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ESSAY

COME THE REVOLUTION: ARE WE FINALLY READY FOR UNIVERSAL HEALTH INSURANCE?

SUSAN ADLER CHANNICK*

I. THE STATUS QUO

The front page story of the November 25, 2002 *New York Times* highlighted, yet again, the ongoing saga of the growing number of Americans who are without health insurance.¹ While this topic has been written about many times, the *New York Times* article had a slightly different take on the problem: no longer is this a problem exclusive to the poor and unemployed; it is a problem now shared by the middle class even, in some cases, the employed middle class.² Amazingly, the fastest growing segment of the newly uninsured is the group that has been earning in excess of \$75,000.³ These approximately 800,000 individuals (of the 1.2 million recently uninsured) lost their health insurance when they lost their jobs or were priced out of the market because of the rising cost of health insurance. And while there is nominally federal protection for those whose loss of employment means a loss of health insurance as well, both such programs—the COBRA program, enacted as part of the Consolidated Budget Reconciliation Act of 1986, and HIPAA, the Health Insurance Portability and Accountability Act—erect substantial procedural and economic barriers for the recently unemployed to obtain health insurance.⁴ The irony is that for many people who recently have

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1. See John M. Broder, *Problem of Lost Health Benefits is Reaching into the Middle Class*, N.Y. TIMES, Nov. 25, 2002, at A1.

2. A recent article written by economist Karen Davis, President of the Commonwealth Fund, entitled “Work In America: New Challenges for Health Care,” the author states that approximately 158 million Americans—nearly two out of three people under the age of 65—have health insurance provided by their employers. KAREN DAVIS, COMMONWEALTH FUND, WORK IN AMERICA: NEW CHALLENGES FOR HEALTH CARE 5 (Apr. 2002) (publication no. 521) at <http://www.cmwf.org/annrept/2001/presmess.pdf>.

3. Broder, *supra* note 1.

4. In order to qualify for both COBRA and HIPAA coverage, the employee must have been employed by an employer that provided its employees with health insurance. The cost of

become unemployed, COBRA and HIPAA provide no real protection against the risk of illness or disease.⁵

To some extent, of course, the explanation for the phenomenon of the uninsured in America is "the economy, stupid." The United States has been experiencing an at least two-and-one-half year economic recession exacerbated by the economic effects of September 11, 2001, and, more recently, the war in Iraq.⁶ For many reasons, the economy has not enjoyed as robust a recovery as was once predicted so that many businesses have been forced to lay off significant portions of their workforce in order to survive or, at least, as a concession to the bottom line. These newly unemployed find themselves not only without jobs, but too often without health insurance as well, adding to the already growing numbers of uninsured in the country. In addition, the rising cost of health insurance premiums (12% in 2001 and a projected 15% in 2002) creates an additional burden for many employers, particularly small employers, to continue providing health insurance for their employees. In order to ensure their own economic survival, many businesses are cutting back on health insurance as an employee benefit and are passing increasing costs of health insurance to employees in the forms of higher premium shares, less coverage for dependents, and higher cost-sharing. So, although recent surveys by both the Employee Benefit Research Institute and the Commonwealth Fund put health benefits first when ranking the importance of employment fringe benefits, workers may find paradoxically that this benefit is no longer provided or has been substantially reduced.⁷

The problem of the uninsured is a creature bred of a confluence of factors. Most individuals who are not covered under public health insurance programs like Medicare, Medicaid and SCHIP, have, as stated above, had access to private insurance through their employment. Health insurance as an employment benefit has been the norm since the 1950s due, in large part, to the favorable income tax treatment accorded to employers who offer this benefit to their employees.⁸ To a significant extent, access to health insur-

COBRA protection, which is effective for only 18 months, is 102% of the cost of coverage for current employees which cost is fully borne by the insured. The guarantee of HIPAA is access to individual insurance, but with no limit on the premiums that insurers can offer for such coverage. In some cases, the cost of HIPAA health insurance is more than 200% of comparable non-HIPAA policies.

5. See JACK A. MEYER & LARRY S. STEPNIK, COMMONWEALTH FUND, PORTABILITY OF COVERAGE: HIPAA AND COBRA (Nov. 2002) (publication no. 569) at http://www.cmf.org/programs/insurance/meyer_hipaacobra_ib_569.pdf.

6. On March 25, 2003, President Bush submitted a request to Congress for a fiscal year 2003 supplemental appropriation of \$74.7 billion for funding of the invasion of Iraq and to reward key allies. The President set an April 11 deadline for completion. Congress approved the President's request, increasing the 2003 budget deficit to a projected \$400 billion. Earlier, Congress approved a 10-year \$760 million cut in income and corporate dividends taxes. This week the Senate reversed itself by a narrow margin in favor of paring the tax cut by \$350 billion.

7. WORK IN AMERICA: NEW CHALLENGES FOR HEALTH CARE, *supra* note 2, at 6.

8. In many ways, the employment based health insurance system is an artifact of the tax

2003] ARE WE FINALLY READY FOR UNIVERSAL HEALTH INSURANCE? 305

ance is an artifact of income; while only 6% of persons with an income in excess of 300% of the federal poverty level are uninsured, 32% of persons below the federal poverty level are uninsured.⁹ While about 20% of this disparity can be attributed to unemployment, the remaining 80% of the uninsured are employed, but remain uninsured for other reasons.¹⁰ Either their employers do not offer insurance (60%), or, if the employer does offer insurance, the employee is ineligible (11%) or does not participate in the group insurance plan (22%).¹¹

Some eligible employees do not participate in a group health insurance plan because they have other, more attractive alternatives like a spouse's insurance plan. Others do not participate because it has simply become too expensive a preference. For families who earn less than 200% of federal poverty level, approximately \$35,000 for a family of four, purchasing a health insurance policy can cost 10% of family income.¹² Considering the myriad of expenses that a family of four has, health insurance is a luxury and "going bare" may be a reluctant, but preferable option. The question of whether access to health care should ever, in a civilized, wealthy country be a foregone option is at the core of much of today's health care policy debate. The Institute of Medicine estimates that 18,000 people between the ages of 25 and 64 die each year because they lack health insurance making lack of health insurance the sixth-leading cause of death among people under age 65, a statistic that many have called a national disgrace.¹³

code. Since post-WWII, employers have received a tax deduction for their payments toward employee health insurance and such payments are excluded from the employees' taxable income. As long as health insurance costs remained relatively low, these tax preferences were perceived as beneficial to employers who were able to give their employees a tax-subsidized increase in compensation. As health insurance costs have risen, the value of this employee benefit to employees has gone up while its value to employers has fallen. See Jonathan Gruber & Larry Levitt, *Tax Subsidies for Health Insurance: Costs and Benefits*, HEALTH AFF., Jan.-Feb. 2000, at 72 available at <http://www.healthaffairs.org/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v19n1/s5.pdf>.

9. *In Critical Condition: America's Ailing Health Care System: Hearing Before the Senate Special Comm. On Aging*, 108th Cong. (Mar. 10, 2003) (testimony of Karen Davis, President of The Commonwealth Fund) reprinted in KAREN DAVIS, COMMONWEALTH FUND, TIME FOR CHANGE: THE HIDDEN COST OF A FRAGMENTED HEALTH INSURANCE SYSTEM, Chart No. 3 (Document No. 622) at http://www.cmf.org/programs/insurance/davissenatecommittee testimony_622.pdf (Mar. 10, 2003) [hereinafter TIME FOR CHANGE: THE HIDDEN COST OF A FRAGMENTED HEALTH INSURANCE SYSTEM].

10. INSTITUTE OF MEDICINE, SUMMARY OF A SHARED DESTINY: EFFECTS OF UNINSURANCE ON INDIVIDUALS, FAMILIES AND COMMUNITIES (Mar. 2003) at [http://www.iom.edu/iom/iomhome.nsf/Wfiles/Uninsured4final/\\$file/Uninsured4final.pdf](http://www.iom.edu/iom/iomhome.nsf/Wfiles/Uninsured4final/$file/Uninsured4final.pdf) [hereinafter A SHARED DESTINY].

11. S. COLLINS, ET AL., THE COMMONWEALTH FUND, ON THE EDGE: THE HEALTH INSURANCE COVERAGE OF LOW-WAGE WORKERS FINDINGS FROM THE 2001 COMMONWEALTH FUND HEALTH INSURANCE SURVEY (forthcoming, on file with author).

12. A SHARED DESTINY, *supra* note 10.

13. TIME FOR CHANGE: THE HIDDEN COST OF A FRAGMENTED HEALTH INSURANCE SYSTEM, *supra* note 9.

Initially, health insurance was strictly indemnity insurance that reimbursed providers of health care on the basis of services rendered to the employee-patient. Employers contracted with non-profit insurers like Blue Cross/Blue Shield that were required by law to offer insurance for premiums that were community rated as opposed to being experience rated or individually underwritten.¹⁴ Community rating requires that the entire community, however defined, be rated by the insurer as a whole with all participants charged roughly the same premium for their health insurance regardless of their personal health status and risk. The benefit of community rating to the insured is that it generates lower premiums, particularly for high users of health care, because of the effect of large numbers on the probability that the insured risk will occur in any one member of the community. Premiums paid by those who do not incur health care costs subsidize the costs of those with a greater need for health care.

This cross-subsidization has a social insurance effect on health insurance in that the cost of the insurance is, to a great extent, delinked from the cost of care. Those members of a community rated insurance pool with a demand for health care due to acute or chronic health conditions in excess of their insurance premiums will have their health care costs subsidized by those whose demand for health care is less than their insurance premiums. Cross-subsidization is at the core of what Professor Deborah Stone calls a mutual aid system, a community whose members share a definition of the legitimate reasons for the redistribution of goods and services.¹⁵ In a mutual aid system, the members agree in what circumstances and to whom people should give up something of their own and offer help. Although there is often disagreement over what circumstances trigger redistribution, in most societies sickness is just such a circumstance.¹⁶

In the United States, however, many policymakers, who Professor Uwe Reinhardt identifies as belonging, in the main, to the insured elite, believe that "rationing by price and ability to pay actually serves a greater national purpose" by controlling the overuse of health care and the concomitant cost.¹⁷ Citing Richard Epstein as a respected academic whose views on the distribution of health care both reflect and bolster the views of the policy-making elite, Professor Reinhardt quotes from an Epstein editorial published in the *New York Times*: "We could do better with less regulation and less subsidy. Scarcity matters, even in health care."¹⁸ Professor Epstein represents the view that health care is a commodity and that access to it should be

14. See *infra* notes 32-34 and accompanying text.

15. Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL'Y & L. 287, 289 (1993).

16. *Id.*

17. Uwe E. Reinhardt, Commentary, *Wanted: A Clearly Articulated Social Ethic for American Health Care*, 278 J. AM. MED. ASS'N 1446 (1997).

18. *Id.* (quoting Richard A. Epstein, Letter to the Editor, *Healthcare Law Shows Big Government Lives*, N.Y. TIMES, Aug. 10, 1997, § 4 (Magazine), at 14).

controlled by the free market even if that means that as the cost of health care rises, so do the ranks of those without access to health care. Admittedly, subsidization of the kind advocated by Professors Reinhardt and Stone, where resources are allocated to those in need without the ability to pay is likely to result in a slower growth of national material wealth.¹⁹ The real struggle of health care in the United States is that policymaking is caught in a clash of ideological values: universal access versus wealth rationed access. Each ideology has its benefits and burdens to which a society must be committed. Where the commitment has not been made, as in the United States, exogenous factors can exert an enormous influence on policymaking.

One of the commonly accepted burdens of universal access is cost²⁰ so that when health care costs rise, the policy pendulum tends to swing in the direction of wealth rationed health care. The 1970s and 1980s saw an explosion of health care costs driven by increasingly more sophisticated technologies, higher cost treatments, increases in the numbers and costs of prescription drugs, and overuse of the health care system due to perverse incentives in both the health insurance and reimbursement schemes. In 1980, the United States spent \$600 billion on health care; estimates are that we spent \$1.5 trillion in 2002, approximately 14.5% of GDP.²¹ Health insurance premiums grew correlatively. Initially, the brunt of these increases was felt by employers who had been providing health benefits in the form of insurance premiums threatening the viability of the private health insurance paradigm. The change from a service reimbursement model to a managed care model was intended to promote competition in health insurance and induce providers to not inappropriately overuse health care. Those who could provide health care most efficiently, both from the standpoint of cost and, presumably quality would prevail in a competitive marketplace because of employers' economic incentives.

Once a competitive marketplace in health insurance arose, participating health plans naturally wanted to compete profitably. In order to do this, plans began experience rating their insurance pools, i.e., rating on the basis of risk experience, rather than using community rating.²² Because plans were not permitted to individually underwrite health insurance policies, they relied on a number of proxies for risk such as age and socioeconomic status, as well as past actual health care usage. Experience rating provided an incentive for the health plans to attract the healthiest populations that would utilize the least

19. *Id.* at 1447.

20. See *infra* notes 38-42 and accompanying text.

21. Stephen Heffler et al., *Health Spending Projections for 2002-2012*, HEALTH AFF., Mar.-Apr. 2003, <http://www.healthaffairs.org/WebExclusives/2202Heffler.pdf> (Feb. 7, 2003).

22. Community rated health insurance is the centerpiece of almost every proposal for increasing access to health care. This is true whether the reform envisions a single-payer or a competitive marketplace. The community rate is defined as the rate charged by a competitive insurer for a person of average risk for a standardized benefits package. John F. Holahan, Len M. Nichols & Linda J. Blumberg, *Expanding Health Insurance Coverage*, in URBAN INSTITUTE, COVERING AM.—REAL REMEDIES FOR THE UNINSURED, 103 (June 1, 2002).

amount of health care leaving the sickest populations to some other plan.²³ The generally more favorable treatment accorded to self-funded employee benefit plans by ERISA (the Employee Retirement Insurance Security Act), motivated many large employers to take themselves out of the health insurance community, another adverse selection phenomenon that has caused insurance premiums to employers who are not self-funded to rise.²⁴

What happens when an insurance marketplace becomes competitive is that insurers are motivated to increasingly segment the pool of insureds in order to match health insurance premiums to the risk of health care use. Many employers who had borne much of the cost of health insurance in the past have either elected not to provide their employees with health insurance or to shift the cost of the insurance to the employee. The irony of this segmentation in a health insurance marketplace is that those individuals who most need health insurance, i.e., the chronically ill or those with pre-existing conditions, may be locked out of the market because they simply cannot afford the cost.²⁵ This so-called “actuarial fairness” model²⁶ makes complete sense for the competitive insurer whose economic interest is best served by excluding individuals with a high probability of high usage of health care. It also makes sense for the insured elite, i.e., those persons who can afford the increasingly higher cost or share of cost of health care.²⁷ But the logic and methods of actuarial fairness mean denying insurance to those who most

23. For example, a health plan might offer a set of benefits that more heavily reimburse preventive care over prolonged hospital stays on the theory that healthier individuals, rather than sicker individuals, are more likely to enroll in such a plan. This so-called adverse selection means that the sicker populations are more likely to select a plan that emphasizes hospital stays or expensive and more frequent medical treatments. The latter plan is more likely to incur greater costs than the former and be less profitable; in order to be profitable, it must raise its premium costs pricing certain segments of the unhealthy population out of the insurance market.

24. ERISA, the federal law regulating employee benefits including health benefits, permits employers to avoid state insurance premium taxes, state benefits mandates and other special taxes used to subsidize uncompensated care and high-risk pools. Self-insured plans need not hold reserves or meet solvency standards and, under ERISA, workers have less recourse to redress grievances about plan administration. Robert A. Berenson, *Beyond Competition*, HEALTH AFF., Mar. -Apr. 1997, at 171-72 at <http://www.healthaffairs.org/reader-agent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v16n2/s23.pdf>.

25. While it certainly is true that choosing to purchase health insurance with available income is an exercise of individual preferences, it is also true that preference is constrained by income. Those with limited incomes may not have a real choice with regard to health insurance, however much they might choose to have such insurance. The 12/3/02 TOTN was on the rising numbers of uninsured in America and quoted the statistic that the average cost of health insurance to a family of four in 2002 is \$8,000.

26. See generally Stone, *supra* note 15, at 287.

27. In an actuarial fairness model, the cost of health insurance is directly linked to health care usage. For those participants whose risk of usage is high, the cost of procuring health insurance will be high. But for those whose health care usage risk is low, the cost of health insurance will be correlatively low.

need medical care; therefore the consequences to individuals who are priced out of the group market may be grave.²⁸

Left outside an insurance pool, their choices are very limited. In most states, insurers are permitted to medically underwrite persons applying for individual health insurance. While very few Americans are truly uninsurable because of their health condition or history, a 2001 Henry J. Kaiser Family Foundation study of medical underwriting practices suggests that many Americans with only mild health problems are turned down by health insurers.²⁹ For those who qualify for individual health insurance, the premiums will be higher and the coverage more meager than comparable group insurance.

Rochester, New York, a community cited in 1992 by then-President Clinton, as a model of health care is a cogent example of how universal access to health care can be impacted when a community's health insurance market becomes competitive and insurance risk pools become segmented. In 1992, Rochester was acknowledged to have a much more cost-effective health care system with substantially lower costs, better insurance coverage, and much better access to care than in the rest of the country.³⁰ Rochester's remarkable success was the result, in large part, of the cooperation among the most important players in the health insurance and delivery scheme: Rochester's big employers, its dominant insurer (Blue Cross, Blue Shield of Rochester) and its provider community. Instead of segmenting the insurance market on an actuarial fairness model, Rochester developed a so-called uniform or all-payer system that prevented the cream-skimming and adverse selection in insurance coverage.³¹

Then Eastman Kodak, the largest employer in Rochester, elected the ERISA option of self-funding its group health insurance benefit and withdrew from the community insurance pool taking with it tens of thousands of healthy young employees. As *City Newspaper's* columnist Joan Collins Lambert put it, "Kodak had broken the all-for-one, one-for-all approach to health care in favor of an each-man-for-himself philosophy."³² While Rochester's record on health care is still exemplary relative to the rest of the country, some feel that there is reason to fear that Rochester's much-acknowledged managed cooperation health care model is at risk. Humphrey

28. *Id.* at 308.

29. Karen Pollitz & Richard Sorian, *Ensuring Health Security: Is the Individual Market Ready for Prime Time*, HEALTH AFF., Oct. 23, 2002 <http://www.healthaffairs.org/WebExclusives/2106Pollitz.pdf>.

30. HarrisInteractive, *Rochester, NY Health Care System Still a Model for Success* (Mar. 27, 2001) available at <http://www.Harrisinteractive.com/news/allnewsbydate.asp?NewsID=256>.

31. *Id.*

32. FIRST UNITARIAN CHURCH OF ROCHESTER, IS HEALTH CARE A COMMODITY? IS EVERYTHING FOR SALE? <http://www.rochesterunitarian.org/1999-2000/20000326.html> (quoting Joan Collins Lambert, *Can This Health Care System be Saved?* CITY NEWSPAPER, July 7-13, 1999, at 8).

Taylor, chairman of *The Harris Poll*, HarrisInteractive, has commented, “If they behave as they are beginning to, more like the rest of the nation, health care in Rochester may look much more like health care elsewhere—i.e. more uninsured, higher costs, and greater dissatisfaction.”³³

More recently, the growing backlash against managed care has contributed to the rise in the cost of health insurance. Health plans afraid of losing business because of public perceptions that they are engaged in so-called health care rationing, have decided to loosen the reins of utilization review and allow patients independent access to specialists and specialist care. This concession to “customer satisfaction” is likely to be expensive to the health plan and will not come without a correlative cost in the form of an increased premium. In addition, the issue of health care quality is undergoing a quiet but persistent revolution.³⁴ There is empirical evidence to suggest that poor quality, most particularly institutional quality health care leads to “at least 44,000 and perhaps as many as 98,000 deaths per year.”³⁵ The cost of “cleaning up the system” is estimated to be “between \$17 and \$29 billion” annually, a cost that will translate into higher costs of care that will eventually reach the consumer in the form of higher health insurance premiums.³⁶ One of the arguments in favor of retaining the existing competitive, multi-payer system is that, although expensive,³⁷ the health care system in the United States is the best in the world. In 2002, the estimated cost per capita for health care was \$5,427 with the government’s share being \$3,245.³⁸ In 1998, the cost of health care in the United States was more than twice as much measured both per capita and as a percentage of GDP than the Organization for Economic Cooperation and Development (“OECD”) median and far more than its closest competitor, Switzerland.³⁹ So it is clear that far more money is spent on health care in the United States than in any other industrialized country. A cogent question is: what is the *quid pro quo* for this large expenditure of GDP? Much depends on agreement as to what constitutes a good health care system. A system that is rated only by those with affordable access to it will value measurements such as quality of care, the good health of its population, ease of use, and technological capability.

33. *Rochester, NY Health Care System Still a Model for Success*, *supra* note 30, at 3.

34. See INSTITUTE OF MEDICINE REPORT BRIEF, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Nov. 1999) at http://books.nap.edu/html/to_err_is_human/reportbrief.pdf.

35. *Id.* at 1.

36. *Id.*

37. In 2002, \$110 billion was devoted to health insurance administrative costs alone. TIME FOR CHANGE: THE HIDDEN COST OF A FRAGMENTED HEALTH INSURANCE SYSTEM, *supra* note 9, at 17.

38. See BUREAU OF LABOR EDUCATION OF THE UNIVERSITY OF MAINE, THE U.S. HEALTH CARE SYSTEM: BEST IN THE WORLD, OR JUST THE MOST EXPENSIVE?, at 2 n.4 available at <http://dll.umaine.edu/ble/U.S.%20HCweb.pdf> (Summer 2001) (citing OECD, *OECD Health Data 2000: A Comparative Analysis of Twenty-nine Countries* (Paris: IECD, 2000)).

39. *Id.* at 3, figure 1.

For those to whom access is effectively denied because of lack of affordability, these measurements mean little.

Certainly one could argue that the measurements of a good health care system must look also to overall good health, i.e., the health of all citizens, a fair distribution of good health, a fair distribution of responsiveness across population groups, and a fair distribution of financing health care.⁴⁰ A health care system that excludes a significant percentage of the population arguably should not be considered good and certainly cannot be considered fair. And yet the United States' health care system, the most expensive in the world, excludes approximately 43 million people by making access to health care a function of price and income.⁴¹

The result of a system that excludes 43 million people completely and at least another 20 million sometime during the year is just as one might expect. While the insured are generally entitled to excellent care, the uninsured lack access to a full range of preventive, chronic and acute care services that are an important predicate of better health and longer life.⁴² Access to good and consistent health care has not only individual effects, but family and community effects as well. The effect of a serious illness for one member of an insured family is severe, to be sure, but is not as likely to have serious economic consequences to the whole family as the same event in an uninsured family. Uninsured families, who pay more than 40% of their medical costs by themselves, tend to use far fewer health services, often waiting until a crisis occurs. While such behavior may save money in the short run, the long-term costs of serious illness can be far greater.⁴³ A recent study estimates that an uninsured individual's earnings are 15-20% lower than a comparable insured individual because of decreased productivity due to illness.⁴⁴ Lowered productivity inures, of course, to the detriment of employers whose productivity is also adversely affected. The ill effects of lack of access to health care ripples from individuals to families to societies.

A related and equally serious issue is the cost of uncompensated care. When an uninsured person or family cannot pay for expensive emergency health care, who picks up the cost of care? The answer is, of course, that we

40. *Id.* at 1. See also WORLD HEALTH ORGANIZATION, THE WORLD HEALTH REPORT 2000—HEALTH SYSTEMS: IMPROVING PERFORMANCE (Geneva: WHO, 2000).

41. It has been argued that emergency care is available even to those outside the system through federal legislation such as the EMTALA (Emergency Medical Treatment and Labor Act) which requires that all hospitals with emergency departments provide a modicum of care (diagnosis and stabilizing) to any person regardless of health insurance status. Providers who used to subsidize care for the uninsured through higher payments from the insured or otherwise paying patient population have lost the wherewithal to do so because of harder bargaining by health plans which leave providers little overage with which to subsidize.

42. INSTITUTE OF MEDICINE REPORT BRIEF, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE (May 2002) at http://books.nap.edu/html/care_without/reportbrief.pdf.

43. A SHARED DESTINY, *supra* note 10.

44. JACK HADLEY, KAISER COMMISSION ON MEDICAID & THE UNINSURED, SICKER AND POORER: THE CONSEQUENCES OF BEING UNINSURED (2002) available at <http://www.kff.org/content/2002/20020510/4004.pdf> (May 2002), at 1, 81-82, 84-85.

all do. As the Institute of Medicine report on the effects of uninsurance states, "The unreimbursed costs of caring for uninsured Americans are ultimately paid for by higher taxes and higher prices for services and insurance. Local communities tend to bear the main economic burden of subsidizing service delivery, while the costs of public insurance are more broadly spread across state and federal budgets."⁴⁵ However, as the federal and state budget surpluses of the last decade of the 20th century give way to the budget deficits of the first decade of the 21st century, this subsidy cushion is quickly disappearing. In 2001, the cost to the system of caring for the uninsured is estimated to have been \$40.6 billion, \$24 billion of which was borne by providers.⁴⁶ When providers are uncompensated, they often reduce access to services such as "clinic-based primary care, specialty health services, and hospital-based care, particularly emergency medical services and trauma care, [which] may also result in lessened availability of other primary and preventive care and the closure or privatization of community hospitals."⁴⁷

Covering the costs of uncompensated care is but one example of how a fragmented health insurance system shifts the cost of care. As Karen Davis, economist and president of The Commonwealth Fund, explains, in a multi-payer system, there are many paths to health care coverage: employer-based coverage which accounts for 160 million people, public health insurance programs like Medicare (39 million people) and Medicaid (40 million people), and individual health insurance plans that provide coverage for about 15 million people.⁴⁸ As health care costs rise, it is in the interest of any payer to shift the cost of care to someone else; in a multi-payer system, "passing the buck" is both possible and desirable. Passing the buck is exactly what employers who shift the cost of health insurance to their employees are doing. Employees who either choose not to or cannot pick up the additional cost share become part of the growing numbers of uninsured Americans.

A fragmented health insurance system where passing the buck is the name of the game increases the probability of adverse consequences to individuals, families and society in the form of higher administrative costs, more uncompensated care, and greater numbers of uninsured individuals. The state of the health insurance system and indeed, the health care system in America today is, in large part, the result of the choice, whether conscious or negligent, to ration health care by price and wealth. As Professor Deborah Stone notes, a long-standing public policy that has encouraged competition and a market economy has "so deeply embedded" the principle of actuarial fairness in the health insurance structure that it will be harder than one might

45. A SHARED DESTINY, *supra* note 10.

46. Jack Hadley & John Holahan, *How Much Medical Care Do the Uninsured Use, and Who Pays for it?* HEALTH AFF., at <http://www.healthaffairs.org/WebExclusives/2202Hadley.pdf> (Feb. 12, 2003).

47. A SHARED DESTINY, *supra* note 10.

48. TIME FOR CHANGE: THE HIDDEN COST OF A FRAGMENTED HEALTH INSURANCE SYSTEM, *supra* note 9.

suppose to eradicate it.⁴⁹ Since the ideology of subsidization runs exactly counter to the principle of actuarial fairness, it is difficult to imagine that universal coverage could be realized. But a confluence of forces, many of which have been discussed, may create a “perfect storm” strong enough to overcome the inertial resistance of the status quo.⁵⁰

II. COME THE REVOLUTION?

In a recent commentary in the *Journal of the American Medical Association*, Professor Uwe Reinhardt baldly illustrates the ideological debate of American health care by choosing the hardest case. “As a matter of national policy, and to the extent that a nation’s health system can make it possible, should the child of a poor American family have the same chance of avoiding preventable illness or of being cured from a given illness as does the child of a rich American family?”⁵¹ Framing the issue of affordable access to health care this starkly should force us to directly confront the moral, equitable and social components of health care. And while it would be socially irresponsible and politically impossible to ignore the financial impact of saying yes to Professor Reinhardt’s question, is it not equally socially irresponsible and even politically immoral to say no?

Since the publication of Professor Reinhardt’s commentary, the numbers of Americans excluded from affordable health care has grown to include, as John Broder’s *New York Times* article illustrates, the working middle class. While that change makes Professor Reinhardt’s access to affordable health care dilemma somewhat less morally shocking, as a matter of class warfare it makes it eminently more politically exigent. When members of a more politically powerful group suffer a diminution in access to health care, they are more likely to experience the loss as one of a perceived preexisting right.⁵² The irony is that there has never been a political consensus in the United States about the status of health care as a right of citizenship or a market commodity.⁵³ Nonetheless, it is not unlikely that the middle class will experience the loss of it as the loss of a right. The more relevant question to health care policy is whether the fear that their health and the

49. Stone, *supra* note 15, at 313.

50. JOEL E. MILLER, NAT’L COALITION ON HEALTH CARE, A PERFECT STORM: THE CONFLUENCE OF FORCES AFFECTING HEALTH CARE COVERAGE, (Nov. 2001) at <http://www.nchc.org/APerfectStorm.pdf>.

51. Reinhardt, *supra* note 17, at 446.

52. The tendency of Americans to frame social issues in terms of individual rights has engendered a growing body of literature. Professor Mary Ann Glendon persuasively argues that rights talk elevates the interests of individuals over the interests of communities and, in so doing, impoverishes political discourse about societal values. “A kind of blind spot seems to float across our political vision where the communal and social, as distinct from individual or strictly economic, dimensions of a problem are concerned.” MARY ANN GLENDON, RIGHTS TALK: THE IMPOVERISHMENT OF POLITICAL DISCOURSE 112 (The Free Press, 1991) (1993).

53. Stone, *supra* note 15, at 288.

health of their families will be compromised and their indignation at the loss of a perceived right will translate into political power sufficient to change the status quo.

There is, to the extent possible, at a time when the United States is waging an expensive war on terror and governments at all levels are experiencing severe budget deficits, a surprisingly broad coalition weighing in on the future of health care. This coalition ranges from the Bush Administration's support of a market-based Medicare prescription drug benefit that would inure only to Medicare beneficiaries who participate in Medicare+Choice,⁵⁴ to a multitude of initiatives supporting some form of a universal health insurance,⁵⁵ two proposals that are on opposite ends of the health care ideological spectrum. Although the universal health insurance proposals differ, some of them radically with regard to how to get the job done, the unifying principle of all these movements is inclusiveness. "Affordable health care for all" is the rallying cry.⁵⁶ The mandate with seemingly the greatest momentum and the broadest appeal is a change from a multi-payer to a single-payer system, based on what appears to be compelling evidence that the administrative and other non-health care costs of a multiple payer system are crippling, unproductive and unnecessary.⁵⁷

An ironic consequence of the momentum in favor of a single-payer system is that the multiple player constituency, most particularly private insurers, has joined the ranks of those in favor of extending coverage to as many as possible. A recent article in the Business Section of the *New York Times* entitled "Some Tentative First Steps Toward Universal Health Care" describes not single-payer legislation, but rather steps that the private health insurers, fearful that mounting numbers of uninsured will inevitably lead to

54. The Balanced Budget Act of 1997 added a Part C, Medicare+Choice, to Medicare in order to expand the choices of Medicare beneficiaries beyond traditional Medicare indemnity insurance to various managed care options. The impetus for this legislation was the increasing cost burden to the federal government of insuring the health care of Americans age 65 and older. Medicare+Choice was intended to shift the burden of senior health insurance from the public to the private sector.

55. The groups supporting some form of universal health insurance range from physician groups to various states single payer movements to private health insurers like Blue Cross.

56. A measure of the broad base of this movement is the recent *Cover the Uninsured Week* sponsored by the Robert Wood Johnson Foundation generated a significant amount of optimism from all parts of the ideological spectrum. Columnist David Broder of the *Washington Post* writes that while the struggle to "reach agreement" on any significant health care legislation "so far has yielded more frustration than results," *Cover the Uninsured Week* "did not try to define a solution. . . their message was that this is a problem that cannot be ignored." David S. Broder, Editorial, *Health Care Hopes*, WASH. POST.COM, Mar. 16, 2003, at B7 at www.washingtonpost.com/ac2/wp-dyn?pagename=article&node=&contentId=A27802-2003Mar14¬found=true.

57. "The Congressional Budget Office projects that a national single-payer system would reduce overall health costs by \$225 billion by 2004 despite the expansion of comprehensive care to all Americans." PHYSICIANS FOR A NATIONAL HEALTH PROGRAM (PNHP), SINGLE-PAYER FACT SHEET at http://www.pnhp.org/hcinfo/?go=single_payer (last visited May 4, 2003).

single-payer legislation that will threaten the continued viability of the private insurance market, are taking to maintain the status quo.⁵⁸ Some health insurers are developing products with slimmer coverage and lower premiums; others are pressing state legislators to raise the cigarette tax to subsidize basic coverage. “Dr. William W. McGuire, chief executive of the UnitedHealthGroup, the largest private insurer, has written to every member of Congress calling for ‘essential health care for all Americans.’”⁵⁹

While the private sector certainly is seeking a public relations bonanza by endorsing a more comprehensive approach to access to health care, its business interests are advanced by its advocacy of universal coverage. Rising health insurance premiums and a shift from employers to employees means that more people, often the young and healthy, who gamble on their lower probability of illness, are dropping health insurance as an employee benefit leaving the older, sicker (and wealthier) in the risk pool. This adverse selection means that the risk pool is not as broad as it once was and increases the potential of higher costs to health plans creating an ever-increasing need to raise the cost of premiums. All of the plans advocated by the private health insurance sector seek to bring the younger and healthier back into the risk pool thereby reversing the adverse selection phenomenon. “If we don’t do something in a darn hurry about the uninsured, the whole health care system in this country is going to collapse and the government will step in,” said Chuck Butler, a vice president of Blue Cross Blue Shield of Montana.⁶⁰

The last time momentum built for universal coverage was during the late 1980s and 1990s when similar forces existed. The numbers of uninsured steadily increased during the 1980s and the 1990-1991 economic recession caused consumers to worry about the risks of losing coverage.⁶¹ Then, as today, rising health care costs caused concern among employers, particularly small employers, about the cost of employee benefits. Former university president and Democrat, Harris Wofford’s wholly unexpected 1991 triumph over Republican Richard Thornburg, a two-time former governor of Pennsylvania, to fill the Pennsylvania Senate seat vacated by the untimely death of Republican John Heinz, epitomized the changing political climate.⁶² Wofford was so impressed with the importance of ensuring all Americans access to affordable health care that the tag line for his campaign was: “[i]f criminals have the right to a lawyer, I think working Americans should have the

58. Milt Freudenheim, N.Y. TIMES, *Some Tentative First Steps Toward Universal Health Care*, Dec. 7, 2002, at C1.

59. *Id.*

60. *Id.*

61. Linda T. Bilheimer & David C. Colby, *Expanding Coverage: Reflections on Recent Efforts*, HEALTH AFF., Jan.-Feb. 2001, at 83 available at 2001 WL 10696847.

62. Dale Russakof, *How Wofford Rode Healthcare to Washington*, WASH. POST. (Weekly Ed.), Nov. 25-Dec. 1, 1991, at 14, 15.

right to a doctor.”⁶³ Bill Clinton and the Democrats rode to victory in 1992 partly on the wave of comprehensive health reform.

When the Clinton pay-or-play Health Security Act⁶⁴ was defeated in 1994, the states undertook the task of expanding health insurance coverage to more at-risk populations. Some states took advantage of options provided by the federal government to expand Medicaid coverage to more adults. The enactment of SCHIP (State Children’s Health Insurance Program) in 1997, in which all states are currently participating, provided extended coverage for previously uninsured children who, in 1995 made up a full 25% of uninsured Americans.⁶⁵ But today, staggering state budget deficits already threaten to unravel the public health insurance safety net created by the states over the past seven or so years. Although the rise in the numbers of uninsured Americans in 2002 was due to loss of private insurance, in the coming year, public coverage is likely to erode as states seek to cut budget deficits by restricting public insurance programs such as Medicaid and SCHIP.⁶⁶

So the traditional impetuses for universal or at least more comprehensive health insurance coverage exist again today. Of course, the other side of the universal coverage coin is the public cost of providing this coverage that continues to increase as more and more Americans lose their private health insurance. If universal coverage will require, as it surely will, an increase in public subsidies as well as increases in private cross-subsidization, it will be a hard sell to a voting polity, the majority of whom are currently insured, and therefore not likely to immediately benefit from universal coverage. And given the predilection of the current administration to spend money abroad rather than fund social programs at home,⁶⁷ it would be a real turn-about for the administration to be amenable to a publicly subsidized universal health insurance program. There are, however, a number of vocal and powerful members of the current health care system who argue that the so-called pri-

63. HAYNES JOHNSON & DAVID BRODER, *THE SYSTEM: THE AMERICAN WAY OF POLITICS AT THE BREAKING POINT* 601 (Little, Brown, & Co. 1996).

64. The Health Security Act, built on a preexisting employment-based structure, pay-or-play, required employers to provide health insurance to their employees or pay into a fund that would provide health insurance to employees. A similar employer pay-or-play approach forms the basis for SB2, a comprehensive health insurance bill sponsored by CA state senator John Burton (D).

65. EMPLOYEE BENEFIT RESEARCH INSTITUTE, *ISSUE BRIEF NO. 179 SOURCES OF HEALTH AND THE CHARACTERISTICS OF THE UNINSURED: ANALYSIS OF THE MARCH 1996 CURRENT POPULATION SURVEY* (Nov. 1996).

66. *TIME FOR CHANGE: THE HIDDEN COST OF A FRAGMENTED HEALTH INSURANCE SYSTEM*, *supra* note 9, at 5.

67. As noted above, President Bush asked Congress to supplement the 2003 federal budget by, at least initially, \$74.7 billion to pay for the war in Iraq. Congress already approved the President’s \$760 billion 10-year tax cut. The projected budget deficit for 2003 hovers around \$400 billion. Given this administration’s preference for private market solutions to public problems, the likelihood of appropriating public money to fund the cost of universal access to health care seems remote.

vate health care system in the United States is really a mixed system in which the government already plays a prominent role.⁶⁸

Drs. Steffie Woolhandler and David Himmelstein, both associate professors of medicine at Harvard Medical School and founders of Physicians for a National Health Program,⁶⁹ a nationwide group with more than 9,000 members, have written extensively to demonstrate that the cost to the government of funding national health insurance would not be nearly as great as most Americans believe. While the direct spending by the government is above the radar screen,⁷⁰ approximately 15% more of current health care spending is below the radar screen in the form of health care related tax subsidies and public employees' health benefits.⁷¹ The result, they estimate, is that a full 60% of current spending on health in the United States is already subsidized by taxes.⁷² For example, while employer payments to health insurers and providers on behalf of their employees are popularly characterized as "private," these payments are subsidized by taxes and are therefore more properly attributable to both private and public financing. Employers deduct, as a business expense, payments made as part of an employee benefits plan and, correlatively, employees are not required to recognize such payments as income. When the government grants these tax preferences to insured individuals, it either redistributes economic privilege or income from other taxpayers. The argument is that these redistributions are a form of "tax financing" on behalf of individuals who are so-called privately insured.⁷³

68. Jonathan Oberlander, *Perspective: Are Americans Closer Than We Think to National Health Insurance?* HEALTH AFF., July-Aug. 2002 at 103 available at 2002 WL 12361292.

69. Physicians for a National Health Program (PNHP) "is a not-for-profit organization of physicians, medical students, and other health care professionals that support a national health insurance program." The organization advocates in favor of "a single-payer system (where the government finances health care, but keeps the delivery of health care in mostly private control) [as] the only solution to solving the United States' many health care problems" including the problem of "43 million uninsured Americans, skyrocketing health insurance premiums," "and relatively poor health indicators compared to similar industrialized nations." PHYSICIANS FOR A NAT'L HEALTH PROG., HOME PAGE, at <http://www.pnhp.org/>. The list of PNHP members reads like a "Who's Who in American Medicine."

70. In 1999, the Centers for Medicare and Medicaid Services estimated that that the government's share of health spending in the United States was 45.3 percent. CENTERS FOR MEDICARE AND MEDICAID SERVICES, NATIONAL HEALTH EXPENDITURES BY TYPE OF SERVICE AND SOURCE OF FUNDS: CALENDAR YEARS 1960-99, available at www.hcfa.gov/stats/nhe-oact/tables/nhe99.csv (Nov. 12, 2001).

71. Steffie Woolhandler & David U. Himmelstein, *Paying for National Health Insurance—and Not Getting it*, HEALTH AFF., July-Aug. 2002 at 88 available at 2002 WL 12361289.

72. Tax-financed health spending in the United States now exceeds total spending on medical care in all countries except Switzerland.

73. The authors use the example of an employer who pays \$6,000 toward an employee's health insurance premium or cost of care. Since the employee is not required to recognize the \$6,000, she saves \$2779 in taxes. If the government wishes to balance its budget, it must make up for this loss of revenue either by reducing its spending on other programs to the detriment of the beneficiaries of that program, or alternatively, raising the taxes of other taxpayers. Woolhandler & Himmelstein, *supra* note 71.

Drs. Woolhandler and Himmelstein argue that the enormous cost of administering a multi-payer system is added to the already publicly subsidized health spending, the costs of universal health insurance may be less than taxpayers, fearful of huge tax increases, might expect. Even skeptics of national health insurance agree that "U.S. health care costs need not rise under national health insurance because administrative savings would roughly offset the increased costs of care for today's uninsured and underinsured persons."⁷⁴ Drs. Woolhandler and Himmelstein estimate that the cost to the government of getting us from here to there would be approximately \$130,000 billion per year, the amount of the current employee tax exclusion.⁷⁵ So if Drs. Woolhandler and Himmelstein are right, why aren't we already there?

Professor Jonathan Oberlander, a professor of social medicine at University of North Carolina Medical School, says that even though the 60% public share of health spending in the United States is within sight of the 70% public share of health spending subsidized by the Canadian government to maintain its single-payer health system, the likelihood of closing that 10% gap and realizing a single-payer universal health insurance system in the United States is small. He believes that the divide between the economic significance of raising taxes and the political significance of raising taxes will halt the progress of national health insurance in its tracks. "Raising income or payroll taxes to fund national health insurance imposes a visible cost on Americans, a cost that so far taxpayers have shown little willingness to fund."⁷⁶ This statement illustrates, as clearly as any can, the philosophical "struggle for the soul of health insurance" in America.⁷⁷ Can insured Americans agree that access to health care is a basic right to which we are all entitled regardless of income, employment, or health status and, more importantly, agree to directly subsidize the cost of that right through increased taxes? Professor Oberlander says no, at least not yet. So if national health insurance is not yet ready for prime time, are there other ways to increase the inclusiveness of access to health care?

A recent Robert Wood Johnson Foundation initiative, "Covering America," asked prominent experts in health policy to analyze the various options for expanding health insurance coverage. Urban Institute researchers more fully developed two of the ten proposals submitted to the "Covering America" initiative. One of the proposals, "Expanding Health Insurance Coverage," builds on the existing federal/state Medicaid and SCHIP structures but provides more generous federal funding. The second developed proposal,

74. J.F. SHEILS & R. A. HAUGHT, THE VERMONT HRSA STATE FUNDING GRANT, OFFICE OF VERMONT HEALTH ACCESS, ANALYSIS OF THE COSTS AND IMPACT OF UNIVERSAL HEALTH CARE COVERAGE UNDER A SINGLE PAYER MODEL FOR THE STATE OF VERMONT (Lewin Group, Aug. 2001) available at <http://www.dsw.state.vt.us/districts/ovha/AnalysoftheCosts.pdf>.

75. Woolhandler & Himmelstein, *supra* note 71.

76. *Are Americans Closer Than We Think to National Health Insurance?*, *supra* note 68.

77. Stone, *supra* note 15.

crafted by Alan Weil,⁷⁸ an Urban Institute researcher, is entitled “The Medical Security System: A Proposal to Ensure Health Insurance Coverage for All Americans” (the “MSS”).⁷⁹

The MSS Plan, like Drs. Woolhandler and Himmelstein’s, proposes converting the current employee tax exclusion to a new payroll tax that would be used to fund basic health insurance for all employed people and their dependents. Like the current Social Security and Medicare payroll tax, the payroll tax used to fund the MSS would be shared by employers and employees.⁸⁰ Employers could opt out of the payroll tax by continuing to provide and pay a significant portion of health insurance premiums for their employees.⁸¹ Other funding sources, such as the funds currently allocated to Medicaid’s low-income and adult component and the SCHIP program, would be available to fund health insurance for the unemployed.

Although the financing and universal access components of the two proposals are similar, the proposals are different operationally. Drs. Woolhandler and Himmelstein as well as Physicians for a National Health Program (PNHP) endorse an American national health insurance in the Canadian single-payer style. This universal health insurance program would be an expansion of the current Medicare program and, like Medicare, would guarantee all Americans a basic health benefits package. As it does with the current Medicare program, Congress would appropriate amounts for the program’s annual budget to include payments for providers, both physicians and institutions, capitation payments to health plans and administrative expenses. While the financing, pricing, reimbursement and administrative aspects of this national health insurance system would be public, the provision of care would remain in the hands of the private sector.

Under the Medical Security System, all Americans under the age of 65 who do not have access to health insurance through their employers would be eligible for a no-cost basic benefits health plan and could purchase higher-cost coverage if they chose. Unlike the American national health insurance plan, the MSS does not dismantle the current Medicare system but rather operates alongside it. The MSS would operate using managed competition principles⁸² through health insurance exchanges that serve to organize

78. Alan R. Weil, J.D., M.P.P., is Director of the Assessing the New Federalism project at the Urban Institute.

79. Alan R. Weil, *The Medical Security System: A Proposal to Ensure Health Insurance Coverage for All Americans*, in URBAN INSTITUTE, COVERING AM.—REAL REMEDIES FOR THE UNINSURED 175 (July 1, 2002).

80. Weil suggests that an employer contribution of 7.7% and an employee contribution of 3.3% of the Social Security wage base would generate approximately the amount spent on private insurance premiums and would distribute the costs between employers and employees in accordance with the national average contributions for family coverage. *Id.*

81. This type of financing structure was known as “pay-or-play” in the Clinton Health Security Act.

82. Managed competition is a market-oriented approach to health care reform which focuses on correcting the asymmetry of the health insurance market by creating so-called

the health insurance market.⁸³ Exchanges themselves would not bear insurance risk, but would contract with private licensed health plans that would be required to offer health insurance at community rates. Exchanges would not be permitted to refuse to enroll any eligible person, defined as any resident within the geographic area that the exchange serves.⁸⁴ Enrollees would be eligible at no additional cost for a basic benefits package but, could choose an enhanced benefits package for an additional premium. Under the MSS, the government would need to decide on a process for making payments to licensed exchanges. Among other matters, this process would require the government to determine how payments should be risk-adjusted to account for health status, a process that has been articulated as one of the primary reasons for the failure of managed care in the current Medicare program.⁸⁵

While the MSS values the universality of health insurance in that no person can be denied access to health care as a function of cost or income, it also creates an option for individual preferences that may very well be a function of cost and income. It also values the role of competition. Health exchanges are paid a risk capitated fee per enrollee by the federal government, a fee determined by the cost of providing a specific benefits package. The health exchanges then enter into risk contracts with multiple health insurers who contract with providers. Under the MSS, the government is the guarantor of access to health care for all Americans under the age of 65 regardless of health, wealth or employment status. However, the MSS is not a single-payer system. Although the federal government is the sole payer to the health exchanges, the competitive health exchange and health plan components make the MSS a multiple-payer system with regard to providers. Presumably, competition will determine which health exchanges will survive in the health exchange marketplace as well as operate to drive down the costs of procuring health insurance and care.

“sponsors” to perform the same functions for consumers as employers currently do: researching the health insurance marketplace and structuring purchasing options. The sponsor would then prepare for consumers a menu of available benefits packages options which would be required to be standardized. *See generally* ALAIN ENTHOVAN, *THE THEORY AND PRACTICE OF MANAGED COMPETITION IN HEALTH CARE FINANCE* (1988).

83. Weil describes the health insurance exchange as loosely based on the stock exchange. Stock exchanges create a marketplace for highly regulated goods, securities, by attracting buyers and sellers to the market. Health insurance exchanges would create a marketplace in what will be a regulated good, health insurance, and will succeed only if they can attract both buyers and sellers. Health insurance will be regulated in the sense that health exchanges must provide all nationally standardized basic benefits packages, including at least one no-cost option, and may provide other options as well. All benefits packages must be offered to participants on a community-rated basis. Weil, *supra* note 77, at 178.

84. *See generally id.*

85. Joseph P. Newhouse, Melinda Beeuwkes Buntin, & John D. Chapman, *Risk Adjustment and Medicare: Taking a Closer Look*, *HEALTH AFF.*, Sept.- Oct. 1997 at 26 available at <http://www.healthaffairs.org/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v16n5/s3.pdf>.

2003] ARE WE FINALLY READY FOR UNIVERSAL HEALTH INSURANCE? 321

While the Medical Security Act is still in the proposal stage, the national health insurance plan is not.⁸⁶ On February 2, 2003, Representative John Conyer introduced a bill to the House of Representatives⁸⁷ entitled “United States National Health Insurance Act” (“USNHI”) (or the “Expanded and Improved Medicare for All Act”). The USNHI would provide health care coverage in the form of a single universal benefits package.⁸⁸ Private health plans are prohibited from selling coverage that duplicates the benefits of the USNHI program, but may provide coverage for non-duplicative health care such as cosmetic surgery and other medically unnecessary care.⁸⁹ Under the USNHI, there is no competition for enrollees; all basic health care is paid for by a single payer, the federal government, through a service reimbursement administered pricing system.⁹⁰

Proponents of the legislation estimate that the cost of national health insurance will be \$1.8 trillion annually, a reduction of \$109 billion over current costs. The USNHI would be funded by an additional payroll tax of 3.3% on employers only.⁹¹ The Act envisions also that low and middle income families pay a smaller share of their incomes for health care than the wealthiest 5% of Americans upon whom a health income tax will be imposed. The out-of-pocket costs of health care for lower and middle-income families are calculated to be substantially reduced under the USNHI; these costs would be shifted to the wealthiest individuals and families and to employers. While employers today can offer health insurance as a tax-subsidized employee benefit as a matter of business and personal preference, under the USNHI, the employer payroll tax to subsidize universal health care

86. In addition to HR676, there are a number of states that are contemplating such legislation including California, Minnesota, and Wisconsin. The California single-payer bill, SB921, sponsored by Senator Sheila Kuehl (D-Santa Monica) was introduced to the California Senate on March 2, 2003. SB921 creates a system of public financing of health care similar to that used for Medicare. PHYSICIANS FOR A NATIONAL HEALTH PROGRAM, CALIFORNIA SINGLE-PAYER BILL INTRODUCED at <http://www.pnhp.org/news/archives/001682.php> (Mar. 4, 2003).

87. This Bill, HR676, is known as the United States National Health Insurance Act or the Expanded and Improved Medicare for All Act. United States National Health Insurance Act, H.R. 676, 108th Cong. (2003).

88. The benefits package includes primary care and prevention, inpatient care, outpatient care, emergency care, prescription drugs, durable medical equipment, long term care, mental health services, dental services, substance abuse treatment services, chiropractic services and basic vision care and correction. *Id.* § 102 (a).

89. *See id.* §§ 102 (a) (9), 104.

90. *See id.* §§ 102 (b), 201(c). Currently, under Medicare Parts A and B, the federal government reimburses providers for services at rates set by the Centers for Medicare and Medicaid Services (CMS). Under the current system, both physicians and institutions are reimbursed prospectively in an effort to align the economic interests of the provider and the payer.

91. Employers and employees would continue to pay the 1.45% Medicare payroll tax already imposed so that employers would, under the USNHI, be paying a 4.7% payroll tax for health care. Compare this with the payroll tax proposed by the MSS—3.3% for employees and 7.7% for employers—to be applied to the Social Security wage base. PHYSICIANS FOR A NATIONAL HEALTH PROGRAM, EXECUTIVE SUMMARY OF THE UNITED STATES NATIONAL HEALTH INSURANCE ACT (HR676) at http://pnhp.org/nhibill/nhi_execsumm.html.

would be mandatory. Not only would employers not have a choice with regard to providing health insurance, but also the direct cost shifting from employers to employees that is a reality of health insurance today could not occur.

As always, there is no free lunch and the increased cost of providing universal coverage would necessitate some changes. These could take the form of cross-subsidization from the insured elite to the uninsured, a direct or indirect tax on employers, decreased reimbursement to providers, or from public subsidies paid by increasing payroll and/or income taxes, by an allocation of a greater percentage of GDP to health care spending, or from all of these sources. Whatever the sources of revenue to fund such a program, it is certain that a decision to provide universal health coverage to all Americans is a commitment. If history is a teacher, Americans are unlikely to make this commitment at this time; we are a polity generally too acculturated in individual rights and not enough in community responsibility. And, at a time when our lives are filled with terrorism, war, huge budget deficits, rising unemployment, a sinking stock market, skyrocketing health care costs, and a very strong free market orientation, what is the probability that we can make universal health coverage a reality? I, like Professor Oberlander, think it very unlikely.⁹²

92. See *supra* notes 77-78 and accompanying text.