimate sanction of expulsion from Medicare-Medicaid participation. Through 1989, only one physician had been cited for dumping. *See* Schutte, *Did this Doctor Dump his Patient or Exercise Prudent Care?*, MEDICAL ECONOMICS 66 (Nov. 1989); *see also* Bankhead, *MD Loses Patient Dumping Case*, Medical World News, Aug. 28, 1989.

[34] I. HILL, BROADENING MEDICAID COVERAGE OF PREGNANT WOMEN AND CHILDREN: STATE POLICY RESPONSES (1987) (Nat'l Governors Ass'n). The Omnibus Budget Reconciliation Act of 1986 (SOBRA) allowed states to cover poor pregnant women and their infants who are above current income eligibility limits. 1990 amendments required states to cover all poor children through the age of 19, phasing the requirement in to continue coverage as the existing cohort of covered children ages, one year at a time. *See, e.g.*, Pear, *Deficit or No Deficit, Unlikely Allies Bring About Expansion in Medicaid*, N.Y. Times, Nov. 4, 1990, at 1.

[35] Another provision of COBRA allows those terminated from employment (and divorced or widowed spouses) to continue coverage at their own expense, paying the average group rate for up to 18 months. *See* Abramowitz, *U.S. Begins Mandating Health Care*, Washington Post, Aug. 12, 1986, at D.1.

[36] For a good history of efforts to promote more universal health coverage, *see* P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 235-89 (1982); *see also* Levey & Hill, *National Health Insurance – The Triumph of Equivocation*, 321 N. ENGL. J. MED. 1750 (1989) (adds recent history).

[37] For a brief description of Britain, *see* H. AARON & W. SCHWARTZ, THE PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE 14-25 (1984).

provision of medical services.[38] However, most Americans think of national health *insurance*. Just what kind of coverage NHI would provide, how much it would vary according to individual or social preferences, and who should pay for it are major variables. So is the extent to which NHI plans would restructure the provision of care and the bearing of insurance risk, as well as the approach taken for regulatory or competitive cost controls.

The diversity of possibilities is enormous.[39] Proponents often look to other countries' NHI plans for inspiration, especially Canada[40] and the Federal Republic of Germany.[41] Canada and Germany are of course much more like the United States than is Great Britain, not only socially and in economic development, but also in having federal systems.[42] It is not necessary to look overseas to find models for NHI, however, as there are numerous home-grown approaches that could be adapted. One existing national insurance model is Medicare. Medicare puts all the (social security covered) aged under one uniform national plan, federally defined and funded, with regulatory authority, but with contracted-for private administration of provider payments.[43] Medicare could be expanded to

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[38] At the federal level, there is the nationally funded and operated veterans hospital system. *See, e.g.*, F. WILSON & D. NEUHAUSER, HEALTH SERVICES IN THE UNITED STATES 100, (2d ed. 1982). At the state and local level, public health is a long-standing governmental function, and many medical services are provided by public institutions and personnel. *See, e.g.*, Jain, *Role of State and Local Gov'ts in Relation to Personal Health Services*, 71 AM. J. PUB. HEALTH (supplemental issue 1981).

[39] It is impossible to summarize all the many variants of NHI that have been proposed. For a selection of recent proposals, *see* S. BUTLER & E. HAISLMAIER, A NATIONAL HEALTH SYSTEM FOR AMERICA (1989) (mandatory individually purchased coverage of major risks; tax benefits changed to encourage economizing); NATIONAL LEADERSHIP COMMISSION ON HEALTH CARE, FOR THE HEALTH OF A NATION: A SHARED RESPONSIBILITY (1989) (mixed public-private-employer system of universal coverage); Himmelstein, Woolhandler, Writing Committee of the Working Group on Program Design, *A National Health Program for the United States: A Physicians' Proposal*, N. ENGL. J. MED. 102 (1989) (universal coverage; hospitals on budgets, other services paid from single payer, federal funding through income tax); A. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE (1980); Enthoven & Kronick, *A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy*, 320 N. ENGL. J. MED. 29, 94 (parts 1 & 2, 1989) (very thorough restructuring of coverage into competing HMOs or HMO-like entities, with federal tax credits for all citizens).

[40] *See, e.g.*, Iglehart, *Canada's Health Care System*, 315 N. ENGL. J. MED 202, 778, 1623 (1986); Linton, *The Canadian Health Care System: A Canadian Physician's Perspective*, 322 N. ENGL. J. MED. 197 (1990).

[41] *See, e.g.*, Reinhardt, *West Germany's Health-Care and Health-Insurance System: Combining Universal Access with Cost Control* (Report for U.S. Bipartisan Comm. on Comprehensive Health Care) (June 25, 1990). For an older but useful description of eight countries' plans, *see* NATIONAL HEALTH INSURANCE RESOURCE BOOK, 275-428 (1974) (Prepared by the Staff of the Committee on Ways and Means).

[42] I owe this insight to my colleague, Lawrence D. Brown of Columbia University.

[43] On the current state of Medicare, *see, e.g.*, M. PAULY & W. KISSICK, eds. LESSONS FROM THE FIRST TWENTY YEARS OF MEDICARE (1988).

the entire population. A "national" but joint federal-state insurance approach is Medicaid, with minimum standards set federally, with sliding-scale federal subsidy, and with major options open to state determination and with state administration.[44] Essentially on this model, it has been proposed that minimum national standards be set for state-by-state determination of the insurance mandates to be imposed.[45] A national but privately operated system is the Federal Employees Health Benefit Plan, under which the employer sets basic rules and levels of contributions, but employees and private insurers (including HMOs) determine the exact contours of coverage.[46] Other possibilities include a national version of compulsory employer provisions of health insurance. This could mean the Hawaii or Massachusetts plans writ large.[47] This approach is essentially that suggested by the Kennedy-Waxman proposals and the recent Pepper Commission report.[48]

B. The Shifting Prospects for National Health Insurance

Will Americans move to a more global system? In the long run, the answer has always seemed likely to be yes. Why? In large part, because every other advanced nation has done so. So it seems very probable that eventually we will opt for some variant of NHI.[49] National health insurance has been on the American national agenda at least since the 1930s, before there was even significant private health insurance.[50] NHI probably came closest to fruition in the early 1970s. Many powerful politicians and interests were lined up in favor; what they were against was mainly organized medicine. Agreement seemed near as President Richard Nixon, his HEW Secretary Elliot Richardson, Senator Edward Kennedy, and Congressmen Wilbur Mills, among others, all made different but seemingly reconcilable proposals.

One way to recall how the prospects for NHI seeped away is to note the curiously hydraulic fashion in which its principals melted away. President Nixon fell victim to Watergate. Congressman Mills was washed up after his Tidal Basin escapades. Senator Kennedy's fortunes took a dip

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[44] *See generally* R.A. STEVENS & R. STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID (1974); R. BOVBJERG AND J. HOLAHAN, MEDICAID IN THE REAGAN ERA: FEDERAL POLICY AND STATE CHOICES (1982).

[45] Cohodes, *There May Be More Than One Path to Nirvana*, 27 INQUIRY 5 (Spring 1990).

[46] The FEHBP indeed inspired Alain Enthoven's NHI Plans, *see supra* note 22.

[47] *See e.g., The Hawaii Prepaid Health Care Act of 1974, codified*, HAW. REV. STAT. 393-1—393-51.

[48] *See* Basic Health Benefits for ALI Americans Act of 1989 (Senate Bill of Sen. Kennedy); McIlrath, *Pepper Commision Ensures Insurance, Long Term Care*, Am. Med. News, March 16, 1990, at 1, col. 2; *see also supra* notes 10 and *infra* notes 117 and 118.

[49] NHI seems virtually unique; although other social welfare programs, like child allowances, are also common outside the United States, unlike NHI they are not well weigh universal.

[50] *See generally* P. STARR, *supra* note 36.

at Chappaquiddick. Watergate also beached ex-HEW Secretary Elliot Richardson, who ironically ended the decade as Ambassador to the conference on the law of the sea. These metaphors may be all wet; but in any event, President Jimmy Carter's subsequent NHI campaign promises sank without a trace. In the latter 1970s, the ill-fated hospital cost-control bill that he considered an essential precursor to NHI was twice soundly defeated by Congress. In the conservative tide of the 1980s, no serious federal legislative effort ever surfaced.[51]

The short-run view of NHI's prospects has always seemed less favorable to enactment than the long run. A few years ago, the near-term answer about NHI was a clear, "absolutely no way," certainly not, by the end of the century. "Pro-competitive," privately oriented approaches were in vogue, both to contain health spending and to promote health coverage.[52] Additional public spending on new programs was taboo, especially at the federal level, and even "off-budget" mandates were out of favor. At the dawn of the 1990s, it seems more of a 50/50 proposition that we might enact some kind of mandate nationally. There might even be some federal funding or tax incentives. It is really quite surprising that the outlook should have changed so much.

What has changed the short-run outlook? The political climate is notoriously hard to predict even as far as the next election, but the current White House no longer claims that "government is the problem, not the solution," to all new initiatives. Further, the federal government expanded Medicaid for children during the autumn 1990 budget debacle, even while facing a restive electorate, uncertain economic forecasts, and new obligations of growing magnitude for the savings and loan bailout and military operations in the Middle East.[53] The policy backdrop also seems to be shifting. Perhaps, most importantly, the sheer bulk of the uninsured claims more attention. Fully one-sixth of the non-elderly population lacks coverage when surveyed at a single point in time, and considerably more lack coverage at some time during one year.[54] A contributing factor is the *trend* in this statistic. The 1980s witnessed a continuing decline in coverage, reversing our accustomed historical pattern of steady growth. Sixteen percent of the population without coverage seems like a bigger number when it is growing than when it promises to decline with no particular public effort. It appears that our reliance on private insurance with public tax subsidy, which has served so well for so long, may be reaching its natural limit.[55]

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[51] For a good, readable overview of the ebb and flow of federal health policy over the last generation, *see* L. BROWN, HEALTH POLICY IN THE UNITED STATES: ISSUES AND OPTIONS, FORD FOUNDATION, OCCASIONAL PAPER, No. 4 (Sept. 1981).

[52] *See, e.g.*, C. HAVIGHURST, DEREGULATING THE HEALTH CARE INDUSTRY (1982); Bovbjerg, *Competition versus Regulation in Medical Care: An Overdrawn Dichotomy*, 34 VAND. L. REV. 965 (1981). Even President Carter's former pro-regulatory Secretary of HEW joined the bandwagon for private action, J. CALIFANO, AMERICA'S HEALTH CARE REVOLUTION (1986).

[53] *See supra* notes 34 and *infra* note 91.

[54] *See supra* notes 1 & 2.

[55] *See* Bovbjerg & Kopit, *supra* note 7, at 892.

All over the country, the public's appreciation of the magnitude of uninsurance woes has increased. The impact of these statistics has been intensified by heartrending stories about the agonies of people who have lost or exhausted their health coverage.[56] Such developments prompt calls for action at both state and federal levels,[57] although willingness to pay for major new initiatives remain suspect.[58] In Cleveland and in Ohio, for example, the rise in the uninsured has drawn considerable attention,[59] even though the area is better off than comparable areas,[60] apparently for a variety of reasons.

A second reason for renewed interest in a comprehensive, national plan is the continuing rapid growth in the price of private coverage. Early business optimism that better management and competitive initiatives could control health care spending[61] has faded. There is a growing sense among many opinion leaders that no one payor alone can "fix" cost-containment problems. Private and public commentators alike harp on the continuing growth of health spending, especially in comparison to other countries.[62] The U.S. ranks far ahead of any national system in spending as a share of GNP,[63] yet is readily castigated for its relatively poor showing on such measures of health as infant mortality and life expectancy.[64] Some private companies that once found national mandates or controls anathema to the free enterprise system have begun to support some form of centralized intervention.[65] Similarly, physicians and hospital interests

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[56] *See Illness*, *supra* note 9, at 12. Recipients of public assistance, like Medicaid, are better off than those with no Medicaid coverage. But for many reasons, including low allowable fees, even Medicaid recipients may have trouble seeing doctors. *See, e.g.*, Hill, *Medical Care Is Running out for Poor Women*, Washington Post, Aug. 9, 1990, at C1, col. 2.

[57] *E.g.*, Pollner, *Access to Care: Odds of National Plan Grow with Grass-Roots Discontent*, MEDICAL WORLD NEWS 53 (Nov. 27, 1989).

[58] *See infra* Section VI and accompanying notes 112-126.

[59] *See* Austrian & Cleeton, *The Medically Uninsured: A Focus on the Cleveland Metropolitan Area*, REI REVIEW 21 (Spring 1989).

[60] *Id.*

[61] *E.g.*, J. CALIFANO, *supra* note 52.

[62] *E.g.*, Stevens, *Why Business is Rushing to Support NHI*, MEDICAL ECONOMICS 132 (Aug. 21, 1989). Wagner, *Business Agitates for Health System Revamp*, MODERN HEALTHCARE 16 (Nov. 24, 1989).

[63] Schiever & Pouiller, *International Health Care Expenditure Trends: 1987*, 8 HEALTH AFFAIRS 169 no.3, (Fall 1989).

[64] *See generally* Wegman, *Annual Summary of Vital Statistics—1985*, 78 PEDIATRICS 983 (1986) (U.S. infant mortality of 10.6 per 1000 births, versus 8.4 in Canada, 6.7 in Sweden). Of course, health care does far more than save lives, with great expenditures going to making patients better functioning and more comfortable, not to mention making health care more convenient and more pleasant.

[65] *E.g.*, Winslow, *National Health Plan Wins Unlikely Backer: Business*, Wall St. J., April 5, 1989 at B1, col. 3; Bacon, *Business and Labor Reach a Consensus on Need to Overhaul Health-Care System*, Wall St. J., Nov. 1, 1989, at A16; Swoboda, *Major Firms, Unions Join in National Health Insurance Bid*, Washington Post, March 14, 1990, at F1, col. 2.

are speaking up in favor of NHI rather than opposing it as a means of governmental control of their professions.[66] Even organized medicine has moved from stand-fast opposition to promotion of its own plan. The American Medical Association favors mandatory workplace coverage and state Medicaid for everyone below the poverty line.[67] To be sure, most opponents are not convinced, and there is no consensus on what form centralized efforts should take. Yet, the signs of change in the once uniformly hostile climate of opinion are striking.

Finally, some current portents favor more action on coverage. The new disease, AIDS, has shown how suddenly major new medical spending can become needed and how impossible insurance can be to get.[68] In addition to this, the publicity about continuing scientific breakthroughs in genetic and other screening raises the possibility that many more people will soon be finding that insurers (and employers) are excluding them from coverage (or jobs),[69] despite laws meant to prevent such discrimination.[70] Such discrimination is an extreme form of the continuing risk segmentation of health insurance markets. Risk selection is a key component of the insurance business, and insurers have become ever more accomplished underwriting risks and using experience rating. Increased competition and increased pressure from insureds to economize on spending seems to have exacerbated these tendencies in recent years.[71] This makes coverage less expensive for those with good (expected) experience, but far more expensive for others. There is some fear that continuing risk selection will make the entire system unravel, particularly in the market for small-business coverage.

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[66] *E.g.*, Relman, *Universal Health Insurance: Its Time Has Come*, 320 N. ENGL. J. MED. 117 (1989).

[67] *E.g.*, Perrone, *AMA's Health Access America Would Cut Costs, Cover All*, Am. Med. News, March 16, 1990, at 1, col. 2.

[68] *See* Francis & Chin, *The Prevention of Acquired Immunodeficiency Syndrome in the United States*, 257 J.A.M.A. 1357 (1987); J. EDEN, L. MOUNT, & L. MIIKE, AIDS AND HEALTH INSURANCE: AN OTA SURVEY (1988) (U.S. Congress Office of Technology Assessment, Staff Paper).

[69] D. NELSON AND L. TANCREDI, DANGEROUS DIAGNOSTICS (1989); Bovbjerg & Curtis, *States Are Confronting Adverse Side Effects of Health Competition*, 4 BUS. & HEALTH 49 (1987).

[70] The National Association of Insurance Commissioners (NAIC) has promulgated model rules against use of medical testing for antibodies to the AIDS HIV virus. Most states have not adopted such rules; *see, e.g.*, Schatz, *The AIDS Insurance Crisis: Underwriting or Overreaching*, 100 HARV. L. REV. 1782 (1987) (calling for stronger provisions to assure cross-subsidy for AIDS coverage); Clifford & Iuculano, *AIDS and Insurance: The Rationale for AIDS-Related Testing*, 100 HARV. L. REV. 1806 (1987) (explaining traditional view of insurers as spreading risk among like insureds, rejecting cross-subsidy); J. EDEN, L. MOUNT, & L. MIIKE, *supra* note 68 (efforts to weed out HIV infected people are common in the markets for individual and small group insurance).

[71] *See* Bovbjerg and Curtis, *supra* note 69.

C. Liberals, Conservatives, and Consensus

Intellectually, the traditional arguments for national health insurance are liberal ones:[72] life chances should be equalized, risk of poor health should be spread or socialized, and all of society should help because all benefit from having the whole population be healthy. Therefore, needy people should get health benefits through a redistribution of (in-kind) income. Moreover, people with means should paternalistically be required to cover themselves and their families, just as we require all car owners to buy insurance.[73] Conservatives have traditionally opposed an enlarged public role in health insurance as in other areas, emphasizing the importance of economic freedom and individual choice.[74]

There are also good, if underappreciated, conservative arguments for broader coverage. The most important is that society should encourage people to work. A good way to make work more attractive is to ensure that some basic level of health benefits is uniformly attached to a job. We certainly do not want work to be less attractive than welfare, with its Medicaid benefits.[75] Another notable conservative rationale for a public role is that mandates of certain coverage are warranted as a way of preventing people from "free riding" on the social safety net by failing to insure themselves. This rationale applies with much force to "catastrophic" expenditures for which public assistance is most likely through public hospitals, private hospitals' COBRA obligations, or otherwise.[76] Moreover, business people have come to appreciate that their hospital bills are somewhat higher because hospitals have to make up for bills unpaid by the uninsured.[77] Pragmatic conservatives also note that no private health plan gets a better price for hospital or physician services than Medicare or Medicaid.[78]

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[72] *See, e.g.*, E. KENNEDY, IN CRITICAL CONDITION: THE CRISIS IN AMERICA'S HEALTH CARE (1972).

[73] A large share of the uninsured are not impoverished. Three quarters work or are dependents of workers. And three million or so children are uninsured in families where a parent is insured. M. SULVETTA & K. SWARTZ, THE UNINSURED AND UNCOMPENSATED CARE: A CHARTBOOK (1986) This finding strongly suggests that families give insurance lower priority for personal spending than do many advocates of NHI.

[74] Auto insurance can be distinguished because traditional mandates required liability coverage, not first-party insurance for one's self and family. No-fault coverage, however, has also been made mandatory.

[75] Glazer, *Reform Work, Not Welfare*, 40 THE PUBLIC INTEREST 3, 7-8 (1975). In recent years, states have been allowed to continue Medicaid coverage for up to six months for recipients losing eligibility for cash assistance because of taking a job.

[76] *See* Havighurst, Blumstein & Bovbjerg, *Strategies in Underwriting the Costs of Catastrophic Disease*, 40 LAW & CONTEMP. PROB. 122 (1976).

[77] Note, however, that the uninsured use considerably less care than the insured, *see supra* note 5, so that it is not true that supplying coverage would typically be cheaper than subsidizing care (less) after the fact.

[78] Arguments continue, however, about the relative utilization and quality of the services received.

Finally, consider two less familiar arguments that should appeal to conservatives and liberals alike. First, the insurance market now organized around work place groups simply does not offer conventional coverage with a promise of renewability to retirement age. There is no private safety net for sale. Second, entrepreneurship is inhibited by the difficulty and high cost of finding individual or small-group insurance. Someone leaving IBM to start the next Apple Computers often cannot afford to take his IBM health care coverage with him, even if his health is exemplary.[79] Small firms have a disproportionately hard time affording coverage,[80] yet many believe that they contribute disproportionately to the development of new jobs and the country's ability to compete globally.[81]

Thus, there are a lot more voices being heard lately on this topic—and different ones than the liberals who were heard in the 1970s. Supporters are not just big labor and public health officials any more. Still, all these voices are as yet still something of a babble. The multitude of advocates have not agreed on a single course of action; everyone continues to favor their own perspective.[82] There are also considerable differences in possible approaches by levels of government, to which this article turns next.

IV. FEDERALISM: WHY STATES AND LOCALITIES MATTER

Differences of opinion make horse races. They also underlie our federal system. Federalism allows quite different approaches to social policy to coexist, and incidentally allows social experimentation on a scale unknown elsewhere in the world. This section considers the respective roles of different levels of government, whether under NHI or not. This is not to slight the role of the private sector, which insures most non-elderly

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[79] The 1989 Budget Act extended COBRA continuation protection even to those leaving voluntarily and to those whose new job's coverage is not as good as the old. Sloan, *But What about Your Insurance?* N.Y. Times, Apr. 7, 1990, at 32, col. 1. But most do not take such coverage. Of course the founder's COBRA continuation cannot help prospective employees of the fledgling firm.

[80] *See Health Insurance: Availability and Adequacy for Small Businesses Before the Subcomm. on Health and the Environment, House Comm. on Energy and Commerce*, Oct. 16, 1989 (statement of M. Nadel for the U.S. General Accounting Office); *see also* Bovbjerg, *Insuring the Uninsured through Private Action: Ideas and Initiatives*, 23 INQUIRY 403 (1986) (discusses inherent advantages of larger groups for insurance purposes).

[81] *See Did America's Small Firms Ever Get off the Launching Pad?*, ECONOMIST 61 (June 30, 1990) (casts doubt on 1980s conventional wisdom that as many as eight of ten new jobs are created in small firms, noting inter alia that small firms lack health insurance and have trouble competing for employees).

[82] For example, one may note that the United States' auto companies, facing competitors with much lower health costs, especially for retirees, are among the most vocal in changing position. Further, physicians are very concerned that the "wrong" type of NHI should not be enacted — from their perspective.

Americans.[83] Achieving major changes in insurance is going to take some combination of new mandates and new money—public functions in addition to some restructuring and some education.[84]

What level of government, however, is expected to take action? Historically, the reason for state and local involvement is that our major social safety net is maintained at the state and local level.[85] The federal government has come late to health care.[86] Even then, it has accepted only specified responsibilities to certain defined populations, not a general duty to everyone or the responsibility of provider of last resort. In contrast, we have a history of local general public hospitals and of charity care.[87] This "system" is not systematic. Provision of health services is generally not a formal legal obligation,[88] but it is the major practical safety net, and it is state and local.

Today's situation is very different from the early 1970s. Then, when people talked about NHI or any other expansion of the public role in health care, they clearly envisioned a centralized, "top-down" model. A lot of things in those days were top-down models.[89] Today is different for many reasons. For the moment, we are looking to the states in part by default. As of the early 1990s, federal initiative has been immobilized by budgetary paralysis and political reluctance to chop existing obligations

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[83] It bears re-emphasizing that the private sector is the reason that the "glass" of health care coverage is 5/6 full rather than mostly empty, as it was in the early 1950s. Private employers and private insurers (of course encouraged by tax incentives) cover by far the majority of the population. *See generally* HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA (1989). The respective strengths and weakness of public and private action are a complex matter worthy of more extended discussion elsewhere. It suffices here to note that the public sector must do more in order to reach many or most of the 17% of the non-elderly now without health coverage. Further private action can improve access to coverage, but there are limits to what wholly private action can achieve. *See* Bovbjerg, *supra* note 80.

[84] It should not be surprising that bringing coverage to the currently uninsured should take mandates and money. After all, that is how most of us get our coverage now. Employers and unions paternalistically give us a very constrained choice — take wholly or heavily subsidized coverage as a tax-free fringe benefit or get no benefit at all. Individuals and workers in less paternalistic (usually, smaller) firms do not face this type of private, subsidized "mandate." Bovbjerg, *Health Insurance for the Working Uninsured: A Framework for Policy Development*, in FACILITATING HEALTH CARE COVERAGE FOR THE WORKING UNINSURED: ALTERNATIVE STATE STRATEGIES (National Governors' Ass'n. ed. 1987).

[85] *See e.g.*, S. JAIN, *supra* note 38.

[86] Exceptions to this generalization concern early federal hospitals and the Public Health Service for merchant mariners, as well as coverage for federal employees, military and civilian, where the government acts more in the capacity of an employer than a government. *See generally* F. WILSON & D. NEUHAUSER, *supra* note 38, *passim*.

[87] H. DOWLING, CITY HOSPITALS: THE UNDERCARE OF THE UNDERPRIVILEGED (1982).

[88] *See supra* note 7; *see also supra* note 24.

[89] *E.g.*, Blumstein, *Effective Health Planning in a Competitive Environment*, in COST, QUALITY ACCESS IN HEALTH CARE, 21 28-37 (F. Sloan, J. Blumstein & J. Pemen eds. 1988).

or raise federal taxes,[90] even before the recent realization of the extent of the Savings and Loan crisis and mobilization for the Middle East crisis.[91] For the future, we may look to the states by choice, as the appropriate locus to operate many aspects of even a national system.

The renewed appreciation for the value of state and local action has many roots. One is the traditional conservative view that social issues are best dealt with (or not dealt with) by the governments closest to the people.[92] Another, newer reason, is a growing appreciation for the expertise of states and the growth in their abilities to tackle social problems. In fact, in the last twenty years, certainly in health policy, many of the most creative ideas for change have not been imposed from the top down but rather have risen from the bottom up.[93] Even "DRGs" for hospital payment,[94] the one big 1980s success in federal health policy and cost-containment, at least from a federal policymaker's perspective, came from the states.[95] Other examples could also be cited, and the creativity and talent of state officials have not gone unremarked elsewhere.[96]

We also look to state and local action because circumstances differ. Rural areas differ from urban. Unemployed uninsured are different from employed. And so on. Perhaps more importantly, lacking national consensus at least for the present, we defer to state-by-state differences in attitudes about insurance and about public action. States do genuinely differ in political philosophy, not only about the extent of appropriate governmental intervention in these matters but also about the means by which to intervene.[97] Arizona is very different from Massachusetts, and

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[90] *See, e.g.*, *One Excuse after Another*, ECONOMIST 29 (Aug. 11, 1990).

[91] *See, e.g.*, Knight, *Risks Rise as S&L Crisis Grows More Intractable*, Washington Post, Aug. 12, 1990, at H1, col.1; *See, e.g.*, Atkinson & Hoffman, *Suddenly, a Long, Costly Crisis Looms: Gulf Confrontation Holds High Stakes for U.S. as Hopes of Diplomatic Solution Fade*, Washington Post, Aug. 12, 1990, at A1, col. 3.

[92] President Ronald W. Reagan, like President Nixon before him, called for a "New Federalism." The unspoken understanding is that non-federal governments cannot print money and do not accept high levels of taxation.

[93] *See* Bovbjerg, *Nurturing Policy Ideas: In Search of Creative New Insights*, 8 J. POLY ANAL. & MGMT 328 (1989) (on general creativity at state versus federal level).

[94] DRG is the acronym for "diagnosis related group," the key component of prospective payment for inpatient hospital care implemented in 1983. *See, e.g.*, Schramm & Gabel, *Prospective Payment: Some Retrospective Observations*, 318 N. ENGL. J. MED. 1681 (1988).

[95] The DRG method was invented at Yale and was first implemented in New Jersey (with federal support). States had earlier pioneered prospective payment and state regulation of hospital budgets; *see, e.g.*, Bauer, *Hospital Rate Setting—This Way to Salvation?* in HOSPITAL COST CONTAINMENT 324 (M. Zubkoff, I. Raskin & R. Hanft eds. 1978); *see, e.g.*, Biles, Schramm & Atkinson, *Hospital Cost Inflation under State Rate-Setting Programs*, 303 N. ENGL. J. MED. 664 (1980) (New Jersey was the first to adapt DRG methods to this end, and the method was then adapted for federal payment under Medicare.)

[96] National political columnist David Broder routinely gives prominence to this theme. *See, e.g.*, Broder, *The Return Of Lawton Chiles*, Washington Post, Apr. 18, 1990, at A27, col.1.

[97] States also differ in their fiscal resources, which is a standard argument for federal intervention, as in Medicaid, to redistribute income and to make health

national social consensus is much harder to achieve in the United States than in more homogeneous foreign countries.[98]

Finally, recall that medical markets are mainly local. People go to doctors and hospitals near them, styles of practice vary with locality, health care labor is bought in local labor markets, and medical prices vary by metropolitan areas.[99] Intervening with any specificity in how medical care is delivered calls for some form of local administration. It is quite hard to accomplish directly from Washington.[100] Similarly, in the markets for insurance or HMOs, much of sales and service is local. States have experience dealing with local medical providers and HMOs in operating Medicaid and other programs. Thus, not only do states play a role when the federal government does not, but they also have important advantages in their own right.

To be sure, there are limits to what states acting in isolation can accomplish. Mandating coverage for all is expensive, and even a state desiring to do so has to worry about imposing higher costs on its citizens or businesses because people are mobile. High-priced states can lose out in the competition for relocating business and citizens. It is probably not insignificant that the first state to attempt any such mandate was Hawaii,

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programs more equal. However, states vary greatly in their willingness to spend state dollars on Medicaid — even holding constant objective factors like state income, percentage of people under poverty line, and level of federal matching payment. *See* J. HOLAHAN & J. COHEN, MEDICAID: THE TRADE-OFF BETWEEN COST CONTAINMENT AND ACCESS TO CARE (1986) (relative to Midwest, East 28% higher in per capita Medicaid spending, West 25% lower, and South 43% lower). *Cf.* Englehardt, *Allocating Scarce Medical Resources: The Availability of Urban Transplantation*, 311 N. ENGL. J. MED. 66 (1984) (difficulty of consensus on transplants).

[98] Many Europeans, for example, simply cannot comprehend that people are allowed to go without health care (or food or lodging) in the United States, which could never happen in, say, Denmark or Holland, which are small, relatively well to do countries where social consensus is strong, as is the cultural history of the welfare state. Few Europeans have any concept of the difference between Massachusetts and Arizona, although they are getting a taste of differences in a federal system as they bargain about further economic and political integration. In the U.S., it is very, very hard to reach consensus on these issues because people (and different states' taxpayers) have such fundamentally different values with regard to individual and social responsibilities and about the appropriate role of government. Americans are quite charitable on a one-on-one basis; and our private charity exceeds general European levels. In most of Europe, however, people are much more comfortable with having the public sector make such transfers.

[99] Medicare policies are made nationally and greatly affect the finances of hospitals, the largest medical spenders. Many private insurers also operate nationally, and some contracts with national businesses apply nationwide. But even Medicare hospital prices are separately computed for each metropolitan area, and local hospitals and physicians affected by national rules must adapt within a local marketplace.

[100] This does not mean that the basic contours cannot be agreed nationally. The structure of fee schedules, basic coverage of benefits, minimum guidelines for quality medical practice — these can all be national, and perhaps should be. Their administration in the field is another matter.

an island.[101] Yet, the state role is apt to remain primary for the immediate future. Thus, many different approaches can be expected, according to state preferences and how they see the problems.

V. FACING TRADE-OFFS AND DESIGNING SOLUTIONS

A. The Inevitability of Trade-Offs

As noted, we lack consensus on goals in health care, not only philosophically but in terms of what affected interests want. Patients want free access to care. They want relatively free choice of providers, or at least most of them do. Physicians want freedom of clinical practice, freedom to take any patient and still be paid, freedom from (what they see as) petty bureaucracy. Doctors also want freedom of contract with the patient, freedom to set their own fees. Hospitals certainly want freedom from uncompensated care and from a lot of regulations. Business and insurers want freedom from a lot of the mandates they have been getting. Everybody, it would seem, wants freedom from the lawyers,[102] especially from the malpractice lawyers.[103]

Freedom, of course, is good news. Hence, the rejoicing over events in Eastern Europe. Who could be against freedom? However, one cannot have all these freedoms at once and have freedom from fiscal folly. And controlling spending is a sine qua non of expanded access to care, which, other things equal, will raise medical prices considerably for everyone. One lesson of the relatively new discipline of health economics is that in health care, as elsewhere, an increase in (subsidized) demand, with no change in supply, will raise prices.[104] It is simply impossible to fulfill all these conflicting demands equally and at once.[105] Some choices must be made to reconcile these conflicts, sorting out relative priorities. Such choices are not easy.

If there were an easy, inexpensive solution, we would have enacted it long ago.[106] There is none. Hence, social and political leadership has a

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[101] No direct state mandates on employee benefit plans other than Hawaii's are allowed under the federal ERISA legislation, but states can impose taxes on businesses that do not insure to accomplish essentially the same objective, as Massachusetts has done. *See supra* note 7, at 906-09 and note 21.

[102] *See, e.g.*, Sansing, *First, Kill All the Lawyers*, WASHINGTONIAN 132 (Nov. 1990) (nation's capital especially "over-lawyered").

[103] *See, e.g.*, A.M.A., A PROPOSED ALTERNATIVE TO THE CIVIL JUSTICE SYSTEM FOR RESOLVING MEDICAL LIABILITY DISPUTES: A FAULT-BASED, ADMINISTRATIVE SYSTEM, (AMA/Speciality Society Medical Liability Project, 1988).

[104] *See, e.g.*, Newhouse, Manning, & Morris, *Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance*, 305 N. ENGL. J. MED. 1501 (1981).

[105] *See* Reinhardt, *Uncompensated Hospital Care*, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 1-15 (F. Sloan, J. Blumstein & J. Perrin eds. 1985) (cannot achieve equity, freedom, and budgetary control at once).

[106] The ins and outs of reconciling other goals with cost containment really calls for another conference entirely, certainly for a much longer article than this one.

considerable role to play in making these choices.[107] Moreover, any short discussion of possible solutions, like the following, can necessarily only begin to indicate the complexity of possible choices.

B. Approaches Toward Solutions

A jurisdiction seeking solution(s) needs to begin by deciding the nature and extent of its problem(s), the available tools and traditions for fashioning policy options, and its political desires. In crafting the best solution, it is helpful to consider various objective circumstances, as well as to reach certain political value judgments. How bad are problems for different categories of the uninsured? Categories are usefully defined by relation to policy instruments—such as the wholly uninsurable (e.g., chronically ill), those on the boundary of Medicaid, poor not covered by Medicaid, workers in small businesses, and dependents of all of the above. What direct and indirect costs are imposed on the public sector now? On private parties? Such a focused assessment helps show the benefit to be derived from improving access to care, and altruistic pleasure in helping others should count as a benefit, where it is politically perceived as one.

What policy "infrastructure" is available in the jurisdiction? Places vary. Are there strong public hospitals or a "chain" of public clinics to build on? Is there a tradition of charity care among private physicians? Are physicians located in areas of highest uninsurance? Are there Medicaid or HMOs or other providers with whom to contract? How interventionist is the jurisdiction with regard to hospital and physician fees (either through regulatory or competitive means)? All these and more questions of circumstances matter as to what options seem feasible in an area.

What approaches will the political culture support? This goes to the values discussed in the prior section and the willingness to pay which is discussed next. Basically this means deciding (a) whether one wants to address medical services (hospital or other) or instead health insurance of some kind and (b) whether one wants a global approach, or gap-filling approach. The argument from this corner is that an insurance approach is generally preferable. It focuses on the needy, not on health care providers, promotes access to a variety of care including less expensive non-institutional care, encourages quality-enhancing competition, and has other desirable characteristics. Yet, creating an insurance entitlement makes costs harder to predict and control. If funds are deemed very short, it makes a good deal of sense to focus on a provider of last resort, like a public hospital.[108] Public hospitals offer an unusual combination of addressing needs for the most urgent care and prospects for budgetary control. Rather than having to exclude most potentially needy in advance

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[107] For an excellent argument on the importance of leadership in achieving public goals, as distinct from policy analysis or structural reform, *see* Behn, *What Counts?, Leadership Counts*, J. POL'Y ANAL. & MGMT (1989).

[108] *See* Bovbjerg, Held & Pauly, *Privatization and Bidding in the Health Care Sector*, 6 J. POL'Y ANALYSIS AND MGMT 648, 652-53 (1987).

through a poorly funded insurance plan, a jurisdiction can expect to see a medical-fiscal triage by a hospital make specific decisions to relative needs.

Given sufficient commitment to proceed with an insurance approach, the most important issue is whether to attempt to be comprehensive, as almost no jurisdiction has yet attempted. Incremental approaches are more common. Note that those who prefer the latter promote it as a "building block" or "incremental" approach. Those with more global preferences deride it as a "patchwork" or even a "crazy quilt."[109] There are reputable arguments both ways, and jurisdictions may certainly differ in their choices. Incrementalists suggest not intervening more than necessary to fix what seems to be "broke," allowing different approaches to flourish, and being wary of monopoly provision of services, whether public or private. Globalists suggest that multiple systems leave cracks for people to fall through and claim that only centralized cost containment can succeed.[110]

Once such basic assessments are complete, designers of any plan must specify, at a minimum: (a) Who is to be covered? Everyone, all citizens, or specified populations? (b) What care or coverage is to be provided (or required)? A bare-bones policy, comprehensive coverage, or something in between? (c) What methods and levels of payments to providers are contemplated? The current system, capitation, negotiated fees, or discounted cost? (d) What administrative and financing approach is to be taken? Public, private or mixed administration? Full specification gets complex, without even getting to what, if any, quality or cost-oriented initiatives are to be part of the picture.

How is a policy maker or a jurisdiction to evaluate the possibilities? A primary criterion is how many more people will be covered, of what types, and with what benefits? In general, there is a trade-off between depth of coverage (elaborateness of protection) and breadth of coverage (number of people) at any given level of social willingness to finance coverage and any given level of prevailing medical prices and style of practice. For many globalists, cost containment is of the essence. One can imagine

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[109] At the conference referenced above, speakers in the morning sessions twice used such terms — once each way. *See also* Freudenheim, *Volleyball on Health Care Costs*, New York Times, December 7, 1989 at D1 ("frayed quilt" of U.S. health care policy causes rising tensions); *see also* Kinzer, *Universal Entitlement to Health Care: Can We Get There from Here?* 322 N. ENGL. J. MED. 467 (1990) (dislikes policies of "disjointed incrementalism," term coined by John Dunlop).

[110] Globalists point to the relative success of other countries in slowing the growth of health spending. Certain foreign-model health plans look untransportable if only because Americans are accustomed to a lot of individual choice and (at least seeming) individual control. Confronted with a newly powerful central government 200 years ago, individualistic Americans invent the Bill of Rights. More recently, and more mundanely, Americans confronted with lower speed limits have bought a lot of Fuzz-Busters. In health care, how well would waiting lists for elective surgery "play" with American patients, premium payers, or voters? Consider that Americans, asked to line up for anything, form not a queue but a funnel.

achieving economies on medical spending, but only with very significant realignments of consumer and provider incentives going well beyond people who now lack coverage. Indeed, the short-run impact of improving access to care among those who now lack it is probably inflationary; increasing the dollars flowing through insurance or to hospitals will raise demand for services and reduce price discipline on providers. In addition, any assessment must consider the revenue options and distributional effects of new taxes, premiums, and fees.

In making such judgments, policymakers should ponder the likely dynamics of any new system(s). Given new incentives, behavior will surely change. Of course, that is the point; we want change or we would not enact the program. However, the static picture that we look at now—with so many uninsured, such patterns of usage, and the Blues doing this and the Travelers doing that—may alter in unexpected ways. And unintended consequences are all too common. Especially if fundamentals of today's system are left unchanged, look out for dynamic shifts, because people will act in their own self-interest, not in the interest of policy planners.

Space is lacking for any description, much less evaluation of the innumerable possible solutions. In considering any of them, the following are reasonable suggestions. Policymakers need to be clear on the extent of access desired, and on incentives for quality and cost containment. They must also face the trade-offs between access and cost.[111] They need to achieve consensus on specific goals and design plans specifically to meet them, for it is easy to envisage disillusionment from promising more than can be delivered. Simple as any given plan may be in conceptual outline, the details are necessarily complex, and our various views of rights and freedoms can easily come into conflict. So implementation can readily prove economically and politically intractable. In part, this reflects uncertainty about costs and achievements; in particular, no one knows for sure how to ensure that higher-intensity care is worth its cost. Nor has any single approach to cost containment proven itself dominant. Mostly, however, we do not agree on the value of the likely achievements in relation to their costs.

Ultimately, it would seem that policymakers need to perform a rough cost-benefit calculation. How much benefit goes to the uninsured, to providers of their services, to those at risk of uninsurance, and (altruistically) to people at large? How much cost is borne by taxpayers or businesses in exchange? Beyond the aggregate calculation, politics must of course consider who are the winners and losers. It seems easiest to weigh costs and benefits for small changes, add-ons of various kinds for different constituencies, like the uninsurable, welfare mothers, and all the others. Indeed, the recent past has been characterized by a series of small, COBRA-

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[111] *See* Shortell & McNerney, *Criteria and Guideline for Reforming the U.S. Health Care System*, 322 N. ENGL. J. MED. 462 (1990) (attempt to set out framework for judging NHI proposals).

like shifts. The calculus gets harder where bigger changes are at stake, especially changing the rules for people who already have coverage, for people in general are content with their personal health care, although they often say "the system" is in trouble. On the one hand, it seems prudent not to try to "fix" what is not obviously "broke." On the other hand, past some point, simple add-ons of coverage may be unacceptably costly without more basic change in how everyone buys health care. This brings us to the next section.

VI. AFFORDABILITY AND WILLINGNESS TO PAY

There is little doubt that reasonable approaches could cover many or most of those now without insurance. Anyone can design good-looking additional health benefits, and newly covered people (and their providers) would benefit. Similarly, however, many of us could also design theoretically marvelous additions to our houses or apartments, perhaps for the benefit of a new child or weekend visitors. The main question is just what additions are worth their cost. Cost is properly measured not only in dollars, but also in loss of freedom, convenience, diversity, and catering to individual and group preferences.[112] For this discussion, however, let us stick mainly to financial costs, as they are easier to quantify and discuss.

Realistic plans for increasing coverage recognize that they will cost money, certainly in the short run, even if new controls promise longer-run offsetting reductions in spending or spending increases.[113] How do people feel about spending more money, through taxes or increased private spending? One of the hard facts for analysts to face, and even harder for pro-NHI advocates, is that ordinary people and voters do not seem to value insurance coverage as highly as many health analysts do. Many people seem to think that available coverage costs too much. Consider that very few people are wholly uninsurable.[114] Rather, they have chosen

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[112] This point of course sidesteps the issues of transfer-separate people paying and benefiting, at least directly.

[113] The Pepper Commision estimated a price tag of $66 billion, including expansions of coverage for long term care, not part of other proposals. *See infra* notes 117 & 118 and accompanying text. A detailed simulation has estimated the cost of a broad employer mandate to provide coverage for workers at a cost of $41 billion in 1988 pretax dollars (reaching 22 million additional people, with a rise of 34% from current spending). S. ZEDLEWSKI, EXPANDING THE EMPLOYER-PROVIDED HEALTH INSURANCE SYSTEM (1990) (Urban Institute).

[114] Some of them are, in that they have health conditions or history that makes them uninsurable at normal rates, yet unable to afford the premium for specialized coverages. By various estimates, up to one percent of the population cannot get health insurance at normal rates, *see supra* note 15 (although, technically, even many of these could be insured—at some price—if they were willing to apply to Lloyd's of London or the like, to be specially underwritten and pay very high premiums.) Even for those not normally insurable, in almost half the states, special state-sponsored high risk pools offer comprehensive policies at heavily subsidized prices. *See generally* A. TRIPPLER, COMPREHENSIVE HEALTH INSURANCE FOR HIGH-RISK INDIVIDUALS: A STATE-BY-STATE ANALYSIS (4th ed. 1990). Yet risk pools have always fallen far short of reaching all those who could benefit. At the end of 1989, risk pools in fact insured a total of just over 50,000 people in 14 states (with pools in 10 other states just begun or not yet operational). *Id.*

not to insure themselves, their employers have chosen not to insure them, and their governments have chosen not to insure them.[115] Why is that? The main problem for the non-poor and for society alike is that we are not willing to pay for the style of coverage we want.[116] The social issue is whether society is ready to force the uninsured or their employers or states to buy coverage, and probably also to subsidize that choice.

It would seem that our wishes exceed our wallet, as President Bush might say, not only individually but also collectively. Despite the frequently urged "fundamental" nature of health care, other priorities come first. It is notable that the difficulties of achieving political consensus on supporting significant new health spending led the Pepper Commission initially to recommend how to increase coverage, estimating a price tag of $6.6 billion without specifying how to meet that price with new taxes, controls, or mandates.[117] The final report does not make specific recommendations, either. However, it does discuss numerous revenue options, together with several criteria for judging their appropriateness.[118]

As another indicator, consider the opinion polls. Pollsters periodically ask people (phrasing the question in different ways): Do you think we should guarantee everyone health insurance. Usually, an overwhelming majority of Americans say yes, we should.[119] Pollsters used to stop at that point. Since California gave us Proposition 13 and Ronald Reagan, polls now ask, quite appropriately: how much more are you willing to pay in taxes? The answers are discouraging for expansions of coverage. Polls generally find that fewer than a quarter of respondents are willing to spend as much as $50 or more a year.[120] Many observers have read the results of the 1990 elections in the same light.[121]

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[115] Most of those 30 odd million uninsured people are not desperately poor. *See* M. SULVETTA & K. SWARTZ, *supra* note 73 (two thirds above poverty line, one third above twice poverty).

[116] Additional problems of course exist: Coverages available for sale (or enactment) can be too "rich" for buyers' "tastes." The uninsured may also misperceive their risk of needing coverage or overestimate the comprehensiveness of the social safety net for the uninsured. There are also organizational difficulties for the small businesses seeking insurance for employees, especially that the regulatory and informational cost is enormous, and risk selection works against many of them. Still, we ought to remember that failure to buy coverage reflects a consumer and workplace choice. It may make many of us unhappy to see nonpoor parents not protecting their children, for example, but in some sense they are making that choice.

[117] E.g., Wagner, *Pepper Panel's Healthcare Blueprint Omits Funding, Bipartisian Support*, MODERN HEALTHCARE 20 (March 12, 1990).

[118] Pepper Report, *supra* note 10, at 137-38 and Appendix 7.

[119] *See* Stevens, *Patients Give Uncle Sam a Big Vote*, MEDICAL ECONOMICS 83 (April 23, 1990) (in 1989 survey, 31% of public favored national health service or Canadian-style insurance, 46% traditional U.S. fee-for-service medicine, versus 20% and 61% in 1976).

[120] *Id.* at 90; *see also* Berg, *Poll: Increase Health Care, but Not Costs*, American Medical News, July 27, 1990, at 6, col. 2; *see generally* Gabel, Cohen & Fink, *supra* note 30.

[121] *See, e.g.*, Apple, *The Big Vote Is for "No,"* New York Times, Nov. 8, 1990, at A1, col. 4; Stone, *Voters Turn Tight-Fisted; Theme: "Hold Line on New Spending,"* USA Today, Nov. 8, 1990, at A1, col. 4.

How might people be led to want less (query on the realism of this plan), to accept major changes and reallocations in health care (query again), or to be willing to pay more, as premium-payers, employees, employers, members of business coalitions, or taxpayers? Despite current fears and uncertainties, the U.S. is not a poor country,[122] and we can afford to pay more if we want to, through taxes or otherwise.[123] As yet, people are not convinced that paying more is a worthwhile "deal."[124] We need to do more to ensure that payers get good value for health care. People really are not convinced of that. The problem is how such economizing choices can be identified and effectuated. Clearly, it is possible to spend less and still have a decent life. Many countries accomplish this trick. But identifying low-value care in advance is not easy, and patients' perceptions of value may differ from that of academic or government reviewers. This line of thought leads us back into the whole cost containment discussion and questions of what might work and be acceptable in an American context.[125]

It would also help, and it is healthy, that people are beginning to feel a little more mortal. That is one of the side effects of today's tremendous

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[122] Herbert Stein has noted that at current United States and Japanese growth rates, Japan will not attain the United States per capita GNP for 33 years. *See* Penner, *Japan and the United States: Can this Marriage Be Saved?* POLICY BITES, June 1990 [Urban Inst. bimonthly publ., no. 1].

[123] Again, this article sidesteps the political debate about what taxes, if any, are appropriate. It can be noted in passing that "sin" taxes and pollution (or carbon) taxes have a politically appealing connection to poor health. California has recently expanded health coverage using a higher cigarette tax. Academic debates rage on the relative efficiency of different forms of taxation. The Pepper Report gives a good listing of potential federal revenue sources, *supra* note 10, Appendix F.

[124] For example, 43% of respondents to one poll thought that increased public involvement to ensure full access would be a "costly mistake," 76% that even doubling expenditures still should not pay for all the care the public wants—indicating skepticism about the value of such care. Berg, *supra* note 120. Some assert that money is not needed, merely reallocation, *see Medisplurge: America's Exorbitant Health Care System Does Not Require More Spending*, ECONOMIST 5 (March 10, 1990); but whether any savings in one area (e.g., privately insured spending on elective surgery) can be reallocated elsewhere (e.g., prenatal care for uninsured mothers to be) is problematic. However, having a more cost-effective medical system would likely raise political willingness to expand public funding, as noted in text.

[125] Americans would probably be willing collectively to get 95% of the measurable health outcomes we now get for two thirds of the cost, if that was the choice. In some areas of medicine, there may be trade-offs of this magnitude, although this is much debated, and the presence of non-measurable outcomes, like reassurance, complicates the issue. Of course, as fully insured individuals, we are less prone to make trade-offs if life or even peace of mind is at stake. When we are conventionally insured, we all want Mercedes medicine, which certainly does not encourage low-style care among doctors and hospitals competing for our patronage. It would be instructive if people were really given a choice of a Hyundai health care option, but that has never had a true test, and it is quite unclear that individuals would choose it. Interestingly, Hyundai itself is now attempting to move its cars "upmarket." *South Korea's Carmakers: Starting Over*, THE ECONOMIST 78 (Nov. 3, 1990).

focus on personal health, not to mention the AIDS epidemic. Quite a few people are without insurance for some period of time, and more may come to appreciate that true adversity could happen to them. The likelihood of losing a job has come home to more people, even middle class, well insured people. Not even the phone company provides the kind of employment security it once did. And perhaps when it is not merely "the other guy" at risk, people will be more open to greater protections.

These thoughts are speculative at best.[126] A larger question is whether political leadership or social change will give Americans more of the communal sense that much of the world has about health services. Today, we do not have the sense that "we are all in this together." We do not even seem to have the same intergenerational compact that we used to have about Social Security and Medicare. Traditional liberals argue that the social base of public programs has to be broader to maintain public support. Others are more mistrustful of public efforts.

VII. A FINAL NOTE

In sum, we need to know more about the value of different health benefits, and we need to come to more consensus on what constitutes acceptable as opposed to achievable levels. The public needs to appreciate the risk of uninsurance, and we need more agreement on how to contain costs. Better crafted plans for increasing coverage or funding might also conceivably help.

What we need most of all, however, is not more information or analysis, but rather more leadership. Leadership is needed to educate, to help forge advance consensus where possible, and to propose hard trade-offs alone where not possible. Such leadership is at least as likely to come from the grass roots as from Washington.

It also seems likely that further American solutions for the uninsured, whenever and wherever they develop, will not be wholly public or wholly private. The private sector and employment-based coverage seem likely to continue, and the public role will probably not be wholly federal or wholly state. In each case, we can expect instead some kind of combination, in recognition of American diversity, both philosophic and geographic. From this conclusion Europhiles may despair, but Americans can find encouragement. The arguments for a federal role are strongest with regard to certain minimum structural changes and for achieving more equal funding. With regard to field operations, however, most of the encouraging developments are occurring outside Washington. A national system should continue to encourage experimentation and diversity.

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[126] Consider, for example, that people do not seem to become more generous during the adversity of a recession. It is notable that the early 1980s recession saw numerous Medicaid cutbacks. Recent increases in the face of feared recession have occurred at the federal level; most states have lobbied against increased mandates without increased revenue. Casual social-political science suggests that recessions do not induce an ethic of "we are all in this together," but rather mainly hurt, marginal, laid-off workers.