

OUR BROKEN HEALTH CARE SYSTEM AND HOW TO FIX IT: AN ESSAY ON HEALTH LAW AND POLICY

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I. INTRODUCTION

The health care system of the United States is in serious trouble. Nearly forty-six million Americans (15.7% of the population) lacked health insurance in 2004, the last year for which data are available, and probably more are uninsured today.¹ A recent study by the prestigious Institute of Medicine estimated that 18,000 Americans die every year because they are uninsured and thereby lack access to health care.² Despite the fact that many Americans lack access to health care, we spent over \$1.9 trillion on health care in 2004³—more than we spent on food, housing, transportation, or anything else—and the amount that we spend on health care is increasing every year at rates far in excess of inflation generally.⁴ Though most Americans are aware of these problems, many still believe, as our President has often said, that “we’ve got the best health care system in the world.”⁵ In other words, they

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1. CARMEN DENAVAS-WALT ET AL., U.S. DEP’T OF COMMERCE, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004, at 16 (2005), available at <http://www.census.gov/prod/2005pubs/p60-229.pdf>.

2. INST. OF MED., CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 162 (2002), available at <http://www.nap.edu/books/0309083435/html>.

3. Cynthia Smith et al., *National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending*, HEALTH AFF., Jan./Feb. 2006, at 186, 186.

4. U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2004-2005, at 431 (2004), available at <http://www.census.gov/prod/2004pubs/04statab/income.pdf>. In 2002 American consumers spent \$1.437 trillion on medical care, \$1.145 trillion on housing, \$1.095 trillion on food and tobacco, and \$877 billion on transportation. *Id.*

5. U.S. Dep’t of State, President Bush Discusses Quality, Affordable

believe that we still receive high quality health care. In fact, however, a series of studies over the past decade have shown that the quality of health care in the United States is seriously deficient, and, in particular, that medical errors are common and often have serious consequences.⁶ Indeed, the quality of the health care Americans receive is no better, and in some respects worse, than that provided in many other countries that spend far less on health care and yet provide it for all of their citizens.⁷

As disturbing as these facts are, however, we should be even more troubled by the fact that the solutions most commonly being considered for our access, cost, and quality dilemmas are unlikely to solve these problems and may in fact exacerbate them. The health policy nostrums currently being pressed by Congress—health savings accounts, tax credits for the uninsured, and tort “reform”—are deeply flawed. Though they may promote other agendas, such as cutting taxes or protecting powerful interest groups, they serve primarily to distract us from pursuing measures that could in fact make a difference.

Fortunately, the bankruptcy of these proposals for reforming our health care system does not leave us bereft of hope. In fact, we have available in the world around us a wealth of experience with approaches to organizing health care systems that have improved access, resulted in lower costs, and promoted quality elsewhere and could, with appropriate adjustments, work here. What we need, indeed desperately need, is true evidence-based health care reform—not legislation grounded in untested, ideologically based theories.

Law has a role in this reform. Our current health care system is built on a framework of laws—laws that create and define entitlements in federal and state public insurance programs, laws that regulate private health insurance, laws that create tax incentives for employers to offer health insurance and for hospitals to provide uncompensated care, laws that protect competition, and laws that attempt to ensure the provision of quality care and to

Health Care (Jan. 28, 2004), <http://usinfo.state.gov/usa/s012804.htm>.

6. See INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (2000), available at <http://www.nap.edu/books/0309068371/html> [hereinafter IOM, TO ERR IS HUMAN]; INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 1-2 (2001), available at <http://www.nap.edu/books/0309072808/html> [hereinafter IOM, QUALITY CHASM].

7. See Cathy Schoen et al., *Primary Care and Health System Performance: Adults' Experience in Five Countries*, HEALTH AFF.-WEB EXCLUSIVE, Oct. 28, 2004, at W4-487, W4-500, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.487/DC1>; see also Peter S. Hussey et al., *How Does the Quality of Care Compare in Five Countries?*, HEALTH AFF., May/June 2004, at 89, 91-92.

deter error. This edifice of law has grown by accretion on an ad hoc basis over the decades. The substratum of tort and contract law on which it was built has long since been largely buried, though medical negligence law still is relied upon to address medical error, and contract law plays a marginal role in insurance disputes.⁸

What has superseded the common law is a very complicated, sometimes contradictory, web of regulatory law.⁹ There is no discernable single theory grounding this body of law.¹⁰ Rather, a series of statutes and regulations have been adopted over the years, each pursuing a particular policy or set of policies. The National Health Planning and Resources Development Act of 1974¹¹ and the state certificate of need programs based on it, for example, were grounded in the theory that supply constraints could be relied on to control cost,¹² while the application of the antitrust laws to the health care industry has been directed toward removing artificial restraints on competition.¹³ Some of the statutes enacted to regulate health care, arguably, pursue no defensible policy at all but can only be understood in terms of interest-group politics. Many state insurance-law providers or benefit-coverage mandates, for example, are best explained as the successful efforts of various provider groups to gain access to health insurance dollars.¹⁴

For real reform to happen, we will need to create a unified and coordinated framework of health care law based on a coherent and evidence-based understanding of the fundamental problems that plague our health care system and an understanding of how a health care system should be constructed so as to overcome these problems. This Essay describes what such a framework could look like, the policies on which it would be based, and the strategies that could be pursued to put it into place.

This Essay first describes in some detail the problems that the American health care system faces—problems of access, cost, and quality—and why these problems exist. Only by thoroughly

8. See BARRY R. FURROW ET AL., *HEALTH LAW* § 6-2, at 264-78, § 9-2, at 466-71 (2d ed. 2000).

9. See Timothy Stoltzfus Jost, *Health Law and Administrative Law: A Marriage Most Convenient*, 49 ST. LOUIS U. L.J. 1 (2004).

10. See generally M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247 (2003) (proposing several principles grounding health law).

11. Pub. L. No. 93-641, 88 Stat. 2225 (1974), *repealed by* Pub. L. No. 99-660, 100 Stat. 3743 (1986).

12. FURROW ET AL., *supra* note 8, § 1-19, at 30-31.

13. *Id.* § 14-1, at 671-72.

14. See FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *IMPROVING HEALTH CARE: A DOSE OF COMPETITION* 28 (2004) [hereinafter, *DOSE OF COMPETITION*], available at http://www.usdoj.gov/atr/public/health_care/204694.htm.

understanding these problems and their causes can we begin to understand how to solve them. This Essay next describes the current hodgepodge of laws that govern the health care system. It then sets out the fundamental principles on which a reformed health care system must be built, that is, what we must do to assure access, cost control, and quality. Next, this Essay turns to describing what the legal framework of a reformed health care system would look like. Finally, it sketches a political strategy that could be pursued to put such a framework into place.

II. THE PROBLEMS

A. *Access: The Forty-Six Million Uninsured*

In 2004, according to Census Bureau estimates, nearly forty-six million Americans lacked health insurance at some point in time.¹⁵ To get an accurate perspective on the problem of health insurance in the United States, however, one needs a movie, not a snapshot. If one examines the phenomena of uninsurance over time, one sees many more uninsured—almost eighty-two million, or one-third of all non-elderly Americans—were uninsured at some point during 2002 and 2003.¹⁶ One also sees a very dynamic picture—people moving from private to public insurance, from public to private insurance, or among private insurers; people who lack insurance for long periods of time, perhaps the entire period; and people who are uninsured for a single short period, or for repeated short periods of time.¹⁷

Most uninsured Americans—about eighty percent—are either employed or in households of persons that are employed.¹⁸ This is because many Americans who are unemployable—the elderly, the disabled, and children—are covered by public insurance programs.¹⁹ Most of the uninsured who are employed, however, are part-time or

15. DENAVAS-WALT ET AL., *supra* note 1, at 16.

16. See FAMILIES USA, ONE IN THREE: NON-ELDERLY AMERICANS WITHOUT HEALTH INSURANCE, 2002-2003, at 1 (2004), available at http://www.familiesusa.org/assets/pdfs/82million_uninsured_report6fdc.pdf. For a more thorough analysis of the four-year period from 1996 to 1999, see Pamela Farley Short & Deborah R. Graefe, *Battery-Powered Health Insurance? Stability in Coverage of the Uninsured*, HEALTH AFF., Nov./Dec. 2003, at 244, 247.

17. Short & Graefe, *supra* note 16, at 247-49.

18. Sherry A. Glied, *Challenges and Options for Increasing the Number of Americans with Health Insurance*, 38 INQUIRY 90, 91 (2001).

19. See *In Critical Condition: America's Ailing Health Care System: Before the S. Spec. Comm. on Aging*, 108th Cong. 5 (2003) (statement of Karen Davis, President, The Commonwealth Fund), available at http://www.cmwf.org/usr_doc/davis_senatecommitteetestimony_622.pdf.

seasonal employees, work at low-wage jobs, are self-employed, or work for very small businesses and are not offered health insurance benefits by their employers.²⁰ Most uninsured persons also have very low incomes—one quarter are from households with incomes below the poverty level, fifty-four percent from households with incomes below two-hundred percent of the poverty level.²¹ With health insurance costing hundreds of dollars a month, persons working at minimum wage jobs simply cannot afford it. The uninsured also tend disproportionately to be minorities—especially Hispanics—and to be young.²²

The picture is complicated, however. Many of the uninsured are in fact reasonably well-off—8.4% are from households that earn \$75,000 or more per year.²³ Many of these more wealthy uninsured persons are temporarily between jobs and judge their short-term risk of facing catastrophic health care costs to be low.²⁴ Some of the uninsured are individuals who work for large employers that in fact offer health benefits, but these individuals decline the offer rather than pay the employee's share of premiums (which averaged \$222 per month for family coverage in 2004).²⁵ Some are young people who cannot imagine themselves needing expensive health care. Some no doubt overestimate the extent of the nation's health care safety net.²⁶ A few, probably a very few, decide rationally to self-insure rather than bear the cost of insurance for the long term.²⁷

20. INST. OF MED., COVERAGE MATTERS: INSURANCE AND HEALTH CARE 60-62, 67-70 (2001).

21. Cover the Uninsured Week, Fact Sheet: Income and Poverty Status, <http://covertheuninsuredweek.org/factsheets/display.php?FactSheetID=108> (last visited Feb. 11, 2006).

22. See DENAVAS-WALT ET AL., *supra* note 1, at 18 tbl.7 (stating that 32.7% of Hispanics are uninsured, as are 31.4% of Americans aged eighteen to twenty-four).

23. *Id.*

24. Families with incomes above four hundred percent of the poverty level who are uninsured at some point over a four-year period are most likely to have a single gap of coverage and are rarely uninsured for the entire period. Short & Graefe, *supra* note 16, at 250.

25. Jon Gabel et al., *Health Benefits in 2004: Four Years of Double-Digit Premium Increases Take Their Toll on Coverage*, HEALTH AFF., Sept./Oct. 2004, at 200, 202.

26. Polling data show that a majority of Americans believe that the uninsured are already able to get the medical care that they need. See Kaiser Family Found., Knowledge: Uninsured People's Access to Health Services, http://www.kff.org/healthpollreport/archive_April2004/5.cfm (last visited Feb. 11, 2006).

27. See BOWEN GARRETT, KAISER COMM'N ON MEDICAID AND THE UNINSURED, EMPLOYER-SPONSORED HEALTH INSURANCE COVERAGE: SPONSORSHIP, ELIGIBILITY AND PARTICIPATION PATTERNS IN 2001, at 21-22 (2004) (noting that only 4.6% of

Finally, many are persons who are eligible for public insurance, such as Medicaid or the State Children's Health Insurance Program ("SCHIP"), but for whatever reason—lack of outreach, bureaucratic barriers, stigmatization, fear of identifying themselves to the government, or simple inertia—have not signed up.²⁸

At bottom, however, there are two fundamental reasons why a private insurance-based system will always have many persons who are not insured, and any plan to reduce or eliminate uninsurance from the United States has to address both. The first is the highly skewed nature of health care costs. In any given year, a very small proportion of the population is responsible for most health care costs, while the vast majority of the population experiences few, if any, health care expenses. The most expensive one percent of the population is responsible for over a quarter of health care costs; the most expensive five percent is responsible for over half.²⁹ Conversely, the least expensive half of the population accounts for less than three percent of health care expenditures.³⁰

At all ages, persons with chronic mental and physical disabilities are responsible for most health care spending.³¹ Indeed, treatment of chronic conditions, such as mental disorders, pulmonary conditions, hypertension, asthma, or diabetes, have accounted for a high percentage of the increase in health care spending in recent years.³² But many of these conditions, as well as acute conditions like some forms of cancer or trauma, initially strike capriciously and with little or no warning.

The answer to capricious risk is insurance. Because health care costs are so concentrated, health insurance, either public or private, is ubiquitous in countries wealthy enough to afford expensive, high-technology, health care.³³ Health insurance spreads the risk from

employees who were eligible for employment-covered insurance but declined it thought they did not need insurance, compared to 52.2% who said that it was too expensive).

28. Cindy Mann & Tim Westmoreland, *Attending to Medicaid*, 32 J.L. MED. & ETHICS 416, 419 (2004).

29. Marc L. Berk & Alan C. Monheit, *The Concentration of Health Expenditures, Revisited*, HEALTH AFF., Mar./Apr. 2001, at 9, 12.

30. *Id.* at 13.

31. See Benjamin G. Druss et al., *The Most Expensive Medical Conditions in America*, HEALTH AFF., July/Aug. 2002, at 105, 106-07; Kenneth E. Thorpe, Curtis S. Florence & Peter Joski, *Which Medical Conditions Account for the Rise in Health Care Spending?*, HEALTH AFF.-WEB EXCLUSIVE, Aug. 25, 2004, at W4-437, W4-440 to -441, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.437v1.pdf>.

32. See Thorpe, Florence & Joski, *supra* note 31, at W4-440 to -441.

33. See Timothy Stoltzfus Jost, *Private or Public Approaches to Insuring the Uninsured: Lessons from International Experience with Private Insurance*, 76

those who require high cost health care to those who do not. It thus makes health care more affordable for all. The distribution of the risk of health care costs is not wholly capricious, however. Individuals can to a certain extent predict the likelihood that they will experience high health care costs during a given year, and insurers can make such predictions as well. If health insurance is sold in voluntary market transactions—in which any individual can decide whether or not to purchase insurance, and any insurer can decide whether to offer insurance to any individual—the risk-selection game ensues.³⁴ People who expect themselves to remain healthy decline insurance, while those who expect themselves to be unhealthy purchase it (the latter phenomenon is known as adverse selection).³⁵ Insurers, on the other hand, seek out people who are likely to remain healthy or offer insurance to those who present higher risks only if they pay higher premiums.³⁶

Alternatively, insurers can try to insure preexisting pools of insureds large enough to spread risk broadly and formed in such a way as to make adverse selection less likely. Large groups of employees are one such group, and it is not surprising that not only our health insurance system, but also the social insurance systems of central Europe, are based, at least historically, on employment-based groups.³⁷ The biggest pool of insureds, however, and the one

N.Y.U. L. REV. 419, 452 (2001) (describing the mix of public and private insurance found in other countries).

34. See TIMOTHY STOLTZFUS JOST, *DISENTITLEMENT?: THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE* 13-14 (2003).

35. See MARK A. HALL, *REFORMING PRIVATE HEALTH INSURANCE* 11 (1994); Lea Wortham, *The Economics of Insurance Classification: The Sound of One Invisible Hand Clapping*, 47 OHIO ST. L.J. 835, 844 (1986).

36. See generally Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q. J. ECON. 629 (1976).

37. See Jost, *supra* note 33, at 451. There are, of course, other reasons why employment-based insurance makes sense. Employees like it. Sixty percent of employees in a recent poll rated health insurance as their most important fringe benefit. RACHEL CHRISTENSEN, EMPLOYEE BENEFITS RESEARCH INST., *VALUE OF BENEFITS CONSTANT IN A CHANGING WORLD: FINDINGS FROM THE 2001 EBRI/MGA VALUE OF BENEFITS SURVEY 1* (2002). But, at the same time, employment-related health insurance is also of value to employers, since healthy employees are more productive and less likely to be absent from work. See Ellen O'Brien, *Employers' Benefits from Workers' Health Insurance*, 81 MILBANK Q. 5, 6 (2003). Employment-related health insurance reduces the cost of insurance by reducing the marketing and underwriting costs that attend individual insurance, decreases the risk to the insurer that the insured will default on premium payments, and gives the employees the benefits of the employer's bargaining power and insurance expertise. Finally, because

least vulnerable to adverse selection, is the entire population of a country. Thus, public insurance, provided either through social insurance or through national health insurance systems, has become the norm throughout the developed world.³⁸

The second reason why private insurance is not adequate to cover the population of an entire country is the problem of affordability. For reasons explored below, health care is extraordinarily expensive.³⁹ Because health care is expensive, health insurance is expensive as well. The average employment-related family health insurance policy—the form of insurance most American families have—cost \$9,950 in 2004.⁴⁰ A person who works forty hours a week, fifty-two weeks a year, at the minimum wage of \$5.15 per hour, would have to spend ninety-three percent of pre-tax income to cover the cost of such a policy if she had to buy the policy from her own funds without employer assistance.⁴¹ A household would have to earn over \$66,000 per year, 350% of the federal poverty level, before the cost of health insurance would fall to a more or less affordable fifteen percent of pre-tax income.⁴² The barriers of risk and affordability, moreover, interact perniciously. People in bad health often find it hard to hold down jobs, while lower income people are disproportionately in worse health.⁴³ It is

employment-related health insurance is tax subsidized, it is more affordable to workers. See JOST, *supra* note 34, at 187-90; David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 30-35 (2001).

38. Jost, *supra* note 33, at 434.

39. Gabel et al., *supra* note 25, at 200-02.

40. *Id.* at 202.

41. Some surveys show that premiums for individual insurance policies are much lower. See KAISER FAMILY FOUND., UPDATE ON INDIVIDUAL HEALTH INSURANCE 5 (2004), <http://www.kff.org/insurance/upload/Update-on-Individual-Health-Insurance.pdf>. The benefits of these individual policies, however, seem to be much poorer than those of employment-related insurance. Forty percent of individual insurance policies covered by the survey, for example, had deductibles in excess of \$2,000 in 2003. *Id.* at 6. By contrast, the average deductible for PPO in network employer-based coverage in 2003 was \$275. Gabel et al., *supra* note 25, at 204. Recent research into the medical causes of bankruptcy finds that insurance policies with high deductibles and co-payments leave insureds exposed to financial ruin. David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF.-WEB EXCLUSIVE, Feb. 2, 2005, at W5-63, W5-70, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1>.

42. The 2004 federal poverty level for a family of four is \$18,850. Annual Update of the HHS Poverty Guidelines, 69 Fed. Reg. 7,335, 7,336 (Feb. 13, 2004).

43. See Nancy E. Adler & Katherine Newman, *Socioeconomic Disparities in Health: Pathways and Policies*, HEALTH AFF., Mar./Apr. 2002, at 60, 60; Angus

not surprising that most uninsured Americans are poor and many poor are uninsured.⁴⁴

Most countries address the problem of affordability, as they do the problem of skewed costs, by providing public health insurance, financed either through general taxes or through social health insurance programs that are funded through premiums based on a percentage of wages.⁴⁵ In the United States, we have addressed the affordability problem less effectively by covering some of the poorest or highest-cost populations (the elderly, disabled, and poor families) through public insurance and by tax subsidizing employment-based insurance for the rest of our population, thereby transferring some of the cost of the private insurance to the taxpayers.⁴⁶ The remaining cost of private insurance is largely borne by workers to whom the cost is passed on by their employers as part of their total compensation package. As health insurance has become more and more expensive, however, employers have found it increasingly difficult to pass on the cost of health insurance to workers through holding down wage growth, as they have largely done in the past.⁴⁷ Employers have instead had to pass it on directly through increasing employee cost-sharing but this in turn has encouraged lower-wage workers to decline coverage, causing more low wage or high-risk people to become uninsured.⁴⁸

All of this would not matter so much if health insurance were not so necessary conditional for getting health care in the United States. For reasons explained below, it is possible to gain access to emergency care in the United States without health insurance.⁴⁹ It is much more difficult to gain access to preventive or primary care or to care for chronic conditions. For these reasons, the uninsured get less health care than the insured, and they get it later when it is often less effective.⁵⁰ Accordingly, the uninsured suffer higher

Deaton, *Policy Implications of the Gradient of Health and Wealth*, HEALTH AFF., Mar./Apr. 2002, at 13, 13; Michael Marmot, *The Influence of Income on Health: Views of an Epidemiologist*, HEALTH AFF., Mar./Apr. 2002, at 31, 31.

44. See Adler & Newman, *supra* note 43, at 68.

45. See Jost, *supra* note 33, at 435-36.

46. *Id.* at 433.

47. See Gabel et al., *supra* note 25, at 208.

48. Average monthly employee premium contributions for family coverage grew from \$124 in 1993 to \$201 in 2003. *Id.* at 204. On average, 85% of employees "take up" insurance offered by their employers, but the rate varies by income, with persons earning less than 100% of the poverty level accepting employer-sponsored insurance only 71% of the time. GARRETT, *supra* note 27, at 14-15.

49. See *infra* text accompanying notes 174-75.

50. See Dianne Miller Wolman & Wilhelmine Miller, *The Consequences of Uninsurance for Individuals, Families, Communities, and the Nation*, 32 J.L.

morbidity and mortality rates, and, as noted above, an estimated 18,000 adults die prematurely every year from lack of insurance.⁵¹ Not only do individuals suffer, however, families and communities suffer as well. Medical costs contribute to half of all bankruptcies,⁵² while hospitals in communities with high numbers of the uninsured offer fewer services to vulnerable populations and have worse financial margins.⁵³ Indeed, the entire country loses because of the lost productivity of those whose diseases and disabilities are not addressed because of a lack of health insurance.⁵⁴

Finally, difficulties in gaining access to health care are not just the lot of the uninsured. There are serious gaps in both public and private health insurance programs in the United States, and these gaps limit access to health care. Neither Medicare nor private employment-related health insurance provides much coverage for long-term care. Private health insurance plans are increasingly transferring the cost of health care to their insureds through high cost-sharing obligations, which are likely to discourage the provision of some necessary health care.⁵⁵ Surveys show that even fully insured persons often experience serious financial difficulties because of health care expenses.⁵⁶ Delaying health care because of its costs, however, can result in higher costs down the road when conditions become more grave and must be treated.

B. *Cost: The \$1.9 Trillion Health Care Bill*

In 2004, the last year for which cost data is more or less complete, we spent nearly \$1.9 trillion on health care.⁵⁷ This amounts to \$6,280 per person, 16% of our gross domestic product ("GDP").⁵⁸ We spend far more on health care than any other country does. In 2001, when the United States spent 13.9% of its GDP and

MED. & ETHICS 397, 399 (2004).

51. *Id.* at 399-400.

52. *See* Himmelstein et al., *supra* note 41, at W5-66.

53. Wolman & Miller, *supra* note 50, at 401-02.

54. The Institute of Medicine study estimated the cost to the United States due to "the loss of health and longevity by the uninsured" at between \$65 and \$130 billion a year. *Id.* at 402.

55. Gabel et al., *supra* note 25, at 204.

56. *See Health Care Costs and Instability of Insurance: Impact on Patients' Experiences with Care and Medical Bills: Hearing on a Review of Hospital Billing and Collection Practices Before the Subcomm. on Oversight and Investigations, H. Comm. on Energy and Commerce, 108th Cong. (2004)* (statement of Sara R. Collins, The Commonwealth Fund), available at http://www.cmwf.org/publications/publications_show.htm?doc_id=230634.

57. Smith et al., *supra* note 3, at 188 exh.2.

58. *Id.*

4,887 purchasing-power parity international dollars (“\$PPP”)⁵⁹ on health care, the United Kingdom spent 7.6% of its GDP, \$PPP 1,992 per person; Germany spent 10.7% of its GDP on health care, \$PPP 2,808 per person; while Canada spent 9.7% of its GDP on health care, \$PPP 2,792 per person.⁶⁰ Moreover, the cost of health care is steadily increasing. From 2002 to 2004 the cost of health care increased at an average rate of over 8% per year, causing the percentage of the GDP attributable to health care to grow from 13.8% in 2000 to 16% in 2004.⁶¹ Under current projections, by 2013 the cost of health care will grow to \$3.36 trillion, 18.4% of GDP.⁶²

What causes our high and steadily increasing health care costs? One way of answering this question is to try to identify factors that contribute to high and rising costs. One candidate here is certainly technology.⁶³ New drugs, devices, and procedures are constantly coming on line, and they often cost significantly more than the technologies that they replace.⁶⁴ New technologies permit the treatment of conditions that were previously untreatable. New diagnostic technologies identify otherwise undetected medical conditions, which then must be treated. New “halfway” technologies permit continued functioning in the face of conditions that cannot be cured and previously could only be endured.⁶⁵ But it all costs money.

59. The Organisation for Economic Co-operation and Development (“OECD”) defines PPP as follows: “Purchasing Power Parities (PPPs) are currency conversion rates that both convert to a common currency and equalise the purchasing power of different currencies. In other words, they eliminate the differences in price levels between countries in the process of conversion.” OECD, Definition of Purchasing Power Parity (PPP), http://www.oecd.org/department/0,2688,en_2649_34357_1_1_1_1_1,00.html (last visited Feb. 3, 2006).

60. Uwe E. Reinhardt, Peter S. Hussey & Gerard F. Anderson, *U.S. Health Care Spending in an International Context*, HEALTH AFF., May/June 2004, at 10, 11.

61. Smith et al., *supra* note 3, at 187-88.

62. Stephen Heffler et al., *Health Spending Projections Through 2013*, HEALTH AFF.-WEB EXCLUSIVE, Feb. 11, 2004, at W4-79, W4-80, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.79v1>.

63. See Timothy Stoltzfus Jost, *Methodological Introduction to HEALTH CARE COVERAGE DETERMINATIONS: AN INTERNATIONAL COMPARATIVE STUDY* 1, 1-3 (Timothy Stoltzfus Jost ed., 2005) [hereinafter INTERNATIONAL COMPARATIVE STUDY].

64. See Benton A. Weisbord, *The Nature of Technological Change: Incentives Matter!*, in ADOPTING NEW MEDICAL TECHNOLOGIES 8, 19 (Annetine.C. Gelijns & Holly V. Dawkins eds., 1994). See generally PENNY E. MOHR ET AL., HEALTH INS. ASS'N OF AM. & BLUE CROSS AND BLUE SHIELD ASS'N, THE IMPACT OF MEDICAL TECHNOLOGY ON FUTURE HEALTH CARE COSTS (2001), available at http://www.ahipresearch.org/PDFs/26_FinalRptApp1&3.pdf.

65. See Eugene C. Grochowski, *Ethical Issues in Managed Care: Can the*

In other industries, technological innovation often results in reduced prices. As the speed and power of computers has increased exponentially in recent years, their price has dropped precipitously.⁶⁶ In health care, however, technological improvement often results in increased rather than reduced prices; and even when prices are reduced, utilization rates often increase, resulting in higher total costs. Laparoscopic cholecystectomy, for example, not only costs less than traditional invasive cholecystectomy, but is also more convenient and less risky. This, however, has led to more frequent use, resulting in higher total costs.⁶⁷

Other factors also contribute to increased costs. The population is steadily aging, and older people require more health care (though most European countries have older populations than ours and still experience lower health care costs, and aging accounts for only a small fraction of total cost growth).⁶⁸ Medical malpractice litigation is far more extensive and expensive in the United States than in other countries, though the direct cost of malpractice accounts for less than two percent of health care costs, and the extent of the indirect cost, i.e., “defensive medicine,” is far from clear.⁶⁹ A third important consideration is that the health care sector is very labor intensive, and increased productivity in labor-intensive industries tends to increase, rather than decrease, costs.⁷⁰

Perhaps the most important factor explaining higher costs in the United States, however, is that we simply pay higher prices for health care than other countries do.⁷¹ Americans spend less time in the hospital than do most Europeans and see the doctor about as often.⁷² But we pay higher prices for the same brand name drugs

Traditional Physician-Patient Relationship be Preserved in the Era of Managed Care or Should it be Replaced by a Group Ethic?, 32 U. MICH. J.L. REFORM 619, 625 (1999).

66. See J. Steven Landefeld & Bruce T. Grimm, *A Note on the Impact of Hedonics and Computers on Real GDP*, 80 SURV. CURRENT BUS. 17, 20 (2000).

67. Antonio P. Legorreta et al., *Increased Cholecystectomy Rate After the Introduction of Laparoscopic Cholecystectomy*, 270 JAMA 1429 *passim* (1993).

68. See BRADLEY C. STRUNK & PAUL B. GINSBURG, CENTER FOR STUDYING HEALTH SYSTEM CHANGE, AGING PLAYS LIMITED ROLE IN HEALTH CARE COST TRENDS (2002), <http://www.hschange.com/CONTENT/473/473.pdf>.

69. CONG. BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE 1 (2004), available at <http://www.cbo.gov/ftpdocs/49xx/doc4968/0108-MedicalMalpractice.pdf>.

70. This is called the Baumol effect, named after its discoverer, William J. Baumol. See GRAHAM BANNOCK, R.E. BAXTER & EVAN DAVIS, DICTIONARY OF ECONOMICS 30 (1998).

71. Gerard F. Anderson et al., *It's the Prices, Stupid: Why the United States is so Different from Other Countries*, HEALTH AFF., May/June 2003, at 89, 103.

72. *Id.* at 95, 97.

than do other countries, our doctors earn more than do doctors in other countries, and we pay far more for hospital care than anyone else.⁷³ The United States is in fact more efficient in its use of health care resources than are other countries, but we pay much higher prices for the resources we use.

Why should this be true? Our fundamental problem is that we have neither effective competition nor effective regulation for holding down the cost of health care. In our economy we generally rely on market competition to set prices. Competition does not necessarily guarantee that products are cheap, but it does more or less ensure that we do not pay more for products than they are worth to us. On the whole, moreover, markets generally ensure that necessary goods are available at a price almost anyone can afford.

Markets have had little success in lowering the cost of health care, however. How one explains this depends to a considerable degree on one's political convictions. Conservative theorists assert that the problem is fundamentally one of overinsurance.⁷⁴ Given the severe problems that our country experiences because of underinsurance, the notion that we suffer also from overinsurance seems surprising. It is intuitively obvious, however, that people will consume more of a valued good if it is free or priced below its marginal cost,⁷⁵ and health insurance obviously reduces the cost of health care to the ultimate consumer. There is also solid empirical evidence of the effect of "moral hazard" on health care costs from the RAND Health Insurance Experiment, conducted from 1974 to 1982, and from other research conducted since.⁷⁶ When consumers do not care, or perhaps do not even know, what suppliers charge for a good or service, suppliers can be expected to provide more of a good or service than would otherwise be consumed and may charge higher prices than they would otherwise charge.⁷⁷

No one disputes that moral hazard is an issue in health care. The dispute centers on how much of a problem it is and how to

73. *Id.* at 93, 97-98.

74. *See, e.g.*, NEWT GINGRICH, WINNING THE FUTURE: A 21ST CENTURY CONTRACT WITH AMERICA 110-11 (2005); Michael Tanner, *What's Wrong with the Present System?*, in EMPOWERING HEALTH CARE CONSUMERS THROUGH TAX REFORM 27, (Grace-Marie Arnett ed., 1999); *see also* COUNCIL OF ECON. ADVISERS, ECONOMIC REPORT OF THE PRESIDENT, H.R. DOC. NO. 108-145, at 194-96 (2004) (arguing that excess insurance is a fundamental cause of high health care costs in the United States).

75. *See* COUNCIL OF ECON. ADVISERS, *supra* note 74, at 195.

76. *See generally* JOSEPH P. NEWHOUSE, FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT (1993) (describing the experiment and its findings).

77. *See* DOSE OF COMPETITION, *supra* note 14, at 6; Jost, *supra* note 9, at 25.

address it. The same could be said of the market failures on which observers with less faith in markets tend to focus. The two primary failures on which these commentators tend to focus are information deficiencies and agency problems.⁷⁸ Markets depend on information. Competition only works if consumers have information on price and quality that permits them to make comparative judgments. It is very difficult to evaluate health care quality comparatively, however, because comparative information on which judgments on the quality of health care providers could be made prospectively is sparse and difficult to understand.⁷⁹ Indeed, it is often difficult to evaluate one's own experience with health care retrospectively—perhaps one would have fared better without an intervention that appears to have been a success or would have fared worse without an intervention that seems to have been a failure. It is also often very difficult to learn prospectively the price of health care services because the price often depends on what is actually done and cannot be known until the treatment is completed.⁸⁰

Finally, markets depend on a certain degree of fungibility. In the most price-competitive markets, those for commodities for example, products are nearly perfectly fungible.⁸¹ In virtually all competitive markets for consumer goods, however, products are comparable in ways that can usefully be described and measured, as is demonstrated by any Consumer Reports chart. But the best medical professionals are often possessed of gifts of empathy, commitment, and intuition that are difficult to describe in a report card. And each patient, and each patient's condition, is at some level unique.⁸²

The other problem with health care markets is that of agency. While health care consumers usually make the initial decision as to whether to seek health care, once they have gone to a health care professional or institution, subsequent purchasing decisions—the ordering of tests or consultations, referrals to specialists, prescribing of drugs or devices, and admissions to hospitals—are usually initiated by professionals. The interests of the professional agent of the consumer, however, do not always align with those of the patient principal. Particularly in situations where the professional is selling his or her own services to the patient on a fee-for-service basis or is

78. THOMAS RICE, *THE ECONOMICS OF HEALTH RECONSIDERED* 81-88, 134-43 (2d ed. 2003).

79. *See id.* at 81-88; *see also* DOSE OF COMPETITION, *supra* note 14, at 17-25.

80. *See* DOSE OF COMPETITION, *supra* note 14, at 6; Jost, *supra* note 9, at 25.

81. *See* Thomas G. Kelch & Howard J. Weg, *Forward Contracts, Bankruptcy Safe Harbors, and the Electricity Industry*, 51 WAYNE L. REV. 49, 66 (2005).

82. Sara Rosenbaum contributed this insight in a review of this Essay.

referring or ordering a good or service from a provider or supplier in which the professional has an investment interest or with which the professional has a compensation arrangement, there is the possibility of a conflict of interest.⁸³ While the extent of the phenomena of physician-induced demand remains controversial, no one seriously believes that all health care professionals are motivated solely by the their patient's best interest when selling their services.⁸⁴

Other factors also limit the effectiveness of competition in health care. Both the hospital and the health insurance industries are highly concentrated in some markets. The recent Federal Trade Commission/Department of Justice report on competition in health care, for example, notes that in both St. Louis and San Francisco, four hospital systems control most of the hospitals, while in Cleveland, two hospital chains control nearly seventy percent of inpatient hospital capacity.⁸⁵ The health insurance industry is far more concentrated: in all but three states the largest three insurance plans control over half of the insurance market, and in all but fourteen states they control over sixty-five percent.⁸⁶ Patents and market exclusivity periods give monopoly power to brand name drug manufacturers for considerable periods of time,⁸⁷ while states that have certificate of need ("CON") programs protect providers with CONs from potential competitors.⁸⁸

While there is much talk in the United States about using competition to control health care costs, there is little experience with it elsewhere in the world.⁸⁹ Most countries control health care

83. See generally MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTERESTS* 55-111 (1993) (discussing the range of conflicts of interests faced by physicians to increase services).

84. See Uwe E. Reinhardt, *The Theory of Physician-Induced Demand: Reflections after a Decade*, 4 J. HEALTH ECON. 187, 189-91 (1985) (discussing physician-induced demand); Thomas H. Rice & Roberta J. Labelle, *Do Physicians Induce Demand for Medical Services?*, 14 J. HEALTH POL. POL'Y & L. 587, 587 (1989).

85. DOSE OF COMPETITION, *supra* note 14, at 11-12.

86. James C. Robinson, *Consolidation and the Transformation of Competition in Health Insurance*, HEALTH AFF., Nov./Dec. 2004, at 11, 14-15.

87. There is some competition among brand name drugs within the same therapeutic class, however, and once patent and exclusivity periods expire and generic drugs can be introduced, prices often drop dramatically. See CONG. BUDGET OFFICE, *HOW INCREASED COMPETITION FROM GENERIC DRUGS HAS AFFECTED PRICE AND RETURNS IN THE PHARMACEUTICAL INDUSTRY* 27-32 (1998), available at <http://www.cbo.gov/ftpdocs/6xx/doc655/pharm.pdf>.

88. DOSE OF COMPETITION, *supra* note 14, at 1-6.

89. See generally Timothy Stoltzfus Jost, Diane Dawson & André den Exter, *The Role of Competition in Health Care: A Western European Perspective*,

costs through regulation. With respect to some health care products and services, most often pharmaceuticals, this means price or profit controls.⁹⁰ In more and more countries, new technologies are also subjected to evidence-based review before they are covered by public insurance systems.⁹¹

In most countries, however, costs are controlled through budgets.⁹² Public insurers have global, or more often, sector-specific budgets and either through planning or negotiation allocate these budgets among health care products and services. How these budgets work is further discussed below. In the United States, the federal and state governments currently do not have a serious regulatory program for controlling health care costs, except in public programs.

C. *Quality: The 44,000 Deaths*

The third leg of the health policy triangle is quality. While we have long known that the United States has more people without access to health financing and pays more for health care than does any other developed country, we have still prided ourselves as having “the best health care system in the world.”⁹³ Those who make this claim seem to be saying that we have the smartest doctors, the latest drugs, devices, and procedures, and the best-equipped and shiniest hospitals.

In fact, however, a series of studies over the past decade and a half, beginning with the Harvard New York hospital study⁹⁴ and culminating in the Institute of Medicine’s reports, *To Err is Human*⁹⁵ and *Crossing the Quality Chasm*,⁹⁶ have revealed that the quality of our health care system is seriously deficient. *To Err is Human* reached the startling conclusion that from 44,000 to 98,000 Americans die every year from medical errors, more than those that

31 J. HEALTH POL. POL’Y & L. 685 (2006).

90. See Alan Maynard & Karen Bloor, *Dilemmas in Regulation of the Market for Pharmaceuticals*, HEALTH AFF., May/June 2003, at 31, 37-39.

91. See generally INTERNATIONAL COMPARATIVE STUDY, *supra* note 63 (describing these systems in eight countries).

92. See JOST, *supra* note 34, at 216-17, 243-48.

93. U.S. Dep’t of State, *supra* note 5.

94. See Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370 (1991); Lucian L. Leape et al., *The Nature of Adverse Events in Hospitalized Patients: Results of the Harvard Medical Practice Study II*, 324 NEW ENG. J. MED. 377 (1991).

95. IOM, *TO ERR IS HUMAN*, *supra* note 6.

96. IOM, *QUALITY CHASM*, *supra* note 6.

die of breast cancer, AIDS, or automobile accidents.⁹⁷ These reports, and many others like them, amply document the fact that failures of communication, coordination, knowledge, and sometimes sheer incompetence, plague our health care system.

What should perhaps be most troubling to us, however, is comparative quality data. We have long known that our mortality and morbidity statistics do not compare favorably with other developed countries. The average male in the United States, for example, can at birth expect to live 74.5 years, while the average British male can expect to live 76.2 years, the average German male 75.5 years, and the average Swedish male 77.9 years.⁹⁸ Also, our infant mortality rate of 6.8 deaths per thousand compares unfavorably with British, Swedish, and German infant mortality rates of 5.5, 3.7, and 4.3 deaths per thousand, respectively.⁹⁹ But mortality and morbidity rates depend on many things—diet, education, housing conditions, and genetic predispositions, to name a few—and are not necessarily determined by health care. Also, we have long known that our mortality and morbidity rates are skewed by the terrible statistics that describe the conditions of minority groups in the United States. Although this fact should trouble and embarrass us, it also means that the majority of white Americans, who have the best access to our health care system, are reasonably healthy.¹⁰⁰

In the recent past, however, new studies have emerged that examine directly and comparatively the processes and outcomes of health care. These studies show that health care quality in the United States is comparable to that in other countries.¹⁰¹ We do some things very well, other things rather poorly, and perform at about average levels in most things, just like other countries. As

97. IOM, *TO ERR IS HUMAN*, *supra* note 6, at 1.

98. OECD, *Life Expectancy at Birth, Females, Males, and Total Population* (Oct. 12, 2005), <http://www.oecd.org/dataoecd/7/42/35530071.xls> (data available for 2003).

99. OECD, *Infant Mortality Rate, Deaths per 1,000 Live Births* (Oct. 12, 2005), <http://www.oecd.org/dataoecd/7/41/35530083.xls> (data available for 2001).

100. In 2001, for example, white U.S. males had a life expectancy at birth of 75.0 years while African-American males had a life expectancy of 68.6 years; infant mortality rates were 5.7 per thousand for whites and 13.6 per thousand for African-Americans. NAT'L CENTER FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH AND HUMAN SERVS., *HEALTH, UNITED STATES, 2004*, at 132 tbl.19, 143 tbl.27 (2004).

101. See Cathy Schoen et al., *Taking The Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries*, HEALTH AFF.-WEB EXCLUSIVE, Nov. 3, 2005, at W5-509, W5-510, <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.509v3> (arguing that no country is consistently best or worst across all dimensions of measurable health care).

one would expect given our abundance of specialists and high technology equipment, we do well with conditions that require dramatic interventions like treatments for breast or cervical cancer.¹⁰² As one would also expect, however, given our fragmented and uncoordinated health care system, we do not do so well with chronic conditions that require careful monitoring over the long term, like transplant maintenance.¹⁰³ We score highly at providing quick access to specialists and to elective procedures.¹⁰⁴ Surprisingly, however, we score poorly when access to primary care is considered. While patients in New Zealand and Australia can usually get same-day service when they need to see a primary care physician, patients in the United States (and in Canada) often have to wait.¹⁰⁵

It is more difficult to identify a fundamental cause of our quality failures than it is to describe why we have problems with access and cost. Many analyses of the problem (including the IOM reports), however, point to system and coordination deficiencies.¹⁰⁶ These coordination failures often occur within institutions, resulting, for example, in medication errors that cost us \$2 billion every year.¹⁰⁷ Coordination failures also exist within the larger health care system, as when, for example, a patient with a chronic disease is passed from one physician to another because the patient's employer has changed insurers and thus provider networks or because the patient changed employers and thus had to find a new physician in the new employer's physician network.¹⁰⁸ The system provides few incentives for taking a long-term approach to problems because it is based on short-term relationships—insurance contracts are written on a year-to-year basis. Thus, there is little reason for an insurer to take steps that cost more now but might save money (or health)

102. Hussey et al., *supra* note 7, at 92 exh.1.

103. *Id.*

104. Robert J. Blendon et al., *Common Concerns Amid Diverse Systems: Health Care Experiences in Five Countries*, HEALTH AFF., May/June 2003, at 106, 117 exh.7.

105. Schoen et al., *supra* note 7, at W4-491 exh.1. Patients in the United States also have more difficulty in getting medical care in the evening, at night, or over the weekend than do people from other countries and are much more likely to forego medical care because of cost. *Id.*

106. IOM, QUALITY CHASM, *supra* note 6, at 4-9, 61.

107. IOM, TO ERR IS HUMAN, *supra* note 6, at 2.

108. See Ming Tai-Seale, *Voting with Their Feet: Patient Exit and Intergroup Differences in Propensity for Switching Usual Source of Care*, 29 J. HEALTH POL. POL'Y & L. 491, 508 (2004) (identifying changes in insurance as a primary reason for changing sources of care).

later on because the patient is unlikely to then be the insurer's responsibility.¹⁰⁹

A larger problem, moreover, is that incentives for providing high-quality care are rather weak. As already noted, in most parts of the United States it is difficult for consumers to find information that would allow them to identify the best quality providers.¹¹⁰ Neither public nor private insurance programs do much to reward high-quality providers or to punish those who provide substandard care by "paying for performance."¹¹¹ We do have licensure, certification, and accreditation programs in place that are supposed to ensure that professionals have the basic knowledge and providers have the basic structural capacity to provide adequate quality care.¹¹² These programs have not, however, been successful at assuring high-quality care, nor are they designed to do so.¹¹³ Clearly, if we do have the "best health care system in the world" (and no one knows whether this is true), it is not because the quality of our health care is particularly admirable, but rather because other nations are also struggling to get a handle on how to identify and to achieve high-quality health care and on how to avoid medical errors.

III. THE LEGAL FRAMEWORK

Over the past half century, our country has built a complex framework of laws to try to address the problems that plague our badly flawed health care system. Beginning with the common law of tort and contract and a handful of public health and professional licensure statutes, we have constructed a sometimes almost

109. CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICYMAKERS 31-32 (Regina E. Herzlinger ed., 2004) [hereinafter CONSUMER-DRIVEN HEALTH CARE].

110. DOSE OF COMPETITION, *supra* note 14, at 17-18.

111. *Id.* at 26. Although there are as of yet few operational "pay for performance" programs, there is considerable support for "pay for performance" in health care. *See generally* Robert A. Berenson, *Paying for Quality and Doing It Right*, 60 WASH. & LEE L. REV. 1315 (2003); David A. Hyman & Charles Silver, *You Get What You Pay For: Result-Based Compensation for Health Care*, 58 WASH. & LEE L. REV. 1427 (2001). Others believe, however, that it would be difficult to do well and may not be a good idea. *See* Bruce C. Vladeck, *If Paying for Quality is Such a Bad Idea, Why is Everyone for It?*, 60 WASH. & LEE L. REV. 1345 (2003).

112. *See* Timothy Stoltzfus Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care*, 25 Hous. L. REV. 525, 542-53, 582-87 (1988).

113. At best, they may be able to assure that care is of minimal quality. *Id.*; Timothy Stoltzfus Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 ARIZ. L. REV. 825, 858-66 (1995).

impenetrable maze of laws to enhance access, control cost, and oversee quality. Though the programs and approaches that these laws have created have enjoyed some notable successes, they have so far failed, on the whole, to solve the problems that they address.¹¹⁴

A comprehensive description of this web of law would fill volumes, but an attempt will be made here to sketch out their barest outlines as an introduction to the discussion that follows, which considers how to reform this body of law to bring it in line with policies that might actually achieve our health care goals.¹¹⁵ Recognizing that many of these laws address multiple policy concerns, the laws will be classified in terms of whether they primarily concern access, cost, or quality.

A. *Laws that Promote Access to Care*

Measured simply by sheer volume of legislative and regulatory output, it would seem that our most substantial health policy concern has been access to health care. Laws that promote access fall into four categories: (1) laws that establish and guide the functioning of health care financing programs; (2) tax laws that create incentives for increasing access to health care; (3) state and federal regulatory programs directed at expanding access to private health insurance; and (4) federal and state laws that encourage health care providers to provide free or reduced cost care to indigents.

Though we think of our health care system as fundamentally private in character, almost half of health care in the United States is paid for directly by public insurance programs, compared to only a little over a third financed by private health insurance.¹¹⁶ If one includes the cost of direct health care financing programs (such as Medicare, Medicaid, the Veteran's Administration, or public hospitals), the cost of tax subsidies provided to finance private health insurance, and the money the federal and state governments pay to insure their own employees, the government's share of the total health care budget climbs almost to sixty percent.¹¹⁷ Indeed,

114. The health care industry, as our nation's largest business, is also governed by a host of other laws that have little to do with health policy, such as labor laws, business organization law, and consumer protection law, though even these laws often take on specific characteristics when applied to the health care industry.

115. For a more comprehensive effort, see generally FURROW ET AL., *supra* note 8.

116. To be exact, 45.1% was covered by public funds and 35.1% by private health insurance in 2004. Smith et al., *supra* note 3, at 188 exh.2.

117. Steffie Woolhandler & David U. Himmelstein, *Paying for National Health Insurance—And Not Getting It*, HEALTH AFF., July/Aug. 2002, at 88, 91

the United States spends more public money on health care per capita than any other country in the world spends per capita on health care in total from all funds, public and private.¹¹⁸

Local government programs for providing health care to indigents existed before the founding of the Republic.¹¹⁹ Serious proposals for a national universal public health insurance program emerged in the 1910s, and federal attempts to encourage state indigent health care programs through subsidies date back to the 1950s.¹²⁰ The watershed moment in the history of public health insurance in the United States, however, was 1965, when Congress adopted the Medicare and Medicaid programs.¹²¹

Medicare is a federal program that resembles the social insurance programs of Europe. It is unusual in the international context in that it covers only the elderly and disabled, but is similar to the programs of other countries in that it is not means tested (or at least has not been until very recently)¹²² and is funded in part by payroll taxes.¹²³

The Medicare statute entitles most residents of the United States who are over age sixty-five, have been disabled for at least two years, or have end-stage renal disease to payment for hospital care, physician services, hospice care, home health care, a very limited amount of skilled nursing care, durable medical equipment, and a variety of other professional services and medical supplies.¹²⁴ As of January 1, 2006, the program also covers prescription drugs.¹²⁵ Medicare beneficiaries can receive services either through the traditional Medicare fee-for-service program or through Medicare Advantage managed-care plans, which must provide the full range

exh.2 (stating that the government's share of the total health care budget in 1999 was 59.8%).

118. *Id.* at 93 exh.5.

119. JOST, *supra* note 34, at 67.

120. *Id.* at 72-77, 80-86.

121. See THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 45-86 (2d ed. 2000).

122. The Medicare Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, means tests Medicare in two respects: first by imposing higher Part B premiums on higher income beneficiaries and second by imposing lower premiums and cost-sharing obligations in the Part D prescription drug benefit program on lower income beneficiaries. See Timothy Stoltzfus Jost, *The Most Important Health Care Legislation of the Millennium (So Far): The Medicare Modernization Act*, 5 *YALE J. HEALTH POL'Y L. & ETHICS* 437, 445 (2005).

123. See 26 U.S.C. §§ 1401(b), 3101(b), 3111(b) (2000); 42 U.S.C. § 1395i(a) (2000). Medicare Part B is funded through general revenue funds and premiums paid by beneficiaries.

124. 42 U.S.C. §§ 426(a)(1), 426(b)(2), 426-1, 1395c, 1395d, 1395x(s) (2000).

125. 42 U.S.C. § 1395w-101 (West Supp. 2005).

of Medicare services and may provide additional services.¹²⁶ The Medicare program imposes fairly stiff cost-sharing requirements,¹²⁷ and most beneficiaries have some form of supplemental insurance, such as Medicaid, retiree benefits, or a stand-alone Medicare supplement policy, to cover these cost-sharing obligations.¹²⁸ Medicare benefits are also in general subject to limits; Medicare is not a catastrophic program.¹²⁹

Most physicians, as well as other professionals and providers, participate in Medicare, and Medicare beneficiaries have free choice of these providers except insofar as the beneficiaries voluntarily enroll in a Medicare Advantage managed care plan that limits their choice.¹³⁰ Medicare is administered at the street level by private contractors who process claims.¹³¹ Traditional Medicare pays providers based on administered price systems. The prices it pays are generally based on relative value schedules constructed by comparing the resources consumed in producing a particular service or bundle of services to those consumed in producing other services or bundles of services. The “weights” reached through this process are then multiplied by a conversion factor arrived at through economic predictions and political negotiation to determine actual payment amounts.¹³² Medicare beneficiaries and providers are

126. 42 U.S.C. § 1395w-21(a)(1), 1395w-22(a)(1) (2000).

127. The Part A deductible for 2006 is \$952, the Part B deductible \$124, and the Part B coinsurance obligation for physicians visits and most other services is twenty percent. See Press Release, Centers for Medicare & Medicaid Services, U.S. Dep’t of Health & Human Servs., Fact Sheet, Medicare Premiums and Deductibles for 2006 (Sept. 16, 2005), <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1557>.

128. Mary A. Laschober et al., *Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996-1999*, HEALTH AFF.-WEB EXCLUSIVE, Feb. 27, 2002, at W3-127, W3-129, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.127v1/DC1> (noting that approximately fifty-seven percent of beneficiaries have either free-standing or retiree supplemental policies).

129. For example, the program only covers ninety days of hospital care per spell of illness, plus a one-time sixty-day “life time reserve” period. 42 U.S.C. § 1885d(a) (2000).

130. As of 2002, ninety-six percent of physicians in the United States were accepting some Medicare patients. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 74-75 (2003), http://www.medpac.gov/publications/congressional_reports/Mar03_Ch2B.pdf.

131. These claims processors are currently called intermediaries for Part A and carriers for Part B, but under the Medicare Modernization Act will be called in the future simply Medicare contractors.

132. The two most important of these prospective payments systems, the diagnosis-related groups prospective payment system for hospitals and the resource-based relative value scale for physicians, are described in FURROW ET AL., *supra* note 8, §§ 11-10, 11-16, 11-20.

protected by numerous multilayered appeal processes, and ultimately by judicial review, though the courts are reluctant to second-guess the decisions of those who administer the program.¹³³

The Medicaid program is jointly administered and financed by the federal and state governments to provide health care for those who are without the income or assets needed to pay for health care, and who have a good excuse for being in this condition.¹³⁴ Medicaid began as a program to provide federal subsidies to the states for covering welfare recipients, but the courts interpreted the Medicaid statute as creating a federal entitlement for recipients and providers, a decision subsequently endorsed by Congress.¹³⁵ In fact, however, the Medicaid program is subject to a great deal of state discretion—only some recipients and some services must be covered by the states, while many coverage and benefit categories are optional.

State Medicaid programs must cover people who are over sixty-five, disabled, or blind who received federal Supplemental Security Income (“SSI”) grants,¹³⁶ as well as pregnant women, and children under the age of six whose families earn less than 133% of the poverty level,¹³⁷ and children aged six to eighteen whose families earn less than 100% of the poverty level.¹³⁸ State Medicaid programs must also cover in whole or in part Medicare premiums and cost-sharing requirements of Medicare beneficiaries whose incomes fall below certain levels.¹³⁹ Federal law permits state Medicaid programs, moreover, to cover a host of additional categories of indigent persons at their option, and coverage varies dramatically from state to state.¹⁴⁰ Indeed, the only real federal limit on the

133. See 42 U.S.C. § 1395ff (2000); Timothy Stoltzfus Jost, *Governing Medicare*, 51 ADMIN. L. REV. 39, 45-55, 60-65 (1999).

134. See generally ANDY SCHNEIDER ET AL., KAISER COMM’N ON MEDICAID AND THE UNINSURED, THE MEDICAID RESOURCE BOOK (2002), <http://www.kff.org/medicaid/2236-index.cfm>.

135. See Timothy Stoltzfus Jost, *The Tenuous Nature of the Medicaid Entitlement*, HEALTH AFF., Jan./Feb. 2003, at 145, 145-46.

136. § 1396a(a)(10)(A)(i)(II) (2000). States may at their option use more restrictive income eligibility standards than the SSI program, as long as those standards are not more restrictive than those the state used on January 1, 1972. *Id.* § 1396a(f).

137. *Id.* §§ 1396a(a)(10)(A)(i)(IV), 1396a(a)(10)(A)(i)(VI).

138. *Id.* § 1396a(a)(10)(A)(i)(VI).

139. *Id.* § 1396a(a)(10)(E). Several other categories of poor people must also be covered by state Medicaid programs, including some parents of poor families and a number of categories of disabled people. For a full description, see SCHNEIDER ET AL., *supra* note 134, at 3-48.

140. See FURROW ET AL., *supra* note 8, § 12-2(b), at 590; SCHNEIDER ET AL., *supra* note 134, at 3-48.

states is that they (generally) may not cover healthy, able-bodied adults under the age of sixty-five who are not responsible for children.

State Medicaid programs must cover a fairly limited list of essential medical services, including hospital, physician, and skilled nursing care,¹⁴¹ but most states provide a more generous catalogue of services, recognizing that Medicaid recipients are rarely capable of paying any significant amount for health care out of pocket. Medicaid provider payments are at this point largely unregulated by federal law and vary significantly from state to state, though they are very low almost everywhere. Medicaid does provide, however, significant financial support to safety-net hospitals that also serve the uninsured through disproportionate share payments.¹⁴² Medicaid is supplemented by SCHIP, which provides funds to the states to provide health insurance for children in families with incomes up to 200% of the federal poverty level.¹⁴³ SCHIP does not afford a legal entitlement to its recipients.¹⁴⁴ Medicare and Medicaid are supplemented by a host of smaller (though by no means small) federal and state health care programs, including the Veterans' Administration, the Department of Defense Tricare program, the Indian Health Services, federally-funded Community Health Centers, programs funded under the Ryan White Comprehensive AIDS Resources Emergency ("CARE") Act,¹⁴⁵ state and local public hospitals, and workers' compensation programs. Most of these programs, which collectively cost over \$245 billion in 2004,¹⁴⁶ exist to cover populations that have some special claim to publicly financed health care, but would otherwise fall between the cracks in our

141. §§ 1396a(a)(10)(A), 1396d(a).

142. These payments are supposed to cover the additional costs incurred by hospitals that serve predominantly poorer, and thus presumably sicker, populations. § 1396r-4 (2000). Medicare also subsidizes safety-net hospitals through "disproportionate share" payments and by paying to cover the education costs of teaching hospitals, which also tend to disproportionately serve the poor. See 42 U.S.C. §§ 1395ww(d)(5)(B), (d)(5)(F). The Institute of Medicine estimates that these subsidies amounted to \$14.2 billion in 2001. INST. OF MED., HIDDEN COSTS, VALUE LOST: UNINSURANCE IN AMERICA 54 tbl.3.5 (2003), available at <http://newton.nap.edu/books/030908931X/html/54.html> [hereinafter IOM, HIDDEN COSTS, VALUE LOST].

143. 42 U.S.C. §§ 1397aa-1397jj (2000).

144. See Sara Rosenbaum et al., *Devolution of Authority and Public Health Insurance Design: National SCHIP Study Reveals an Impact on Low-Income Children*, 1 HOUS. J. HEALTH L. & POL'Y 33, 36 (2001).

145. Pub. L. No. 101-381, 104 Stat. 576 (1990).

146. See Smith et al., *supra* note 3, at 188 exh.2 (indicating that "other federal" programs cost \$118 billion and "other state and local" programs cost \$127.7 billion in 2004).

health care financing system.

Our third largest federal health care program is the tax subsidy for employment-based insurance. The amount that employers pay for employee benefits for their employees is a non-taxed business expense to the employer, but neither the value of employer-provided insurance nor the value of its benefits are taxed as income to employees once it is received. The employment-related health insurance subsidy is estimated to have been worth \$202.5 billion in 2004.¹⁴⁷

The value of this tax subsidy to any individual obviously turns on that individual's marginal tax rate—the wealthy find the program very beneficial while those with low incomes get little if any tax benefit from the subsidy.¹⁴⁸ But the existence of the program, as well as nondiscrimination provisions in the tax laws,¹⁴⁹ has encouraged employers to provide health insurance for all employees, and thus the subsidy indirectly helps out individuals too poor to receive a tax benefit from the program. Insuring individuals through their place of employment also permits the creation of large risk-sharing groups and discourages risk selection, thus also helping out higher-risk individuals. But the system also has its drawbacks. Notably, the employment-insurance link results in job lock, as one may have to stay at the same job to avoid having to change providers or even to avoid losing insurance.¹⁵⁰

147. Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 535, 544 (2005). Money that the employer contributes for health insurance is not only excluded from the employee and employer's income tax but also from Social Security and Medicare payroll taxes, which for most workers is more important since two-thirds of workers pay more in payroll than income tax. *Id.* at 543-44.

148. John Sheils & Randall Haught, *The Cost of Tax-Exempt Health Benefits in 2004*, HEALTH AFF.-WEB EXCLUSIVE, Feb. 25, 2004, at W4-106, W4-109 to -10 exh.2, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.106v1/DC1>; see also CLAUDIA WILLIAMS, THE ROBERT WOOD JOHNSON FOUND., TAX SUBSIDIES FOR PRIVATE INSURANCE: WHO CURRENTLY BENEFITS AND WHAT ARE THE IMPLICATIONS FOR NEW POLICIES? 2 (2003), available at http://www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no3_policyprimer.pdf.

149. The federal tax code prohibits self-insured employers from providing highly compensated employees with health insurance benefits superior to those provided to lower-paid employees. 26 U.S.C. § 105(h) (2000).

150. The problem of job lock was a target of the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, Pub. L. No. 104-191, 110 Stat. 1936, which limits the imposition of preexisting conditions clauses by a new insurer when an employee changes employment. 29 U.S.C. § 1181(a) (2000). HIPAA, however, does not solve the problem of a person who is insured through an employer and wants to move to a job with another employer who does not offer health insurance or wants to become self-employed.

The success of employee-benefit tax subsidies has led to a variety of further attempts to use tax-based programs to expand access, an approach that is currently very popular. The Health Savings Account (“HSA”) program¹⁵¹ attempts to use tax subsidies to encourage individuals to establish savings accounts for health care expenditures coupled with high-deductible insurance policies. A small federal tax credit program was adopted in 2003 to help persons displaced by trade agreements.¹⁵²

The merits of HSA and tax credit approaches are discussed below.¹⁵³ One consideration must be noted here, however: a major advantage of the employee-benefit tax subsidy has been the simplicity of its administration. As tax-based strategies become more complex, however, the IRS may be increasingly drawn into administering the program—deciding, for example, what services can be paid for by a HSA. The prospect of the IRS being the prime agency regulating our health care system gives one pause.

The third category of access-promoting laws includes a host of state and federal laws that require insurers to cover individuals, services, or providers that they would not cover or on terms the insurers would not accept if they were not required to do so by law.¹⁵⁴ HIPAA,¹⁵⁵ for example, limits the use of preexisting conditions clauses, a tool that insurers have long used to discourage adverse selection.¹⁵⁶ It also requires insurers that insure in the small group market to guarantee issue and renewal to all small employer groups, though it does not address the rates at which small group insurance must be offered.¹⁵⁷ Finally, HIPAA included a modest attempt to ensure that persons who lost long-term insurance coverage could get access to the individual insurance market, though that provision has been largely undermined by provisions

151. 26 U.S.C. § 223 (2000).

152. The program has had disappointing results. In 2003, only 19,410 of the estimated 200,000 to 250,000 persons eligible for the program enrolled. U.S. GEN. ACCOUNTING OFFICE, HEALTH COVERAGE TAX CREDIT: SIMPLIFIED AND MORE TIMELY ENROLLMENT PROCESS COULD INCREASE PARTICIPATION 5, 21 (2004).

153. See *infra* text accompanying notes 279-319.

154. See FURROW ET AL., *supra* note 8, § 9-4(c), at 476-78; Mark A. Hall, *The Competitive Impact of Small Group Health Insurance Reforms*, 32 U. MICH. J.L. REFORM 685 (1999); Jost, *supra* note 33, at 463-68.

155. Pub. L. No. 104-191, 110 Stat. 1936 (1996).

156. 29 U.S.C. § 1181(a)(1) (2000). HIPAA does not forbid the use of preexisting conditions clauses, but rather limits their duration (to twelve months or less in most instances) in group plans and limits their application to individuals who are moving from one job to another or who have been insured for at least eighteen months and are now seeking individual insurance.

157. 42 U.S.C. §§ 300gg-11(a), 300gg-12(a) (2000).

allowing states to substitute other approaches to coverage.¹⁵⁸ The federal Consolidated Omnibus Budget Reconciliation Act ("COBRA")¹⁵⁹ requires employment-based insurance to cover certain employees and their dependents for one-and-a-half to three years after their coverage otherwise terminates if the employee pays a premium equal to 102% of the cost of the insurance.¹⁶⁰

State laws go further. A few states require insurers to offer insurance to all small groups or individuals in the same geographic region at the same rate (community rating) or at rates modified only to take into account age and gender.¹⁶¹ Other states limit the extent to which insurers can vary premium costs among insureds.¹⁶² Many states have also established high-risk pools to make insurance available to persons who cannot otherwise afford it.¹⁶³ State laws impose a host of mandates requiring insurers to cover particular products or services (such as alcohol treatment or mammography screening), the services of particular providers (such as chiropractors or optometrists), or certain individuals (adopted children or newborns).¹⁶⁴ Yet other laws limit the ability of insurers to control adverse selection through waiting periods or preexisting conditions clauses, while others limit the discretion of insurers to exclude providers from their networks or require insurers to provide internal or external review procedures before they can deny coverage for medical services or products.¹⁶⁵

While these regulatory statutes undoubtedly make insurance available to some who would otherwise not be insured, and review procedures make a good deal of sense from the standpoint of making sure that insureds are treated fairly, any effort to dictate insurance coverage or underwriting practices is problematic. Insurers that are required to lower their rates for high-risk insureds will necessarily

158. *Id.* §§ 300gg-41 to -42, 300gg-44; *see also* FURROW ET AL., *supra* note 8, § 9-4, at 474, § 9-7, at 489.

159. Pub. L. No. 99-272, 100 Stat. 82 (1986).

160. 29 U.S.C. §§ 1161-1168 (2000).

161. *See* BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 613 (5th ed. 2004); *see also* Mark V. Pauly & Allison M. Percy, *Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets*, 25 J. HEALTH POL. POL'Y & L. 9, 22 (2000).

162. This is usually done through the application of rating bands, which limit the ratio of the highest premiums charged to the lowest. *See* FURROW ET AL., *supra* note 161, at 613.

163. *See* TOM MCCORMACK, HEALTH ADMIN. RESPONSIBILITY PROJECT, STATE HIGH RISK HEALTH INSURANCE POOLS, <http://www.harp.org/shrhip.htm> (last visited Feb. 9, 2006).

164. FURROW ET AL., *supra* note 8, § 9-4(b), at 474-76.

165. *See generally* FURROW ET AL., *supra* note 161, at 609-37.

have to raise their rates for other insureds to break even.¹⁶⁶ If insurers are forced to cover services or providers they would not otherwise have covered, they must raise their rates for everyone. Of course, there are sometimes justifications based in market failures or behavioral psychology for requiring insurers to provide coverage that insureds may not otherwise insist on, but many mandates seem more easily explained by public-choice economics than by decisionmaking heuristics.¹⁶⁷ In any event, it is ironic that, on the one hand, we insist on sticking with a private insurance-based health care financing system because of our belief in the superiority of private markets, but, on the other, use regulation to conscript private insurers to provide insurance to all comers in violation of the underwriting principles that competitive markets require private insurers to use.¹⁶⁸

Finally, federal and state law alternatively encourage or compel health care providers to provide health care to all who need it, regardless of the patient's ability to pay. Historically this has been done through tax subsidies, which the federal and state governments have long used to encourage hospitals (and a few other providers) to offer free or reduced-cost care.¹⁶⁹ These tax subsidies include not only income tax exemptions but also exemptions from sales and property tax, as well as the provision of access to tax-exempt bond financing and donations. While these subsidies have undoubtedly resulted in a substantial amount of uncompensated care, what exactly a hospital needs to do to become a "charity" is far from clear in most states¹⁷⁰ since many "charitable" hospitals continue to aggressively pursue the collection of the maximum amount possible against indigent patients.¹⁷¹ Federal tax-exempt

166. This is true unless they are otherwise earning rents and are willing to give them up.

167. See generally Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1 (1999); Frank A. Sloan & Mark A. Hall, *Market Failures and the Evolution of State Regulation of Managed Care*, 65 LAW & CONTEMP. PROBS. 169 (2002) (examining the extent to which managed care regulation responds to these problems).

168. See Jost, *supra* note 33, at 483-92.

169. See FURROW ET AL., *supra* note 8, §§ 2-1 to -16, at 38-57 (exploring the complexities of the charitable tax deduction for health care facilities).

170. See, e.g., BRADLEY E. KARLIN & T.J. SULLIVAN, COAL. FOR NONPROFIT HEALTH CARE, *REDEFINING THE COMMUNITY BENEFIT STANDARD: STATE LAW APPROACHES TO ENSURING THE SOCIAL ACCOUNTABILITY OF NONPROFIT HEALTH CARE ORGANIZATIONS* (1999).

171. Jonathan Cohn, *Uncharitable?*, N.Y. TIMES MAG., Dec. 19, 2004, at 51, 51-52.

status has also resulted in considerable IRS oversight of hospital business practices.¹⁷²

The federal Emergency Medical Treatment and Active Labor Act ("EMTALA")¹⁷³ is much clearer in its demands. Any hospital with an emergency room that accepts Medicare must screen and stabilize any person who comes to the hospital in an emergency, regardless of the ability of that person to pay.¹⁷⁴ This does not mean that the hospital has to provide the service for free—it can aggressively pursue collection later (which undoubtedly deters many indigents from taking advantage of the law). It also does not mean that the hospital has to help out a person with a serious health problem that does not constitute an emergency.¹⁷⁵ Most cancer therapy or maintenance treatment for chronic diseases is not covered by EMTALA.¹⁷⁶ But it does provide a safety net for many who are not insured and cannot otherwise afford care.

Ultimately, the federal bankruptcy code must also be seen as our federal catastrophic health care program. Health care expenses are among the leading causes of bankruptcy in the United States.¹⁷⁷ While bankruptcy allows a family crippled by medical debt to get on with life, it does nothing to guarantee future access to care; indeed, it may discourage providers from extending credit for further treatment in the future.

B. *Laws to Control Cost*

As already noted, we currently have no national strategy to control health care costs. Our output of cost-control laws and regulatory programs, therefore, has been relatively modest compared to the volume of laws we have produced addressing access to care. The one and only major federal effort at cost control to actually be enacted into law was the National Health Planning and Resources Development Act of 1974,¹⁷⁸ which was repealed a decade

172. See FURROW ET AL., *supra* note 8, §§ 2-4 to -15, at 43-57.

173. Pub. L. No. 99-272, 100 Stat. 164 (1986) (codified at 42 U.S.C. § 1395dd (2000)).

174. 42 U.S.C. § 1395dd; see also FURROW ET AL., *supra* note 8, §§ 10-2 to -12, at 512-23.

175. *Teufel v. United States*, No. 89-1272-K, 1992 WL 160908, at *5 (D. Kan. June 15, 1992).

176. See 42 U.S.C. § 1395dd(e)(1)(A) (2000).

177. See Himmelstein et al., *supra* note 41, at W5-69; Melissa B. Jacoby, *The Debtor-Patient: In Search of Non-Debt-Based Alternatives*, 69 BROOK. L. REV. 453, 456 (2004).

178. Pub. L. No. 93-641, 88 Stat. 2225.

later and survives in the CON statutes of a diminishing number of states.¹⁷⁹

All employee benefit plans are governed by the Employees Retirement Income Security Act of 1974 ("ERISA").¹⁸⁰ ERISA, enacted originally to address scandals involving underfunded and mismanaged pension funds, also extends federal authority to cover employee health benefit plans.¹⁸¹ ERISA regulations govern benefit plan disclosures and internal review procedures,¹⁸² while ERISA itself provides a cause of action in federal court for employees denied benefits by ERISA plans.¹⁸³ The greatest impact of ERISA, however, has probably been deregulatory. Section 514(a) of ERISA preempts all state laws that relate to employee benefit plans.¹⁸⁴ While § 514(b)(2)(A) saves from preemption all state laws regulating insurance, § 514(b)(2)(B) has been interpreted to forbid the states from regulating self-insured plans as insurers.¹⁸⁵ The United States Supreme Court has also interpreted § 502 of ERISA to exclude any state contract, tort, or statutory remedies against ERISA plans that would supplement or supplant ERISA's federal cause of action.¹⁸⁶

Though ERISA's preemption provisions have caused the courts a great deal of confusion, their most important effect has been to limit the extent to which state law can impose obligations or liability on employee benefit plans. A plan beneficiary who suffers serious health consequences from being denied a benefit by an employee benefits plan, for example, cannot sue in state court for millions of dollars for bad faith breach of contract, but is instead limited to recovery of the cost of the benefit in a § 502 action in federal court.¹⁸⁷

179. See Elena Salerno Flash et al., *Certificate of Need Regulation*, in 1 HEALTH CARE CORPORATE LAW: FORMATION AND REGULATION § 7, at 7-3 (Mark A. Hall ed., 1999) (describing state CON programs).

180. Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001-1461 (2000)).

181. See Daniel M. Fox & Daniel S. Schaffer, *Semi-Preemption in ERISA: Legislative Process and Health Policy*, 7 AM. J. TAX POL'Y 47, 48-52 (1988) (describing the history of ERISA preemption); Leon E. Irish & Harrison J. Cohen, *ERISA Preemption: Judicial Flexibility and Statutory Rigidity*, 19 U. MICH. J.L. REF. 109, 112-16 (1985) (describing the expansive ERISA preemption clause).

182. 29 C.F.R. §§ 2520.102-3 (plan descriptions), 2570.141 (2005) (review procedures).

183. 29 U.S.C. § 1132(a)(1)(B) (2000).

184. *Id.* § 1144(a) (2000).

185. *FMC Corp. v. Holliday*, 452 U.S. 52, 63 (1990).

186. *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 209 (2004); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987).

187. *Davila*, 542 U.S. at 210; see also Timothy Stoltzfus Jost, *The Supreme Court Limits Lawsuits Against Managed Care Organizations*, HEALTH AFF.-WEB

A state can require an insured employee benefit plan to cover substance abuse services or chiropractors, but if it does so the employer can walk away from the state requirement by self-insuring.¹⁸⁸ ERISA, therefore, gives employers some control over their costs, and thus probably makes it marginally more likely that employers will offer employee benefit plans.¹⁸⁹

The antitrust laws can also be seen as a legal strategy for controlling health care costs. Though the antitrust laws have only been applied to health care professionals since 1975, when the Supreme Court decided that professionals were engaged in “commerce,”¹⁹⁰ the health care industry has been one of the most active arenas for enforcement of the antitrust laws for the past generation. Antitrust law has had its successes: health care professionals and institutions no longer get together to fix prices and allocate markets like they used to and physician attempts to form unions to extract higher prices from managed care plans have largely come to naught.¹⁹¹ A few hospital mergers that might otherwise have gone through have been averted,¹⁹² and professionals are much freer to advertise than they used to be. But the majority of antitrust lawsuits over the past two decades have been brought by disgruntled physicians who have been denied or lost staff privileges or exclusive contracts, and most of these cases have been losers.¹⁹³ Although the government had some success in challenging hospital mergers early on, it has lost most of the cases it has brought since 1995, often because the courts accepted bizarrely broad geographic market definitions.¹⁹⁴ In short, it is difficult to discern a significant effect that antitrust enforcement is having at this point in time on

EXCLUSIVE, Aug. 11, 2004, at W4-417, W4-417, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.417v1>.

188. This is the meaning of the “deemer” clause, 29 U.S.C. § 1144(b)(2)(B) (2000), which prohibits states from regulating self-insured plans.

189. See *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 401-02 (2002) (Thomas, J., dissenting) (stating that ERISA’s exclusive federal remedy is intended to free employers from state insurance regulation and thus to encourage them to voluntarily provide health benefits).

190. See *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975) (finding that lawyers, and thus other professionals, were engaged in commerce and covered by the Sherman Act).

191. William S. Brewbaker III, *Physician Unions and the Future of Competition in the Health Care Sector*, 33 U.C. DAVIS L. REV. 545, 551, 555 (2000).

192. Peter J. Hammer & William M. Sage, *Critical Issues in Hospital Antitrust Law*, HEALTH AFF., Nov./Dec. 2003, at 88, 89.

193. Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and the Courts*, 102 COLUM. L. REV. 545, 567-70 (2002).

194. Hammer & Sage, *supra* note 192, at 90.

restraining health care costs.

The enforcement of the federal and state health care fraud and abuse laws, on the other hand, seems to have had a restraining effect on the growth of the health care costs, at least in government health care programs.¹⁹⁵ The federal civil and criminal False Claims Acts¹⁹⁶ impose stiff penalties on those who attempt to cheat federal and state health care programs, and the qui tam provisions of the federal civil False Claims Act encourage knowledgeable insiders to expose secret fraud and corruption.¹⁹⁷ Federal False Claims Act enforcement can be understood as utilization review on the cheap. The federal government, in contrast to private insurers, examines few claims closely, but when it finds false claims it comes down hard on the violator, thus creating a significant deterrent to dishonest claiming practices.¹⁹⁸ The federal bribe and kickback¹⁹⁹ and self-referral statutes and regulations,²⁰⁰ although they complicate even the simplest health care transactions, also weaken incentives providers face to provide unnecessary services.²⁰¹

A number of states have attempted to address the particular problem of high drug costs by forming purchasing pools or by encouraging generic drug substitution.²⁰² The federal Hatch-Waxman Act²⁰³ also attempts to encourage the market entry of generics by providing protected markets through market exclusivity

195. Timothy Stoltzfus Jost & Sharon L. Davies, *The Empire Strikes Back: A Critique of the Backlash Against Fraud and Abuse Enforcement*, 51 ALA. L. REV. 239, 257 (1999).

196. False Claims Amendments Act of 1986, Pub. L. No. 99-562, 100 Stat. 3153 (codified at 31 U.S.C. § 3729 (2000)).

197. Section 3729 provides for civil penalties of \$5,500 to \$11,000 per claim plus treble damages against those who knowing present false claims or use false records or statements to make claims to the federal government. See Debt Collection Improvement Act of 1996, Pub. L. No. 104-134, 110 Stat. 1321. Section 3730(b)-(c) provides for private qui tam actions to enforce these provisions.

198. Jost & Davies, *supra* note 195, at 278-80. Multimillion-dollar civil penalty settlements under the statute are now common. *Id.* at 242.

199. 42 U.S.C. § 1320a-7b(b) (2000).

200. *Id.* §§ 1395nn, 1396b(s) (2000); 42 C.F.R. § 411.353 (2005).

201. See ALICE G. GOSFIELD, MEDICARE AND MEDICAID FRAUD AND ABUSE, 67-248 (2004) (describing these laws).

202. See NAT'L CONFERENCE OF STATE LEGISLATURES, STATE PHARMACEUTICAL ASSISTANCE PROGRAMS 26 (2006), <http://www.ncsl.org/programs/health/drugaid.htm>; NAT'L CONFERENCE OF STATE LEGISLATURES, PHARMACEUTICAL BULK PURCHASING: MULTI-STATE AND INTER-AGENCY PLANS, 2005, at 1 (2005) <http://www.ncsl.org/programs/health/bulkrx.htm>.

203. Drug Price Competition and Patent Term Restoration (Hatch-Waxman) Act of 1984, Pub. L. No. 98-417, 98 Stat. 1585 (codified in scattered sections of 15, 21, and 35 U.S.C.).

periods for new generics under some circumstances.²⁰⁴ Attempts to outsource drug price regulation to Canada and other countries have been largely blocked by the Food and Drug Administration, supported by federal legislation.²⁰⁵

Finally, and perhaps most importantly, public insurance programs control their own costs through their administered price systems. These have been quite successful in recent years in holding down costs for those programs, though it is widely believed that these measures result in cost-shifting to the private sector, which accordingly experiences increased costs.²⁰⁶ The private sector, on the other hand, also copies measures used by public programs.²⁰⁷ Thus, public efforts at cost control may have some beneficial spillover to the private sector. On the whole, however, the private sector is on its own for controlling costs, with little assistance from regulation.

C. Laws that Provide Quality Oversight

If our output of legislation directed at lowering the cost of health care has been comparatively meager, even less legislation has been forthcoming intended to improve the quality of health care. Though quality oversight was the earliest province of health law, law in this area continues to develop slowly.

This is the one area of health law where the common law continues to hold sway. Medical negligence litigation, based on classic tort law (though in many states affected by “malpractice reform” legislation) is intended to deter negligent medical error and to compensate its victims.²⁰⁸ In recent decades, the reach of medical

204. 21 U.S.C. §§ 355(c)(3)(D), 355(j)(5)(D) (2000).

205. The most recent legislation, included in the Medicare Modernization Act, authorized drug importation but only if the FDA could assure the safety of imported drugs. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1121, 117 Stat. 2066, 2464-65. The FDA has refused to make this finding. See Valerie Jablow, *Consumers, States Challenge Federal Ban on Drug Imports*, 40 TRIAL 12 (2004).

206. See Paul B. Ginsburg, *Can Hospitals and Physicians Shift the Effects of Cuts in Medicare Reimbursement to Private Payers?*, HEALTH AFF.-WEB EXCLUSIVE, Oct. 8, 2003, at W3-472, W3-472, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.472v1.pdf>.

207. See DOSE OF COMPETITION, *supra* note 14, at 8; Uwe E. Reinhardt, *Breaking American Health Policy Gridlock*, HEALTH AFF., Summer 1991, at 96, 99.

208. See Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 N.Y.U. L. REV. 1929, 1931-32, 1939-40, 1985 (2003); David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 915-17 (2005) (exploring the

negligence litigation has expanded through theories of corporate negligence and vicarious liability to cover health care institutions (including, in some states and under certain circumstances, managed care organizations), as well as professionals.²⁰⁹ Institutional liability has in turn spurred institutional risk management programs.²¹⁰

Most commentators agree that our current malpractice system fares poorly as a compensation system. It does little for those who suffer noncatastrophic injuries and imposes very high transaction costs.²¹¹ Even those who suffer catastrophic injuries are often not fully compensated.²¹² It is also not clear that the current system does much to deter error or encourage quality.²¹³ Malpractice remains a perennial political football, however, as trial lawyers are one of the mainstays of the Democratic Party, while organized medicine and business interests give generously to the Republican Party whenever the tocsin of tort reform is sounded. Academics, for their part, regularly push no-fault compensation systems²¹⁴ or enterprise liability,²¹⁵ but their advice falls largely on deaf ears.²¹⁶

deterrent potential of malpractice litigation).

209. FURROW ET AL., *supra* note 8, § 7-2, at 375, § 7-4, at 386.

210. *Id.* § 4-24, at 128.

211. See PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 24, 186-98 (1985); PAUL C. WEILER, *MEDICAL MALPRACTICE ON TRIAL* 13, 61-69 (1991).

212. Frank A. Sloan & Stephen S. van Wert, *Cost and Compensation of Injuries in Medical Malpractice*, 54 *LAW & CONTEMP. PROBS.* 131, 158 (1991).

213. Indeed, some commentators argue that medical malpractice litigation hinders attempts to deal with medical error by masking the systemic problems that cause error. See Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 *AM. J.L. & MED.* 501, 527-31 (2004).

214. See, e.g., Jeffrey O'Connell, *No-Fault Insurance for Injuries Arising from Medical Treatment: A Proposal for Elective Coverage*, 24 *EMORY L.J.* 21 (1975) (arguing that no-fault liability could be effectively applied to the medical profession); David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States*, 27 *AM. J.L. & MED.* 225 (2001) (suggesting methods of implementing a no-fault compensation system).

215. See Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 *HARV. L. REV.* 381, 382-84 (1994); Barry R. Furrow, *Enterprise Liability and Health Care Reform: Managing Care and Managing Risk*, 39 *ST. LOUIS. U. L.J.* 79, 80 (1994).

216. Virginia and Florida have adopted no-fault systems for cases involving brain-damaged infants. See David G. Duff, *Compensation for Neurologically Impaired Infants: Medical No-Fault in Virginia*, 27 *HARV. J. ON LEGIS.* 391, 391-92 (1990). The federal government also has a no-fault compensation program for injuries caused by vaccines. See National Childhood Vaccine Injury Act of

The other classic legal approach to quality oversight is professional and institutional licensure. To become qualified to practice their professions, health care professionals must fulfill specific educational requirements, pass a licensure examination, and be of good “character.”²¹⁷ Licensure assures that health care professionals possess, at least at one point in time, a specific knowledge base relevant to their practice. Licensure agencies can also, at least in theory, discipline their licensees for incompetence or for unethical conduct, though they seldom do.²¹⁸

Private accreditation and certification bodies, such as the Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”) or the medical specialty boards, offer further credentials. Professional certification is based on the acquisition of additional knowledge and experience beyond the basic level required for licensure, and in some cases on periodic demonstration of ongoing competence.²¹⁹ Institutional accreditation requires the fulfillment of additional structural (and sometimes process and outcome) requirements on an ongoing basis.²²⁰ Accredited hospitals can participate in Medicare on the basis of their accreditation; thus the Medicare program encourages private efforts at improving quality.²²¹ There is little firm evidence, however, that accreditation in fact improves quality, though it would seem to assure the basic structural foundation for providing quality care.

Finally, some efforts are being made to generate and disseminate information about quality and error. The National Practitioner Data Bank, for example, accumulates data on malpractice settlement and judgments, hospital staff privilege decisions, and professional discipline actions.²²² These data are not available to the public, however, but rather only to hospitals, managed care organizations, and licensure boards.²²³ Some public agencies are beginning to collect or require the collection of data to

1986, Pub. L. 99-660, 100 Stat. 3756 (codified as amended at 42 U.S.C. §§ 300aa-1 to aa-34 (2000)).

217. Timothy S. Jost, *Oversight of the Competence of Healthcare Professionals*, in *REGULATION OF THE HEALTHCARE PROFESSIONS* 17, 21 (Timothy S. Jost ed., 1997).

218. *Id.* at 21-32.

219. *See* Jost, *supra* note 112, at 542-52 (discussing the role of certification in quality oversight).

220. Timothy S. Jost, *Medicare and the Joint Commission on Accreditation of Healthcare Organizations: A Healthy Relationship?*, 57 *LAW & CONTEMP. PROBS.* 15, 17 (1994).

221. *Id.* at 15; *see also* 42 U.S.C. §§ 1395x(e), 1395bb (2000).

222. *See id.* §§ 11131-11133 (2000); 45 C.F.R. § 60.1 (2005).

223. 42 U.S.C. § 11137(b)(1) (2000); 45 C.F.R. § 60.13 (2005).

be made available to the public for purchasing decisions, but this information remains sparse and primitive.²²⁴

In sum, despite a great deal of discussion about quality oversight in recent years, little has been accomplished yet in terms of implementing a strategy to assure or improve it, at either the state or federal level.

D. Legal Approaches: An Initial Assessment

As one looks over this body of law, one is struck again by its ad hoc nature. The common law foundation has indeed in all areas—other than medical negligence law—been buried under layers of legislation and regulation, but in most instances statutes were adopted to address a particular problem at a particular time, often without careful consideration of how the new law would interact with existing statutes. These laws also reflect different understandings of how our health care system functions and should function, and different philosophies as to how to improve its functioning.

This ad hoc approach to lawmaking has resulted occasionally in intractable conflicts. Some of these conflicts are played out in the arena of federalism—for example, the battle between ERISA preemption and state insurance regulation²²⁵ or between federal Medicaid law and state Medicaid program administration.²²⁶ Others exist because of conflicting policy goals within a single government program—for example, federal pharmaceutical policy pursues both the goal of encouraging innovation through intellectual property protection, on the one hand, and the goal of promoting cost control through encouraging generic competition, on the other. State malpractice law, many believe, encourages physicians to conceal error and thus discourages attempts to deal with error through peer review or systems improvements, which are otherwise encouraged by state law.²²⁷

Our ad hoc production of law also results in considerable redundancy. Federal insurance mandates overlay state insurance mandates; federal Medicare institutional certification requirements coexist with state institutional licensure requirements (and with

224. See David Lansky, *Providing Information to Consumers*, in CONSUMER-DRIVEN HEALTH CARE, *supra* note 109, at 419, 424-25. See generally William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701 (1999) (discussing various rationales for disclosing health care information).

225. See *supra* text accompanying notes 182-89.

226. See Jost, *supra* note 135, at 146-51.

227. See IOM, TO ERR IS HUMAN, *supra* note 6, at 3.

private accreditation standards), which may be identical or may be different. Providers and insurers have to comply with multiple laws and submit to multiple inspections and audits.

Most importantly, however, our health law does not reflect any articulated and coherent understanding of the problems that attend our health care system, nor any coordinated set of policies that we should pursue to try to fix them. Because of this, some problems, like the problems of the uninsured or of medical error, are not addressed effectively by our laws. Others, like the problem of health care cost, are hardly addressed at all. Our laws, in sum, are largely ineffective in dealing with the problems that plague our health care system; they are, indeed, often counterproductive. Unfortunately, however, the leading proposals for changes in our health law and policy are likely to take us in the wrong direction—to make things worse rather than better. It is to these that we now turn.

IV. PROPOSED FIXES

Though we have discussed the problems of access, cost, and quality and the laws that address them separately, it is obvious that proposals for health care reform must address all of these issues together. If we had an unlimited amount of money to spend on health care, we could, perhaps, expand access and improve quality at the same time. But there are limits to how much we are willing to spend on health care, and until we can control the cost of health care we will find it very difficult to expand access. If we place Draconian limits on cost to expand access, however, we may threaten quality. We must try, therefore, to devise solutions that can in fact control cost, expand access, and improve quality.

Addressing any of the three problems, and particularly all three in tandem, will be difficult. It is essential to realize, however, that the task is not impossible. Other countries have health care systems that make health care products and services available to all their citizens at a much lower cost than we do and with equivalent quality.²²⁸ All of these systems have problems, many regard themselves to be in crisis, but none face problems of the severity that we face. These problems are, in sum, not completely intractable—we know how others have solved them. Rather, our limitation is a lack of vision, of imagination, and of the political will to face down the special interests that prosper under, and thus insist on, the continuation of, the current system. Most importantly, we lack the humility and intelligence to break free from settled understandings about the nature of health care and of health care

228. See Timothy Stoltzfus Jost, *Why Can't We Do What They Do?*, *National Health Reform Abroad*, 32 J.L. MED. & ETHICS 433, 435-37 (2004).

markets that have been drilled into us by a media shaped by a steady drumbeat of ideological advocacy²²⁹ and to learn from the experience of other countries in addressing problems common to all.

A. *Providing Access*

The access problem, as noted above, is attributable in part to the skewed distribution of health care costs, and in part to the problem of affordability of health insurance. A workable solution needs to broadly distribute both risk and cost. Employment-based insurance has worked reasonably well in the United States for pooling risk. It has also worked reasonably well for addressing the cost of health insurance, as long as health care costs have borne a reasonable relationship to wages.

The severe increases in health care costs that we have experienced over the past three decades, however, have made our employment-based system increasingly less viable. In the recent past, employers have been able to keep the system afloat in large part by shifting costs to employees through making employees bear a larger share of premium costs and by building more cost-sharing into insurance plans.²³⁰ For a time in the mid-1990s, moreover, they were able to hold costs down effectively through managed care.²³¹ We are currently reaching the point, however, where the cost of health insurance is growing so rapidly and already constitutes such a large part of total employee compensation (at least for low and moderate wage employees) that the viability of our employment-based insurance system is itself threatened.

Moreover, the system has never worked very well for some people. Small employers, who cannot offer insurers large risk pools, have long had problems affording insurance.²³² Employment-related insurance is often not available to part-time, temporary, and seasonal workers, even though these workers comprise a significant share of our workforce.²³³ As we have moved over the past half century toward a workforce of two-worker families, moreover, it

229. See TRUDY LIEBERMAN, *SLANTING THE STORY: THE FORCES THAT SHAPE THE NEWS* 117-48 (2000) (documenting the highly effective campaign of the Heritage Foundation and other conservative advocacy groups to shape media presentation of health care issues).

230. See Gabel et al., *supra* note 25, at 202-03.

231. See Alain C. Enthoven, *Employment-Based Health Insurance is Failing: Now What?*, HEALTH AFF.-WEB EXCLUSIVE, May 28, 2003, at W3-237, W3-237, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.237v1>.

232. See Gabel et al., *supra* note 25, at 206-07.

233. *Id.* at 207; U.S. GEN. ACCOUNTING OFFICE, *CONTINGENT WORKERS: INCOMES AND BENEFITS LAG BEHIND THOSE OF REST OF WORKFORCE* 10-22 (2000), available at <http://www.gao.gov/new.items/he00076.pdf>.

would appear that some businesses—indeed whole industries—have tended to free-ride on other businesses that have offered family policies to their workers.²³⁴

While employment-related insurance has worked reasonably well, the best risk spreader is the government, which can include the entire national population in one risk pool. Most developed countries achieve broad spreading of risk either through social insurance programs, funded through wage-based premiums (essentially payroll taxes), or through national health insurance programs financed through general revenue funds.²³⁵ As an increasing share of national income is being directed in most developed countries toward capital in the form of profits, dividends, or interest, rather than toward labor in the form of wages, broad-based taxes not limited to wages alone have begun to make more sense for spreading the cost broadly.²³⁶

Even those who are ideologically opposed to government finance of health care recognize that government will have to help those who do not have enough income or resources to afford health care.²³⁷ Commentators who are committed to private finance of health care, however, have argued that this should be done by providing tax credits to individuals, who would then use these credits to purchase insurance in the individual health insurance market.²³⁸ This is, for

234. Seventy-two percent of small employers who do not offer health insurance give as an important reason for their not doing so that their employees are covered elsewhere. KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 2004 ANNUAL SURVEY 39 (2004), <http://www.kff.org/insurance/7148/index.cfm>. Only sixty-two percent of workers in retail sales are offered health insurance and only seventy-seven percent of those take it up, resulting in a forty-seven percent coverage rate. By contrast, ninety-one percent of workers in manufacturing are offered health insurance and eighty-seven percent take it up, resulting in a eighty percent coverage rate, while ninety percent of workers in state and local government are offered insurance and ninety-four percent take it up, resulting in a eighty-four percent coverage rate. *Id.* at 49.

235. See Jost, *supra* note 228, at 433-35.

236. See JOST, *supra* note 34, at 256.

237. See Mark V. Pauly, *Conflict and Compromise Over Tradeoffs in Universal Health Insurance Plans*, 32 J.L. MED. & ETHICS 465, 470 (2004).

238. For a small sampling of recent proposals for tax credits, see Stuart M. Butler, *Reforming the Tax Treatment of Health Care to Achieve Universal Coverage*, in COVERING AMERICA: REAL REMEDIES FOR THE UNINSURED 23 (Elliot K. Wicks ed., 2001), available at http://www.esresearch.org/RWJ11PDF/full_document.pdf; Lynn Etheredge, *A Flexible Benefits Tax Credit for Health Insurance and More*, HEALTH AFF.-WEB EXCLUSIVE, Mar. 22, 2001, at W1, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w1.1v1>; Lawrence Zelenak, *A Health Insurance Tax Credit for Uninsured Workers*, 38 INQUIRY 106, 107-08 (2001); see also Jost, *supra* note 33, at 420-21 (describing proposals from various

example, the position of the Bush administration.²³⁹

Tax credit advocates generally recognize that a traditional tax credit—an amount subtracted from tax liability at the time taxes are paid—would do little to make health insurance affordable. Tax credits have to be available in advance on a monthly basis at the time premiums are due.²⁴⁰ They also have to be refundable; available whether or not taxes are actually owed, as forty-five percent of the uninsured are too poor to actually have income tax liabilities.²⁴¹ Tax credits are essentially vouchers made available by the government to individuals to pay for private health insurance.

To really work, moreover, tax credits have to be quite large. The \$1000 credits proposed by George W. Bush as a presidential candidate, for example, might help to make health insurance more affordable to higher-income uninsureds, but would not bring it within the reach of many lower-income uninsureds.²⁴² One analysis concluded that the proposal President Bush made during the 2004 campaign would have only reduced the number of uninsured by 1.8 million (though his more recent proposals are more generous).²⁴³

sources that all rely on the current system of private insurance); U.S. GEN. ACCOUNTING OFFICE, HEALTH INSURANCE: PROPOSALS FOR EXPANDING PRIVATE AND PUBLIC COVERAGE 6-9 (2001), *available at* <http://www.gao.gov/new.items/d01481t.pdf> (proposing additional tax incentives to encourage purchase of private health insurance). *See generally* EMPOWERING HEALTH CARE CONSUMERS THROUGH TAX REFORM (Grace-Marie Arnett ed., 1999).

239. *See* Press Release, The White House, Making Health Care More Affordable (Sept. 2, 2004), <http://www.whitehouse.gov/news/releases/2004/09/print/20040902.html>.

240. JOST, *supra* note 34, at 194. This will require reconciliation at year's end, which will be difficult because the income of many uninsured persons is continually in flux. It might also require repayments for those who receive credits that ultimately exceed their entitlement, which will be difficult for low-income uninsureds. *Id.*

241. Jonathan Gruber & Larry Levitt, *Tax Subsidies for Health Insurance: Costs and Benefits*, HEALTH AFF., Jan./Feb. 2000, at 72, 74.

242. *See* FAMILIES USA, A 10-FOOT ROPE FOR A 40-FOOT HOLE: TAX CREDITS FOR THE UNINSURED, 2004 UPDATE, at 3-5 (2004), *available at* http://www.familiesusa.org/assets/pdfs/10_Foot_Rope_update_2004804d.pdf.

243. KAISER FAMILY FOUND., COVERAGE AND COST IMPACTS OF THE PRESIDENT'S HEALTH INSURANCE TAX CREDIT AND TAX DEDUCTION PROPOSALS 4 (2004), <http://www.kff.org/insurance/upload/Coverage-and-Cost-Impacts-of-the-President-s-Health-Insurance-Tax-Credit-and-Tax-Deduction-Proposals.pdf>.

While 3.1 million uninsured would gain individual insurance under the program, 1.3 million would lose employment-related coverage, and thus become uninsured. *Id.* President Bush has recently offered an increased tax credit of \$1000 for a HSA and \$2000 for an insurance policy for families earning under \$25,000 a year. *See* Press Release, *supra* note 239. This would obviously cover many more of the uninsured, but would still require families headed by a person aged forty-five or older to spend, on average, \$3,865 per year to purchase

Credits would also have to be risk adjusted.²⁴⁴ Because of the skewed nature of health risks, insurers selling policies in the individual market have to charge higher rates to, or refuse to insure, older persons or persons with chronic diseases. This problem can be addressed by risk-adjusted tax credits, but risk adjusting is still a fairly primitive technology,²⁴⁵ and unless we simply agree to pay whatever price insurers decide to charge it is likely that some uninsured persons will experience a much bigger gap between their credit and the cost of insurance than others. Alternatively, one can require all insurers to community rate, but the problems with this approach have already been explored.²⁴⁶

Most tax credit advocates assume that credits will be spent to purchase health insurance in the individual market. Though individual insurance policies often cost less than group policies, they are cheaper only because they offer fewer benefits and require higher cost-sharing.²⁴⁷ Administrative costs, including marketing, underwriting, and risk premiums, are much higher for individual policies than for large group, or even small group, policies, and thus the policies offer less value for money.²⁴⁸ Though the significantly expanded market for individual insurance that could be created by tax credits might bring down administrative costs, the nature of the individual insurance market makes it unlikely that it will ever be as efficient as group markets or direct government provision of insurance.

The enlarged market for individual insurance would, of course, have to be regulated. Government regulators would have to make sure that insurers were adequately capitalized, maintained appropriate reserves, were truthful and transparent in their marketing practices, and were honest and expeditious in their claims practices. To make markets for individual insurance function properly, moreover, someone would need to collect and disseminate

high-deductible, high cost-sharing, low-benefit, policies in the non-group market. See KAISER FAMILY FOUND., *supra* note 41, at 5.

244. See David B. Kendall, *A Health Insurance Tax Credit*, in CONSUMER-DRIVEN HEALTH CARE, *supra* note 109, at 749, 757-58.

245. See JOSEPH P. NEWHOUSE, PRICING THE PRICELESS: A HEALTH CARE CONUNDRUM 169 (2002); Joseph P. Newhouse, *Patients at Risk: Health Reform and Risk Adjustment*, HEALTH AFF., Spring 1994, at 132, 132.

246. See *supra* text accompanying notes 161-68.

247. KAISER FAMILY FOUND., *supra* note 41, at 5.

248. Administrative loads can equal thirty percent to forty percent for individual policies. See Mark A. Hall, *The Geography of Health Insurance Regulation*, HEALTH AFF., Mar./Apr. 2000, at 173, 175; Mark V. Pauly & Allison M. Percy, *Cost and Performance: A Comparison of Individual and Group Health Insurance Markets*, 25 J. HEALTH POL. POL'Y & L. 9, 18-20 (2000).

information on the alternative policies available.²⁴⁹ Individual markets would also work better if standard policies were available, so that true comparative shopping would be possible. Experience with Medicare supplement policies, for example, indicated that the sale of individual policies in unregulated markets led to consumer confusion, and sometimes to fraud.²⁵⁰

One has to wonder, however, what is achieved—other than enriching those who sell insurance—if the government pays for insurance in a heavily regulated market with high regulatory costs and high private transaction costs rather than simply paying for health care.²⁵¹ It seems like the worst of all possible worlds, and one has to be an awfully strong believer in the innate and inevitable superiority of markets to believe that it is worth the effort.²⁵² Indeed, the experiences of other countries that have tried something like it—Chile, for example—does not inspire confidence.²⁵³

Alternatively, governments can provide health insurance through public social insurance or national health service programs. This approach provides for the broadest possible sharing of risk and cost, and assures coverage to all. Government financing of health care does not necessarily bring with it government provision of health care. In fact, in most countries with public insurance programs, primary care is privately provided, and in many countries private, religious, nonprofit or for-profit hospitals continue to coexist with public facilities, much as they do in the United States.²⁵⁴ In a

249. The realization that health insurance markets need to be structured is one of the contributions of Alain Enthoven. See, e.g., Alain C. Enthoven, *Market Forces and Efficient Health Care Systems*, HEALTH AFF., Mar./Apr. 2004, at 25, 27.

250. Medigap policies were eventually standardized. Adam Atherly, *Supplemental Insurance: Medicare's Accidental Stepchild*, 58 MED. CARE RES. & REV. 131, 138-42 (2001).

251. See Jost, *supra* note 33, at 483-91.

252. Alternatively, one can explain the interest in tax credits as an example of public choice economics: insurers stand to make a great deal of money from a tax credit program and thus have a strong incentive to convince Congress to adopt one. See Jonathan Oberlander, *The Politics of Health Reform: Why Do Bad Things Happen to Good Plans?*, HEALTH AFF.-WEB EXCLUSIVE, Aug. 27, 2003, at W3-391, W3-392-93, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.391v1.pdf>.

253. See Timothy Stoltzfus Jost, *Managed Care Regulation: Can We Learn from Others? The Chilean Experience*, 32 U. MICH. J.L. REFORM 863 (1999).

254. See EUROPEAN PARLIAMENT, DIRECTORATE GENERAL RESEARCH, WORKING PAPER: HEALTH CARE SYSTEMS IN THE EU: A COMPARATIVE STUDY (1998), reprinted in FURROW ET AL., *supra* note 161, at 509-13. In Germany, for example, fifty-four percent of hospital beds were in public hospitals, thirty-eight percent in private nonprofit hospitals, and eight percent in for-profit hospitals in 2002. REINHARD BUSSE & ANNETTE RIESBERG, EUROPEAN HEALTH CARE

number of countries with social insurance programs, indeed, public insurance is administered by private, nonprofit entities.²⁵⁵

We know that public health insurance is feasible, because most of the countries in the world use it. Indeed, our own largest insurance programs, Medicare and Medicaid, are public programs and provide insurance coverage to very high-cost populations at a cost that compares very favorably with the private sector.²⁵⁶ Public insurance is not, of course, without its own problems. Most of these relate to the strategies that public programs use to control costs, and are discussed in the next section. Public systems are open to political manipulation, as is evidenced by the difficulty that Medicare has faced in getting a competitive-bidding project underway.²⁵⁷ Public programs also often lack the flexibility and adaptiveness found in some private health insurance programs, since they must usually operate through open and accountable processes that make rapid and dramatic change difficult.²⁵⁸ Public programs are necessarily controlled by bureaucracies, and can thus be afflicted by the inefficiencies and corruption that plague bureaucracies. Finally, public programs are subject to the same problems of moral hazard that afflict private insurers; indeed, they may be subject to a greater risk of moral hazard if individuals are less sensitive to spending public money.

While these problems are serious, they are not insurmountable. Obviously countries throughout the world have managed these problems with greater or lesser success. How well they are managed depends on many factors, including the culture of public service within particular countries, the way in which benefits are structured (the extent of cost-sharing, for example), and the way in which providers relate to the government. Attention needs to be paid to these issues and others, therefore, in determining what role public insurance should play in a health care system.

B. *Controlling Cost*

The solution to the problem of health care cost control is simple.

OBSERVATORY, HEALTH CARE SYSTEMS IN TRANSITION: GERMANY 56 (2004), available at <http://www.euro.who.int/Document/E85472.pdf>.

255. See *id.* at 35 (Germany).

256. See generally MARILYN MOON, BENEATH THE AVERAGES: AN ANALYSIS OF MEDICARE AND PRIVATE EXPENDITURES (1999).

257. See Barbara S. Cooper & Bruce C. Vladeck, *Bringing Competitive Pricing to Medicare*, HEALTH AFF., Sept./Oct. 2000, at 49, 51.

258. This is one of the reasons that Medicare has relied on private accreditation programs to regulate providers. See Timothy S. Jost, *Oversight of the Competence of Healthcare Professionals*, in REGULATION OF THE HEALTHCARE PROFESSIONS, *supra* note 217, at 17, 30.

All we need to do is eliminate the provision of unnecessary health care, control or bring down the prices of health care products and services, and finance and deliver products and services in the most efficient way possible to minimize administrative costs. The difficulty is figuring out how to do this.

Three solutions have been most frequently mooted. Two of them rely on competition and one on regulation. Those who believe that the health care cost dragon can best be slain through competition advocate the creation of competitive markets either for the sale of health insurance or for the sale of health care. That is, they believe that competition is most effective either at the point of time when consumers purchase health insurance or at the point in time when they purchase health care. Regulatory strategies try to control the provision of health care by limiting supply through budgets, health planning, or utilization controls, and controlling prices either through price setting or through negotiation of prices.

Strategies that rely on managed competition for the sale of health insurance were popular throughout the 1980s and 1990s. The theory of managed competition was first articulated by Stanford economist Alain Enthoven,²⁵⁹ but a form of it has long existed in the Federal Employees Health Benefit Program and the California Public Employees Retirement System.²⁶⁰ The theory was the foundation of the Clinton health plan²⁶¹ and underlies the current Medicare Advantage program and the soon-to-be implemented Medicare prescription drug program.

Managed competition attempts to get private health plans to compete with each other in a managed market to provide insurance and care management to individuals.²⁶² Health plans are required to

259. ALAIN C. ENTHOVEN, *HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE* (1980); Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy (First of Two Parts)*, 320 NEW ENG. J. MED. 29 (1989) [hereinafter Enthoven & Kronick, *First of Two Parts*]; Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy (Second of Two Parts)*, 320 NEW ENG. J. MED. 94 (1989).

260. See JOHN C. GOODMAN & GERALD L. MUSGRAVE, NAT'L CTR. FOR POL'Y ANALYSIS, *A PRIMER ON MANAGED COMPETITION: WHAT IS MANAGED COMPETITION?* (1994), available at <http://www.ncpa.org/pub/st/st183/st183.pdf>.

261. See Theda Skocpol, *The Rise and Resounding Demise of the Clinton Plan*, HEALTH AFF., Spring 1995, at 66, 69.

262. The market is managed by "sponsors," such as purchasing cooperatives, which set rules to govern competition, select participating providers, and manage risk selection by, for example, adjusting premiums for risk and manage enrollment. Alain C. Enthoven, *The History and Principles of Managed Competition*, HEALTH AFF., Supp. 1993, at 25, 29-35.

sell comparable products for which each sets its own price.²⁶³ Individual purchasers (whose purchases are often financed in part by employers or by government programs) choose among plans based on price, on such quality information as is available, and on whatever other variables purchasers might find important (for example, a plan's coverage of providers with whom the insured currently has a relationship or a plan's reputation for claims handling).²⁶⁴ Health plans, in turn, try to control cost and utilization through traditional managed care techniques, such as negotiated provider price discounts, utilization review, provider networks limited to those who practice conservatively, or financial incentives to encourage limited utilization of health care.²⁶⁵ Health plans that cannot limit their costs must charge higher prices and will lose market share to those that are successful in holding down costs. On the other hand, plans that stint too much on care or attract poor quality providers will develop a bad reputation and lose out in competition.

On its face, managed competition is an appealing theory. It claims to rely on competition to bring down health care costs, and is thus consistent with the general American preference for private, market-based solutions. It brings the creativity and flexibility of private business to bear on the problem of cost control and is less open to political manipulation than are regulatory solutions. Programs that have actually tried this approach have experienced some modest success in holding down costs.²⁶⁶

On the other hand, managed competition has its own problems, many of which have become apparent in our experiences with managed care over the past decade.²⁶⁷ First, managed competition depends on consumers being able to make rational decisions between alternative health plans at the point that they purchase insurance, and then being willing to be bound by that decision at a

263. *Id.* at 31.

264. Enthoven & Kronick, *First of Two Parts*, *supra* note 259, at 32-33.

265. *Id.* at 35.

266. The leading example usually referred to is the Federal Employees Health Benefits Program. For two competing evaluations of the success of the program compared to the federal Medicare program, compare STUART M. BUTLER, THE HERITAGE FOUND., *COMPARING THE PERFORMANCE OF MEDICARE AND THE FEHBP* (2003), available at <http://www.heritage.org/Research/HealthCare/wm285.cfm>, with MARK MERLIS, KAISER FAMILY FOUND., *FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM: PROGRAM DESIGN, RECENT PERFORMANCE, AND IMPLICATIONS FOR MEDICARE REFORM 15* (2003), <http://www.kff.org/medicare/6081-index.cfm>.

267. Managed competition is not the same as managed care, but does rely on managed care to actually pay providers.

later point when the consumer becomes a patient and actually needs health care.²⁶⁸ For this approach to work at all, the consumer needs much more information at the point of purchase than is often available.²⁶⁹ Even if the consumer had, and was capable of digesting in some useful way, all the information available at the time of health plan purchase regarding the benefits and limitations of each available plan, the consumer still could not know fully at that point whether he or she will need health care in the future, exactly what he or she will need, and whether and to what extent any particular plan will cover that care.²⁷⁰ The decision to agree to a conservative practice style may look attractive to the apparently healthy health plan consumer at the point of purchase if accompanied by a low price tag, but may look very different to the desperate cancer patient nine months later who is flailing about trying to find some hopeful medical treatment upon which to cling.

Further, though managed competition is sold as a demand-driven cost-control strategy, at the back end where costs are actually controlled, it depends on supply controls, just like government health care programs. Managed competition depends on managed care to translate the lower prices paid by consumers for health insurance into actual reductions in health care costs. That is, as the Supreme Court noted in the *Pegram* case, managed care depends on rationing.²⁷¹ The backlash that occurred once patients (and providers) became fully aware of this fact in the late 1990s seriously damaged the credibility and legitimacy of managed care.²⁷² Managed care, moreover, often depends on the most intrusive form of supply control, utilization review, through which managed care plan operatives second-guess the decisions of treating physicians. Many physicians (and patients) find this form of control through “reins” more offensive than control through budget “fences,” which is relied on by many public insurance programs.²⁷³ Finally, the

268. M. Gregg Bloche, *Trust and Betrayal in the Medical Marketplace*, 55 STAN. L. REV. 919, 928-29 (2002); Wendy K. Mariner, *Can Consumer-Choice Plans Satisfy Patients? Problems with Theory and Practice in Health Insurance Contracts*, 69 BROOK. L. REV. 485, 517-19 (2004).

269. For a discussion of the problems involved in informing consumers, see Timothy Stoltzfus Jost, *Health System Reform: Forward or Backward with Quality Oversight?*, 271 JAMA 1508 (1994); Korobkin, *supra* note 167, at 27-62; Sage, *supra* note 224, at 1720-36.

270. Mariner, *supra* note 268, at 517-18.

271. *Pegram v. Herdrich*, 530 U.S. 211, 220-21 (2000).

272. See Peter D. Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365, 370-76 (2003); David Orentlicher, *The Rise and Fall of Managed Care: A Predictable “Tragic Choices” Phenomenon*, 47 ST. LOUIS U. L.J. 411, 419 (2003).

273. See Kevin Grumbach & Thomas Bodenheimer, *Reins or Fences:*

administrative costs of managed competition and managed care are very high, reflecting one additional layer of administration necessary to structure and oversee the competition among health plans, as well as a second layer of administration within plans to actually manage the care rationing process.

While the managed care backlash of the late 1990s, as well as the recent lackluster experience of managed competition programs, has taken some of the wind out of the sails driving managed competition in the national policy agenda, its place in the hearts of conservative health policy analysts (many of whom never believed in it to begin with)²⁷⁴ has been filled with “consumer-driven health care,” based on HSAs.²⁷⁵ Medical savings accounts (“MSAs”) were introduced onto the American health policy stage by the Health Insurance Portability and Accountability Act (“HIPAA”) of 1996, which granted tax subsidies to MSAs on a limited and experimental basis to see if they could live up to the promises of their supporters.²⁷⁶ MSAs were also introduced on an experimental basis into Medicare by the 1997 Balanced Budget Act.²⁷⁷ Despite the fact that both experiments were a dismal failure—no one ever signed up for a Medicare MSA and few people signed up for the HIPAA MSAs²⁷⁸—the supporters of MSAs extended tax benefits to a much larger category of MSAs (rechristened “Health Savings Accounts” or HSAs) through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.²⁷⁹

Consumer-driven health care attempts to direct competition to the point at which health care goods and services are purchased. It is firmly rooted in a belief that overinsurance drives health care cost

Physician's View of Cost Containment, HEALTH AFF., Winter 1990, at 120, 122-25.

274. See, e.g., CONSUMER-DRIVEN HEALTH CARE, *supra* note 109, at 96-97.

275. See *id.* at 83-84, 96-97; Michael E. Porter & Elizabeth Olmsted Teisberg, *Redefining Competition in Health Care*, HARV. BUS. REV., June 2004, at 65, 73.

276. Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended at I.R.C. § 220 (West 2005)).

277. Pub. L. No. 105-33, 111 Stat. 251 (1997).

278. Too few people signed up for the HIPAA demonstration project to allow the GAO to conduct an evaluation. See U.S. GEN. ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL COMMITTEES, MEDICAL SAVINGS ACCOUNTS: RESULTS FROM SURVEYS OF INSURERS 1 (1998), available at <http://www.gao.gov/archive/1999/he99034.pdf>.

279. Pub. L. No. 108-173, 117 Stat. 2066 (2003) (codified as amended at I.R.C. § 223 (West 2005)).

inflation—that moral hazard is the key problem in health policy.²⁸⁰ If we simply strip away insurance, leaving the consumer to purchase health care out of his or her own pocket, and force providers to compete for the consumer's money at the point of need, competition will control health care costs.

This is a true demand-based strategy. People must make health care purchasing decisions just as they make purchasing decisions for everything else. Indeed, they must be prepared to trade their preferences for health care with their preferences for everything else. If consumers are forced to do so, providers and professionals, now having to compete seriously for the consumer dollar, will lower their prices.²⁸¹ Consumers, on the other hand, will buy only the services they really need (or want, or can afford), thus bringing down utilization to the correct level.²⁸²

Making consumers aware of the cost of health care is a part of the health care cost-control strategy of many countries. Countries with public insurance programs impose cost-sharing obligations on consumers for at least some health care products and services to make consumers aware of the fact that health care is not free and to encourage them to some extent to trade health care for other products and services.²⁸³ The fact that making consumers aware of the cost of health care through cost-sharing makes consumers cut back on their consumption of health care is well established, in particular through the RAND experiment mentioned above.²⁸⁴ While it is true, however, that the RAND experiment found that people consume less health care when they have to pay for it (no big surprise here), it also found that people consume less necessary health care to the same extent as they consume less unnecessary health care, and that poorer people with chronic diseases suffered poorer health when faced with high cost sharing (no surprises here either).²⁸⁵

The ultimate solution to the problem of overinsurance—simply

280. See Mark V. Pauly & John C. Goodman, *Tax Credits for Health Insurance and Medical Savings Accounts*, HEALTH AFF., Spring 1995, at 125, 129.

281. They will also hopefully charge lower prices because they save on administrative costs by not having to deal with insurers.

282. JOHN C. GOODMAN & GERALD L. MUSGRAVE, PATIENT POWER: SOLVING AMERICA'S HEALTH CRISIS 80 (1992).

283. See JOST, *supra* note 34, at 218, 246. Cost-sharing also lessens the burden on the public purse and provides an additional source of payment for providers, which are probably the most important reasons why countries with public systems turn to it.

284. See NEWHOUSE, *supra* note 76, at 40, 338-39.

285. See *id.* at 208-11, 218-19, 338-40.

outlawing health insurance—is not embraced by even those most convinced that health insurance is the heart of the health care cost problem.²⁸⁶ Even they understand the problem of the skewed nature of health care costs that accounts for health insurance in the first place. Few people can afford to pay out of pocket for a heart transplant or for the services required to respond to the major traumatic injuries caused by a car accident.²⁸⁷ Many of those afflicted with expensive chronic diseases would also soon find themselves unable to afford further health care.²⁸⁸ Since many of these conditions are caused or aggravated by genetic or environmental factors, it is not fair to hold these persons solely responsible for their suffering, no matter how one may feel about individual, as opposed to societal, responsibility in other contexts. Bankruptcy would solve the problems of some of those faced with enormous expenses and no insurance, but it would only deal with already incurred costs and not assure ongoing care to the chronically ill. Bankruptcy, moreover, only shifts the costs of care to providers, who themselves may be financially unable to absorb the loss.²⁸⁹

Realizing the problems that would accompany the elimination of health insurance, “consumer-driven health care” advocates satisfy themselves with merely calling for the imposition of higher deductibles. They would couple HSAs with high-deductible health insurance policies and offer tax subsidies to cover contributions to the HSAs (whether they come from employers or employees) as well as for the high-deductible policies.²⁹⁰

This is in fact the strategy adopted by the Medicare Modernization Act (“MMA”).²⁹¹ The MMA offers a tax exclusion to employers and a deduction to employees for funds contributed by the

286. RICHARD EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 421 (1997); GOODMAN & MUSGRAVE, *supra* note 282, at 29; Pauly & Goodman, *supra* note 280, at 128-29.

287. According to one recent estimate, heart transplants cost from \$50,000 to \$287,000, averaging \$148,000, while liver transplants cost from \$66,000 to \$367,000, averaging \$235,000. CHFPatients.com, Heart Transplant: The Straight Story, <http://www.chfpatients.com/tx/transplant.htm> (last visited Mar. 6, 2006).

288. See Benjamin G. Druss et al., *The Most Expensive Medical Conditions in America*, HEALTH AFF., July/Aug. 2002, at 105, 106-08.

289. Health care providers already provided nearly \$36 billion in unreimbursed care to the uninsured in 2001. IOM, HIDDEN COSTS, VALUE LOST, *supra* note 142, at 52-53.

290. GOODMAN & MUSGRAVE, *supra* note 282, at 88-92.

291. NINA OWCHARENKO, THE HERITAGE FOUND., HEALTH SAVINGS ACCOUNTS: HOW TO BROADEN HEALTH COVERAGE FOR WORKING FAMILIES (2004), available at <http://www.heritage.org/Research/HealthCare/wm481.cfm>.

employer or employee to a HSA.²⁹² The HSA must, however, be coupled with a high-deductible health insurance policy, which must have a deductible of at least \$1,050 a year for a single individual or \$2,100 a year for family coverage.²⁹³ The tax subsidies for contributions to the HSA are limited to the lesser of the deductible of the insurance plan, or to an absolute limit, adjusted annually for inflation, which for 2006 is \$2,700 for individual coverage and \$5,450 for family coverage.²⁹⁴

Money contributed to the HSA can be spent for “qualified medical expenses,” without being subject to income tax,²⁹⁵ but is subject to both income tax and to a ten percent excise tax if it is spent for other purposes.²⁹⁶ “Qualified medical expenses” are broadly defined, however, to include many things not covered by traditional health insurance, such as nonprescription drugs and transportation or lodging while away from home to receive medical care.²⁹⁷ HSA expenditures are not controlled by the kind of utilization review or claims processing to which normal insurance claims are subjected, but rather by very infrequent audits by IRS auditors who have no health care expertise. It is likely, therefore, that HSA expenditures will be limited only by the imagination, on the one hand, and the good faith, on the other, of their owners. Moreover, if HSA funds are not spent for health care, they can be withdrawn for any purpose once the account holder dies, becomes disabled, or reaches the age of sixty-five.²⁹⁸ Thus HSAs, whatever else they may be, are also another retirement or estate planning vehicle for wealthy persons to use to shelter income from taxation.

While the availability of high-deductible insurance policies will mitigate the problems that consumer-driven health care will cause

292. I.R.C. §§ 62(a)(19), 106(d)(1), 223(a), 3231(e)(11), 3306(b)(18), 3401(a)(22) (2000). An excellent account of the law that governs HSAs and the policy issues that they raise is found in Kaplan, *supra* note 147, at 548-67.

293. §§ 223(c)(2)(A)(i)(I) & (II). The insurer, however, may cover preventive medical expenses, such as the cost of screenings or vaccinations, before the deductible is met. *Id.* § 223(c)(2)(C); I.R.S. Notice 2004-23, 2004-1 C.B. 725. The policy must also limit out-of-pocket expenses to no more than \$5,200 per year for single coverage, \$10,500 per year for family coverage. §§ 223(c)(2)(A)(ii)(I) & (II). These amounts will be indexed for inflation. Press Release, U.S. Dep’t of the Treasury, Indexed Amounts for Health Savings Accounts (Oct. 28, 2005), <http://www.ustreas.gov/press/releases/js2996.htm>.

294. Press Release, *supra* note 293. Persons aged fifty-five to sixty-five may also make an additional “catch up” contribution. § 223(b)(3)(A).

295. *Id.* § 223(f)(1).

296. *Id.* § 223(f)(2), (f)(4)(A).

297. *Id.* § 213(d)(1); Rev. Rul. 2003-102, 2003-2 C.B. 559; I.R.S. Notice 2004-1, 2004-2 C.B. 269, 272.

298. §§ 223(f)(4)(B), (C).

for those consumers who face serious health care expenses, it will not by any stretch of the imagination eliminate them. Persons with chronic diseases will run through their HSAs each year at great expense to themselves, as they will not be able to carry over money in the HSA from year to year but will need to keep refilling it annually.²⁹⁹ Once consumers reach the limits of the deductible, they have little reason to limit their consumption of health care or to pay attention to its price.³⁰⁰ But because of the skewed nature of health care, most health care costs are attributable to persons who would exceed their deductible in any given year,³⁰¹ so most health care expenses would not be any more subject to market discipline under HSAs than they are now. The fact that high-deductible health insurance policies, like those offered through the FEHBP, do not cost dramatically less than standard policies³⁰² is easily understandable given the fact that most medical costs are incurred by those whose costs exceed the deductible. This demonstrates the limited capacity of this strategy to actually save money.

People with low health care expenses, on the other hand, would continue to accumulate money in their HSAs tax free to draw on when they retire. This feature would be very attractive to persons in high tax brackets, but would be of little value to the poor who pay little or no income tax.³⁰³ This disparity also applies to the tax

299. John V. Jacobi, *Consumer-Directed Health Care and the Chronically Ill*, 38 U. MICH. J.L. REFORM 531, 568-69 (2005). If medical savings accounts are offered simply as an alternative to traditional health insurance, moreover, there is likely to be considerable risk segmentation, with low-risk insureds choosing MSAs and high-risk insureds choosing traditional insurance, threatening the affordability of the traditional insurance alternative. See Karen Davis, *Consumer-Directed Health Care: Will it Improve Health System Performance?*, 39 HEALTH SERV. RES. 1219, 1224-25 (2004).

300. Indeed, persons who are reasonably certain that they will reach the deductible limit in any given year have little reason to economize on care even prior to reaching the limit.

301. In 1996, expenditures for most expensive ten percent of privately insured individuals accounted for six percent of health care expenditures, and averaged \$11,319. See Berk & Monheit, *supra* note 29, at 15. These expenditures would obviously be much higher today, and would far exceed the out-of-pocket maximums of \$5,250 for an individual or \$10,500 for a family permitted by the Medicare Modernization Act's HSA provisions. Press Release, *supra* note 293.

302. Karen Davis, President, The Commonwealth Fund, Presentation at the Nat'l Acad. of Soc. Ins.: Medicare Modernization in a Polarized Environment Conference Proceedings & Books: High Deductible Health Plans and Health Savings Accounts: For Better or Worse? Chart 12 (Jan. 27, 2005), available at http://www.nasi.org/publications2763/publications_show.htm (click on link to the author's presentation).

303. *Id.* at Charts 2, 17.

subsidies for employment-related health benefits, but all employees, regardless of income, usually get the same health insurance coverage when employers offer health insurance; with HSAs, however, in which the employer's contribution does not cover the deductible, the cost of contributing to the HSA by the owner will depend heavily on the value of the tax subsidy. Consequently, it will be much higher for low-income than for high-income individuals. It is also possible that HSA owners will spend their tax-subsidized HSA funds on things like eyeglasses or over-the-counter drugs not covered by traditional insurance.

One real advantage of HSAs is that they should lower administrative costs, as health insurance plans will be freed from processing many small claims. But this cost does not go away, but is rather transferred to the HSA owner (or trustee), who must now pay and keep track of all of the bills to justify eventually claiming insurance coverage once the deductible is met (and to satisfy the IRS in an audit). Since expenses that qualify for coverage from the HSA are not necessarily the same as those that will qualify for the deductible, qualifying for insurance coverage once the deductible is met is bound to cause problems for many insureds. This is, of course, always an issue for persons who must meet an insurance deductible, but will be more of an issue with high deductible plans, since more bills will need to be paid and documented to prove that the higher deductible has been met.

One simulation of the effects of MSAs based on the RAND health experiment data predicted that they would at best result in a reduction in health care expenditures of thirteen percent if everyone were required to switch to a high-deductible MSA, but that if people were given a choice to switch to an MSA or to stay with a fee-for-service or HMO plan, MSAs would probably result in either a decrease or increase in total health care spending in the one to two percent range.³⁰⁴ The study noted, however, that results depended heavily on plan design. For example, if MSA owners could use MSA funds to pay for expenses otherwise not covered by health insurance, such as eyeglasses or nursing home care, as is currently allowed by the IRS HSA guidelines, expenses on such services could increase by ten to fifteen percent.³⁰⁵

The success of consumer-driven health care, moreover, ultimately depends on making patients into consumers. This in turn depends on getting consumers the information they need to make consumption decisions. Consumers need to know when to

304. Emmett B. Keeler et al., *Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?*, 275 JAMA 1666, 1670 (1996).

305. *Id.*

seek out professional help, which professionals and providers offer the best quality care, how to find the least expensive professionals and providers, and which products and services recommended by treating professionals are in fact the best and offer the best value for money. Though consumer-driven health care advocates see great promise in the Internet to solve all of these problems,³⁰⁶ someone will have to create the information that will go on the Internet and put it there, and it is not clear who that someone will be. Also, people will have to become much more Internet literate. A recent survey of persons over sixty-five found that seventy-three percent have never gone online.³⁰⁷

A bigger problem is the complexity of health care decision-making. Just try calling five doctors' offices in your town next time you are sick and ask them how much it will cost to treat you. My informed guess is that most will say: "We cannot know until we have seen you, because we do not know what is wrong with you, or even what it will take us to find out. That is why we need to see you." Leaving aside the question of how one makes comparative purchasing decisions while unconscious in the ambulance being taken to an emergency department, even in less urgent circumstances most of us would rather not be forced to make tradeoffs between health care that might save our lives and that new car we have been dreaming about.³⁰⁸ Faced with an unknown, but possibly catastrophic risk, most persons will want health care, if they can afford it, even though with perfect information about the actual risk they face they might forego the health care and buy the car. Many of us would also prefer to trust physicians to decide what referrals, prescriptions, or orders are the best for us, without having to do extensive Internet research and in the end get out a calculator to compare costs and benefits.³⁰⁹

The most important question is what effect high deductible plans will have on the health and economic well-being of consumers.

306. See CONSUMER-DRIVEN HEALTH CARE, *supra* note 109, at 139-41; Jon B. Christianson et al., *Defined-Contribution Health Insurance Products: Development and Prospects*, HEALTH AFF., Jan./Feb. 2002, at 49, 51.

307. Drew Altman, President and CEO, Kaiser Family Found., Presentation at the Nat'l Acad. of Soc. Ins.: Medicare Modernization in a Polarized Environment Conference Proceedings & Books: The MMA: On the Road to Implementation, Chart 16 (Jan. 27, 2005), available at http://www.nasi.org/Publications2763/Publications_Show.htm (click on link to author's presentation).

308. See MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS 35-47 (1997).

309. See Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 477-82, 519-22 (2002) (discussing the importance of trust in physician decision-making in the patient/physician relationship).

The evidence here is decidedly mixed. One study found that persons with high deductible health insurance plans were twice as likely as other privately insured persons not to see a doctor for a specific medical problem, take medicines as often as they should, or fill a prescription given by a doctor, and significantly more likely to not receive medical treatment or follow-up recommended by a doctor or to take a lower dose of a prescription than a doctor recommended.³¹⁰ Insured adults with high deductibles are also much more likely not to be able to pay medical bills, be contacted by a collection agency, or have to change their way of life to pay medical bills.³¹¹ Of course, if an employer funds the HSA, these effects will be mitigated, but so will any effect that the MSA might have on making health care consumers more cost conscious.

All of this may change. Better-educated persons are already using the Internet extensively to diagnose their own diseases and chart their own courses of treatment.³¹² Marketers are also aggressively pushing health care information—one cannot read a magazine or turn on the television without being bombarded by advertising for prescription drugs.³¹³ Physicians and providers may

310. Davis, *supra* note 299, at 1222-23.

311. *Id.*

312. See Drew Altman, *supra* note 307, at Chart 18 (noting that sixty percent of seniors who are college graduates and sixty-five percent of seniors who earn over \$50,000 a year have used the Internet, compared to eighteen percent of seniors with a high school or less education, and fifteen percent of seniors who earn under \$20,000 a year).

313. Our experience with drug advertising has not been an unmixed blessing, and might give us pause as to whether we want to commercialize all of health care to this extent. Studies show that consumers on the whole value the information the advertisements offer. See Joel S. Weissman et al., *Consumers' Reports on the Health Effects of Direct-to-Consumer Drug Advertising*, HEALTH AFF.-WEB EXCLUSIVE, Feb. 26, 2003, at W3-82, W3-91-93, <http://content.healthaffairs.org/webexclusives/index.dtl?year=2003>. However, some physicians see more negative effects from advertising, believing that it encourages patients to seek treatments they do not need or provides unbalanced information on drugs. See Joel S. Weissman et al., *Physicians Report on Patient Encounters Involving Direct-to-Consumer Advertising*, HEALTH AFF.-WEB EXCLUSIVE, Apr. 28, 2004, at W4-219, W4-224, <http://content.healthaffairs.org/webexclusives/index.dtl?year=2004>.

Recent experience with COX-2 inhibitors such as Vioxx, should in particular give us pause about the merits of advertising. Driven by a massive advertising campaign, Vioxx was sold to millions of patients who did not need it, resulting in serious side effects to those patients. See Carolanne Dai et al., *National Trends in Cyclooxygenase-2 Inhibitor Use Since Market Release: Nonselective Diffusion of a Selectively Cost-effective Innovation*, 165 ARCHIVES OF INTERNAL MED. 171, 174-76 (2005), available at <http://archinte.ama-assn.org/cgi/reprint/165/2/171.pdf>.

find ways to bundle their services so as to offer fixed prices for treatments of common ailments. But, to date, empirical evidence gives little hope that consumer-driven health care is a panacea.³¹⁴ Experience from other countries also offers little support for the most ambitious claims of those marketing consumer-driven health care.³¹⁵

The third approach to health care cost control, relied on by most of the rest of the world, is some sort of government oversight. In some countries and with respect to some health care goods and services this is accomplished through government price controls. Some governments control the prices for which products and services are sold in the private sector. Canada, for example, controls pharmaceutical prices at both the federal and provincial level,³¹⁶ while Switzerland sets drug prices at the federal level and negotiates fee schedules for doctors at the cantonal level.³¹⁷ Where governments are purchasers, governments also set prices through administered price systems. The United Kingdom, for example, regulates the profits that drug manufacturers can make on drugs they sell to the NHS,³¹⁸ while the United States Medicare program, as mentioned above, uses prospective payment systems to set prices

314. Davis, *supra* note 299, at 1227; Stephen T. Parente et al., *Evaluation of the Effect of a Consumer-Driven Health Plan on Medical Care Expenditures and Utilization*, 39 HEALTH SERV. RES. 1189, 1204-06 (2004).

315. Timothy Stoltzfus Jost, *Consumer-Driven Health Care in South Africa: Lessons from Comparative Health Policy Studies*, 1 J. HEALTH & BIOMED. L. 83 (2005), available at <http://papers.ssrn.com/sol3/papers.cfm?abstractid=766905>; see also Michael D. Barr, *Medical Savings Accounts in Singapore: A Critical Inquiry*, 26 J. HEALTH POL. POL'Y & L. 709, 720-22 (2001); William C. Hsiao, *Behind the Ideology and Theory: What is the Empirical Evidence for Medical Savings Accounts*, 26 J. HEALTH POL. POL'Y & L. 733, 733-34, 736 (2001); Samuel E.D. Shortt, *Medical Savings Accounts in Publicly Funded Health Care Systems: Enthusiasm versus Evidence*, 167 CANADIAN MED. ASSOC. J. 159, 160-62 (2002), available at <http://www.cmaj.ca/content/vol167/issue2/> (click on link to article).

316. Prescription drugs are not covered under the Canadian federal health scheme, though drug coverage is offered by some provinces for some populations. The Patented Medicine Prices Review Board regulates prices for patented drugs, but the provinces each negotiate with distributors the prices that they pay for drugs that they cover. See Eric Nauenberg et al., *A Complex Taxonomy: Technology Assessment in Canadian Medicare*, in INTERNATIONAL COMPARATIVE STUDY, *supra* note 63, at 57, 61-63.

317. Uwe E. Reinhardt, *The Swiss Health System: Regulated Competition Without Managed Care*, 292 JAMA 1227, 1229 (2004).

318. Eric Nauenberg et al., *A Complex Taxonomy: Technology Assessment in Canadian Medicare*, in INTERNATIONAL COMPARATIVE STUDY, *supra* note 63, at 57, 62.

for a whole range of goods and services (but not for drugs).³¹⁹

Simple price regulation, however, often has only a limited effect, since it does not necessarily control volume. Attempts to limit prices paid to physicians by Medicare in the 1980s were undermined as the volume of services provided by physicians steadily increased.³²⁰ While these volume increases sometimes reflected the fraudulent provision of unnecessary services, the uncertainty that attends much of medical practice makes it very difficult to determine when volume increases are justified and when they are not. Most price regulation, moreover, is keyed to fee-for-service payments, which are in turn keyed to complicated systems of coding. Controls can often be evaded by code-based "payment maximization" strategies, such as upcoding or unbundling.³²¹ While these abuses can be to some extent controlled through vigorous fraud and abuse enforcement, coding is an inexact science and it is difficult to address all but the most egregious practices through law enforcement.³²²

Programs that rely on administered prices, like Medicare, continually face the problem of setting prices correctly. If prices are set too high, providers are tempted to provide unnecessary care. If prices are set too low, providers are reluctant to provide the product or service, or are forced to shift their costs to other payers. Continual tinkering can produce more or less satisfactory results but requires a great deal of time and energy.

In most developed countries, therefore, governments control costs primarily through budgets.³²³ In national health service systems, the government decides how much it is willing to spend on health care and that becomes the amount that is spent. The health care budget must compete with education, defense, roads, and other government priorities for public funds, which must be raised through taxation at whatever levels are acceptable to the nation.³²⁴ Whatever funds are available are spent, often through local or regional purchasing or provider authorities, on health care.³²⁵

319. 42 U.S.C. § 1395w-111(i) (2000).

320. Janet B. Mitchell, Gerard Wedig & Jerry Cromwell, *The Medicare Physician Fee Freeze: What Really Happened?*, HEALTH AFF., Spring 1989, at 21, 21.

321. Jost & Davies, *supra* note 195, at 251-52.

322. *Id.* at 254-65 (discussing enforcement efforts aimed at these types of provider behavior and provider responses).

323. Jost, *supra* note 228, at 436-37.

324. JOST, *supra* note 34, at 216-17; see also Robert G. Evans, *Going for the Gold: The Redistributive Agenda Behind Market-Based Health Care Reform*, 22 J. HEALTH POL. POL'Y & L. 427, 427 (1997) (describing the economic impetus underlying the push for competitive health plan).

325. In England, funds are currently spent by regional primary care trusts.

Because all funds must flow through a single “pipe,” the public budget, these countries are most successful at controlling costs.³²⁶

Countries with social insurance systems have less control over spending. Social health insurance funds are often managed by quasi-public, non-profit insurers or mutualities, which have some degree of control over their own budgets.³²⁷ Government usually sets guidelines for premiums but does not directly control expenditures.³²⁸ Insurance funds in turn negotiate prices with providers, either collectively or individually.³²⁹ In the German system, budgets for medical care are negotiated with doctors’ unions, which in turn distribute the funds among their members based on productivity.³³⁰ In some systems the volume of services provided by individual providers is also reviewed to control those who would try to abuse or defraud the system.³³¹ Though social insurance programs are less successful than single-payer systems at controlling costs, they still hold costs at much lower levels than does the United States, the least disciplined of all health care systems.

Budgeting is essentially a supply constraint strategy. In the end it gives those who produce products and services a fixed amount of money with which they must produce health care. Though in the first instance these funds are often allocated by government or social insurance fund bureaucrats, in the end resources are often “rationed” at the patient level by health care professionals who decide how limited funds will be spent and services allocated.³³² To the extent that professionals are the people most capable of deciding which patients need what services, this approach to allocation works reasonably well.

Budgeting, like all other cost control approaches, is also attended by problems. If health care budgets are too constrained, as they have been historically in the United Kingdom and as they are reportedly for some services in Canada, rationing can become

JOST, *supra* note 34, at 206-07.

326. Josep Figueras et al., *Patterns and Performance in Social Health Insurance Systems*, in SOCIAL HEALTH INSURANCE SYSTEMS IN WESTERN EUROPE 117-18 (Reinhard Busse, Josep Figueras & Richard B. Saltman eds., 2004).

327. See Reinhard Busse et al., *Organization and Financing of Social Health Insurance Systems: Current Status and Recent Policy Developments*, in SOCIAL HEALTH INSURANCE SYSTEMS IN WESTERN EUROPE 34-40 (Reinhard Busse, Josep Figueras & Richard B. Saltman eds., 2004).

328. *Id.* at 58-60.

329. *Id.* at 53-55.

330. JOST, *supra* note 34, at 243-45.

331. See *id.* at 252-55 (describing the German system).

332. This is often done through primary care “gate-keeping” systems. *Id.* at 218-20.

embarrassingly visible.³³³ Waiting lists develop for some products and services. Waiting lists, however, are a complicated phenomenon.³³⁴ They tend to affect certain procedures more than others, particularly those that are non-life threatening, routine and uninteresting.³³⁵ The same procedures—varicose veins, hernias, painful and immobile joints, or cataracts, for example—tend to be those with the longest wait lists in England, year after year, indicating that waiting lists may be as much a manifestation of the difficulty of getting physicians who are paid fixed salaries to take on professionally unsatisfying tasks as they are of an imbalance of supply and demand.³³⁶ In any event, countries like Germany or France that invest more resources in health care do not have serious problems with waiting lists.³³⁷

Countries with government-financed health care systems also tend to exercise more control over the introduction of health care technology. They can, and do, use evidence-based technology assessment to determine whether new technologies are effective, or even cost-effective, before they decide whether or not to finance them.³³⁸ As new technology is one of the biggest cost-drivers in modern health care systems, this strategy has some promise for controlling health care costs. Unfortunately, it is politically very difficult for countries to refuse to finance new technologies.³³⁹ Manufacturers exert considerable political pressure to advocate adoption, often joined by professional or patient groups.³⁴⁰ This pressure is usually difficult to withstand, particularly given the ambiguous nature of the evidence in many cases. Technology assessment can, however, delay the entry of new technologies at least until they have been thoroughly evaluated, and sometimes avoid the funding of technologies that rapidly prove to be ineffective.³⁴¹ Planning can also control the dissemination of

333. See Luigi Siciliani & Jeremy Hurst, OECD, Economic Studies No. 38, 2004/1, *Explaining Waiting-Time Variations for Elective Surgery across OECD Countries*, 96, 99 (2004), available at <http://www.oecd.org/dataoecd/15/52/35028282.pdf>.

334. JOST, *supra* note 34, at 222-25 (exploring the complex causes of wait lists).

335. Stephen Frankel, *The Origins of Waiting Lists*, in RATIONING AND RATIONALITY IN THE NATIONAL HEALTH SERVICE 6 (Stephen Frankel & Robert West eds., 1993).

336. *Id.* at 10-12.

337. Siciliani & Hurst, *supra* note 333, at 104-07.

338. See INTERNATIONAL COMPARATIVE STUDY, *supra* note 63, at 260.

339. *Id.* at 259-62.

340. *Id.* at 259-60.

341. *Id.* at 258.

technologies to avoid wasteful excess capacity.³⁴²

Each cost control strategy has its own strengths and weaknesses, though they are not equal. An ideal health care system would include a mix of government budgeting and price setting, competition, and consumer participation. We will shortly turn to describing such a system. Before leaving the area of cost-control, however, one final issue must be dealt with. This is the red herring of choice.

Right-wing advocacy groups often laud consumer-driven or managed competition systems as affording “choice.”³⁴³ It is true that managed competition gives consumers a choice of health plans that may not be available in a government-financed program.³⁴⁴ On the other hand, if the government decides to “choose” one particular form of insurance for a tax subsidy, as Congress has decided to do with HSAs, it is not giving you a choice, it is making a choice for you.³⁴⁵ Similarly, if an employer offers an employee only a choice of a HSA/high-deductible policy, the choice has been made for the employee.

More importantly, however, managed competition systems, and some forms of consumer-driven health care, sharply limit a choice that is much more important to consumers: choice of provider.³⁴⁶ In fact, government-financed systems often provide the broadest choice of provider, indeed in some countries consumers can choose virtually any provider in the country.³⁴⁷ Insofar as choice is a value that is

342. See generally Jost, Dawson & den Exter, *supra* note 89.

343. See, e.g., SUE A. BLEVINS, THE CATO INST., RESTORING HEALTH FREEDOM: THE CASE FOR A UNIVERSAL TAX CREDIT FOR HEALTH INSURANCE (1997), available at <http://www.cato.org/pubs/pas/pa-290.pdf> (arguing that universal tax credits will restore Americans' freedom of health care choice).

344. Many European social insurance countries do, however, offer consumers a choice of health plans, including Germany, Switzerland, The Netherlands, and Belgium. See Reinhard Busse et al., *Organization and Financing of Social Health Insurance Systems: Current Status and Recent Policy Developments*, in SOCIAL HEALTH INSURANCE SYSTEMS IN WESTERN EUROPE, *supra* note 331, at 39.

345. I am indebted to Jeanne Lambrew for this insight.

346. This is obviously true for managed-competition systems in which consumers must pick a particular managed-care company and stay within its network or pay extra to go out-of-network, but is also true of consumer-driven programs where consumers must construct, and then stay within, their own networks or pick from a menu of benefit packages offering different networks or where consumers must use their HSA to purchase from providers chosen by their plan. See Jon R. Gabel, Anthony T. Lo Sasso & Thomas Rice, *Consumer-Driven Health Plans: Are They More Than Talk Now?*, HEALTH AFF.-WEB EXCLUSIVE, Nov. 20, 2002, at W-395, W-396, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.395v1.pdf>.

347. This is generally true in social insurance countries. See Reinhard

important in itself, it may argue for social insurance systems that maximize the choice that matters.

C. *Ensuring Quality*

Despite the fact that quality is the oldest health care policy concern of the law, it remains the one that we are least able to address. No one has yet designed a health care system that consistently provides high quality care. It is far from clear, moreover, that the mechanisms that we use for promoting or assuring quality are very effective. There is little evidence that malpractice litigation, for example, promotes the quality of health care, though it is certainly arguable that there would be more medical errors without its deterrent effect.³⁴⁸ In the institutional setting, the threat of vicarious or corporate liability has encouraged risk-management programs, but, again, research has not established the effectiveness of these programs.³⁴⁹ There is also little evidence that peer-review-based credentialing programs, accreditation, licensure, or quality regulation programs have been effective, though we can point to some success stories, such as a decline in the use of physical or chemical restraints following the implementation of federal nursing home reform regulation.³⁵⁰ Moreover, quality improvement has sometimes become an excuse to argue for the adoption of special interest legislation that seems to be actually motivated by a desire to protect providers from liability and public oversight.³⁵¹

We do have some ideas about how to improve quality. Professionals and providers tend to be more proficient in doing what they do most often, so a reorganization of the health delivery system to permit the focused and integrated delivery of particular kinds of care might help.³⁵² Better coordination of the management of

Busse et al., *Organization and Financing of Social Health Insurance Systems: Current Status and Recent Policy Developments*, in *SOCIAL HEALTH INSURANCE SYSTEMS IN WESTERN EUROPE*, *supra* note 327, at 55-58. Even in national health services countries, however, choice of primary care physicians is often largely unrestrained, and in some countries choice of secondary or tertiary care providers is also open. *See generally* Jost, Dawson & den Exter, *supra* note 89.

348. *See, e.g.*, Hyman & Silver, *supra* note 208, at 893; Jost, *supra* note 112, at 572-76.

349. Liang & Ren, *supra* note 213, at 525-26.

350. *See* Marshall B. Kapp, *Quality of Care and Quality of Life in Nursing Facilities: What's Regulation Got to Do with It?*, 31 *MCGEORGE L. REV.* 707, 718-19 (2000).

351. *See* Hyman & Silver, *supra* note 111, at 1447.

352. *CONSUMER-DRIVEN HEALTH CARE*, *supra* note 109, at 105-10; IOM, *QUALITY CHASM*, *supra* note 6, at 7.

chronic diseases should improve treatment and, possibly, control cost.³⁵³ Improving systems to reduce the possibility and influence of human error is also important.³⁵⁴ It has often been observed that accident rates in the airlines industry are much lower than in health care in large part because redundant safety technology has greatly reduced the potential damaging influence of human error.³⁵⁵ The use of electronic medical records (a technology already widely adopted in Europe) and automatic reminder systems are examples of such technological improvements.³⁵⁶ Finally, information about errors needs to be continually collected and strategies for addressing error continually refined.³⁵⁷

Health care systems can also be designed to improve quality. If consumers could be armed with better information about quality, they could reward better quality providers with their business and punish poor quality providers by refusing to purchase from them.³⁵⁸ Government purchasers or health plans can “pay for performance” and thus encourage better quality.³⁵⁹ Both strategies, however, are dependent on our being able to find simple ways of identifying high-quality providers, and nothing in this area is simple. Providers who have the highest mortality rates, for example, may be those who are taking on the highest risk patients—they may even be the most proficient.³⁶⁰ Rewarding low mortality rates, therefore, may simply encourage providers to avoid taking on the most desperate cases.³⁶¹ Risk adjusting can help avoid this problem, but here, as elsewhere, risk adjusting is far from an exact science. The most obvious thing that can be said about this area is that we need to learn a lot more about health care quality and how to produce it.

353. CONSUMER-DRIVEN HEALTH CARE, *supra* note 109, at 106-07; IOM, QUALITY CHASM, *supra* note 6, at 9-10.

354. Liang & Ren, *supra* note 213, at 522-23.

355. See Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851, 1855 (1994) for the origin of this observation.

356. See IOM, QUALITY CHASM, *supra* note 6, at 164-77; Amednews.com, Tyler Chin, *Americans Trail Much of Europe in Adopting Electronic Medical Records*, Sept. 2, 2002, <http://www.ama-assn.org/amednews/2002/09/02/bisf0902.htm>.

357. Jost, *supra* note 112, at 594-97; Liang & Ren, *supra* note 213, at 535-38.

358. See DOSE OF COMPETITION, *supra* note 14, at 17-24.

359. See sources cited *supra* note 111.

360. Jost, *supra* note 269, at 1509.

361. It may also discourage providers from caring for minority or poor patients, who often have more complex problems and worse outcomes than wealthier majority white patients. INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE 38-79 (Brian D. Smedley et al. eds., 2003) [hereinafter IOM, UNEQUAL TREATMENT].

V. HOW SHOULD WE SOLVE OUR ACCESS, COST,
AND QUALITY PROBLEMS?

From our discussion so far, a number of principles can be discerned to help us design a health care system. Any health care system that will be politically acceptable in the United States will have to include private enterprise. But virtually all health policy analysts, of whatever political persuasion, agree that government involvement is necessary to make health care affordable to the poor.³⁶² Americans, however, have a strong preference for private markets, and are particularly unlikely to accept government provision of health care.³⁶³ Public opinion is indeed unlikely to accept a total government takeover of health care finance.

Because government is the largest and most efficient risk spreader, it should be relied upon to spread the greatest health care risks. Government should also be used to assure that health care is affordable to those who cannot otherwise afford it. Market competition should, on the other hand, be used to bring down costs and to improve quality where competition is feasible. Budgets should also be used, however, to control costs, particularly for government programs. While public regulation is needed to assure quality, professional oversight should also be encouraged to assist with quality improvement. What is needed, that is to say, is a mix of public and private solutions.

Fortunately, we have a number of models for achieving a mix of government- and private-risk bearing. The recently adopted Medicare prescription drug program offers one such model.³⁶⁴ The

362. See, e.g., CONSUMER-DRIVEN HEALTH CARE, *supra* note 109, at 182.

363. See Robert J. Blendon et al., *Americans' Views of the Uninsured: An Era for Hybrid Proposals*, HEALTH AFF.-WEB EXCLUSIVE, Aug. 27, 2003, at W3-405, W3-408-09 (observing that almost half of Americans surveyed would favor a single-payer health insurance system, half would oppose it, and only about a quarter would prefer it as a means of providing health care to the uninsured). In fact, though there has been a dramatic shift toward support for market approaches to health care among policy elites in recent years, public support for government provision of health care in the United States has never been strong, while public support for a government role in financing of health care, though it has varied over the years, remains robust. Mark Schlesinger, *Reprivatizing the Public Household: Medical Care in the Context of American Public Values*, 29 J. HEALTH POL. POL'Y & L. 969, 974-80 (2004).

364. This program is administered by private risk-bearing prescription drug plans which are paid based on bid premiums, but the plans only bear full risk within specified risk corridors. The government shares the risk for costs above these risk corridors, and the government bears most of the risk of catastrophic payments. See KAISER FAMILY FOUND., PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES: AN OVERVIEW OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003 7 (Jan. 14, 2004),

experience of other health care systems that mix public and private insurance, such as the Dutch, German, and Australian systems, can also assist us.³⁶⁵ The Dutch system is of particular interest, because it divides responsibility between public and private insurance in part based on the nature of the risk borne.³⁶⁶

First, in a reformed health care system, as in the Dutch system and the new Medicare drug benefit program, catastrophic risk should be assumed by the government. Long-term skilled nursing facility care, hospitalizations that last more than a specified period of time (for example, ten days), inpatient mental health care, and certain specific very expensive medical procedures (such as organ transplants), should be financed by the government.³⁶⁷ This would shift the highest risks, and those risks least likely to be bearable by particularly vulnerable groups, to the best risk bearer, i.e., the risk bearer with the greatest financial resources and the ability to spread risk most broadly.³⁶⁸

Second, at the other end of the spectrum, cosmetic procedures and “life-style care”³⁶⁹ should be financed privately, either out-of-pocket or through a private insurance market, if one develops. Most public and private insurance programs, not only in the United States but also in other countries, already take this approach. They seem to be able to distinguish between reconstructive surgery to correct cleft palates or other abnormal disfiguring conditions on the one hand, which are covered by insurance, and cosmetic breast

<http://www.kff.org/medicare/upload/Prescription-Drug-Coverage-for-Medicare-Beneficiaries-An-Overview-of-the-Medicare-Prescription-Drug-Improvement-Act-2003.pdf>.

365. See Jost, *supra* note 33, at 450-63.

366. *Id.* at 460-63. The Dutch health care system has been restructured as of 2006 so that most acute care is now covered through a private insurance managed competition system, but the basic structure of the system remains as described here. See MINISTRY OF HEALTH, WELFARE AND SPORT, HEALTH INSURANCE IN THE NETHERLANDS: THE NEW HEALTH INSURANCE SYSTEM FROM 2006 (2005), available at http://www.europeanvoice.com/downloads/NL_New_Health_Insurance_System.pdf.

367. This list is obviously somewhat arbitrary, but is intended to capture events that are both high in cost and likely to be imposed on patients particularly unable to bear the cost.

368. The federal government is the most appropriate level of government to run such a program for a number of reasons that I have fully explored elsewhere. JOST, *supra* note 34, at 172-78. Among other reasons, a federal program avoids the “race to the bottom” that can occur with state programs, and the federal government is much better able than the states to marshal revenues to fund countercyclical programs. Federal law—i.e., ERISA and tax subsidy law—has already largely displaced state law in the private health insurance sector, and it makes sense that it govern the public sector as well.

369. Such as drugs for addressing erectile dysfunction or toenail fungus.

enlargement or wrinkle removal to improve normal appearance on the other, which are not covered.³⁷⁰

Third, low-cost, predictable items and services should remain the private responsibility of all but the poorest individuals. Eyeglasses, routine dental care, over-the-counter drugs, and routine primary care (up to four visits a year), for example, are relatively predictable and affordable. There is little reason to incur the additional costs of billing and claims processing when routine, low-cost, products and procedures are involved.³⁷¹ It is much like paying for an insurance plan to cover oil changes or replacement tires. This is not to say that insurance for these items and services should be illegal. It should just not be required or tax-subsidized.

An exception would have to be made to this principle, however, for persons with very low incomes, for whom even these expenses should be covered, as they are now by the Medicaid program in most states. For those under 135% of the poverty level, a government program should cover these costs.³⁷² The program should also cover these costs for those with incomes between 135% and 200% of the poverty level, though these beneficiaries should share the cost by bearing some cost-sharing obligations.³⁷³ People with this little income would be unduly burdened by the cost of these basic services, and there is little to be gained by causing them to forego basic primary dental or medical care, which might cause them to require more expensive care later, or which might make it difficult for them to participate in the workforce.³⁷⁴

370. See AM. SOC'Y OF PLASTIC SURGEONS, INSURANCE COVERAGE: A PATIENT'S GUIDE, available at http://www.plasticsurgery.org/public_education/procedures/insurance_coverage.cfm (last visited Apr. 19, 2006).

371. There is, of course, the risk that consumers will fail to purchase medically necessary services, necessitating higher costs later if conditions deteriorate. This risk is considerably lessened under this proposal, however, because preventive services are covered by a separate program.

372. In 2006, this would equal \$12,920 for a single individual, \$17,321 for a couple. See KAISER FAMILY FOUND., MEDICARE FACT SHEET: LOW-INCOME ASSISTANCE UNDER THE MEDICARE DRUG BENEFIT, <http://www.kff.org/medicare/upload/Low-Income-Assistance-Under-the-Medicare-Drug-Benefit-Fact-Sheet.pdf>. The Medicare prescription drug legislation does not require premium payments for individuals whose incomes fall below this level. *Id.*

373. Two hundred percent of the poverty level is the income eligibility level for most State Children's Health Insurance programs. See U.S. DEP'T OF AGRIC., FOOD AND NUTRITION SERVICE, SCHOOL MEALS, THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) (2001), available at <http://www.fns.usda.gov/cnd/SCHIP/factsheet.htm>. States that chose to provide coverage at higher levels would be allowed to do so. *Id.*

374. It would be necessary to develop some simple means of determining who was eligible for these subsidies, for example, using income tax filings. Also, a creative and aggressive outreach program would be needed to assure that

Fourth, a basic set of preventive services should be available to all regardless of ability to pay, financed by a public program. This should include immunizations, preventive screenings, well-baby physicals, prenatal care, and periodic physicals for older people.³⁷⁵ Such services are already covered by Medicare and for low-income children through the Medicaid EPSDT program.³⁷⁶ Preventive services may also be covered without regard to the deductible by insurers that provide high-deductible policies coupled with HSAs under the new federal law.³⁷⁷ This provision would merely spread this government assistance to the rest of the population.

That leaves everything else—most acute care, most care for the management of chronic conditions that do not result in long-term care or hospitalization, prescription drugs, durable medical equipment, and various therapies. These products and services would be covered by insurance. Everyone would be required by law to carry this insurance, just as all but three states now require everyone who owns a car to carry liability insurance.³⁷⁸ Just as car owners cannot shift the cost of accidents to their victims by refusing to carry liability insurance, persons who can afford health insurance should not be able to shift the cost of medical care they might need to society by refusing to carry health insurance. Employers could continue to self-insure or purchase insurance for their employees. Individuals or families could also buy insurance in the non-group insurance market. Insurers, however, would be required to accept all applicants and to community rate, which would save underwriting costs. Because such insurance would no longer need to cover catastrophic costs, and because it would also not have to cover low-cost but widely used routine services, it would be much less expensive. The risks that it covered would also be much more predictable, greatly reducing the threat to insurers posed by adverse selection (and reducing the cost of the insurance). The federal government should offer its own insurance plan, which would compete with employer-provided and individual insurance. It would be run by an independent federal corporation, and would be largely

those eligible for the program would actually be signed up.

375. These services could be provided through local health departments, as some already are, or by private physicians who could be paid to provide them.

376. See Medicare.gov, Preventive Services, <http://www.medicare.gov/Health/Overview.asp> (last visited Apr. 6, 2006); U.S. Dep't of Health & Human Serv., Ctrs. for Medicare & Medicaid Servs., EPSDT Benefits, http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/02_Benefits.asp#TopOfPage (last visited Apr. 6, 2006).

377. I.R.C. § 223(c)(2)(C) (2000). See I.R.S. Notice 2004-23, 2004-1 C.B. 725.

378. See Ins. Info. Inst., Automobile Financial Responsibility Laws, <http://www.iii.org/individuals/auto/a/stateautolaws/> (last visited Apr. 6, 2006).

self-financing from premiums.³⁷⁹

Each plan would be required to cover all necessary and non-experimental health care that did not fall into the four categories of care already discussed.³⁸⁰ Private plans could, however, offer additional coverage, for example, life-style treatments or low-cost and predictable services.

Data would be collected on the risk distribution between various plans. If, as is likely, the government plan ended up with a worse risk distribution than the other plans, it would be subsidized from tax revenues as necessary to compensate for this adverse risk selection and bring the cost of the government plan to the average cost of a private plan.³⁸¹ Individuals who wanted a richer benefit package, however, could pay more for a private plan, while those who were willing to live with more constrained provider networks could also choose cheaper private plans, if any were offered.³⁸²

While this approach to insurance would make sure everyone was insured, steps would still need to be taken to assure that this insurance was affordable to all. Everyone whose income fell below 135% of the poverty level would receive a voucher from the federal government equal to the cost of the government insurance plan. Those whose incomes were between 135% and 300% of poverty would receive a voucher of diminishing value, designed to make sure that no one would need to pay more than ten percent of their income for health care.³⁸³ Finally, those persons who would have otherwise

379. An alternative suggested by Professor David Super would be to create two federal insurance companies that would compete with each other, just as we have two government-sponsored enterprises in the secondary home mortgage market, the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation. Until recently the largest "private insurer" in Australia—Medibank Private—was a government sponsored insurer, created to make certain that a private insurer was available in markets otherwise not served by private insurance. See JOST, *supra* note 34, at 454.

380. These four categories are catastrophic (covered by public insurance), cosmetic or life-style (not covered), low-cost and predictable (not covered, except for the poor), and preventive (covered for all).

381. It would be important, however, not to provide subsidies for the government plan other than those necessary to compensate for risk adjustment, to make sure that it competed with private plans on a fair basis.

382. It would also be possible to create a broader risk-pooling scheme to discourage risk selection on the part of all of the participating plans, as is done in Australia. See Jost, *supra* note 33, at 458-59. Given, however, the fact that most risk will be borne by the government catastrophic care scheme, this should not be necessary.

383. Note that since catastrophic costs were excluded, policies would cost much less than they do now. Ten percent of income is usually considered an upper limit for out-of-pocket medical spending for insured persons before they are considered "underinsured." See HEALTH POL'Y ANALYSIS PROGRAM, UNIV. OF

been eligible for Medicare would be covered by the government program (unless they opted for a private plan), but would need to pay what they would otherwise have paid for Part B premiums.

Finally, cost-sharing should be used where appropriate to ensure that consumers are made sensitive to health care costs where this makes sense. Tiered pharmaceutical plans, for example, that make the insured pay more for non-generic drugs or for therapeutically equivalent brand-name drugs whose manufacturers refuse to offer discounts to insurers, have shown success in controlling health care costs without adverse health consequences, and could continue under the new plan.³⁸⁴ Minimal copayments for physician visits, perhaps in the ten- to fifteen-dollar range, might be appropriate to discourage excessive use. Even higher copayments might be useful for emergency room visits to discourage the use of the emergency room for primary care. These copayments should be waived or reduced, however, for persons who qualify for assistance for routine medical costs because of their income to make sure that these people are able to afford the care that they need.

Cost-sharing should not be imposed in situations where it is inappropriate to create an economic disincentive for the use of care. The patient is rarely the decision maker with respect to hospital care, for example, and, therefore, a financial disincentive is inappropriate.³⁸⁵ Where a patient is receiving either generic or, where necessary, a preferred brand-name pharmaceutical to manage a chronic disease, financial disincentives are inappropriate because we do not want to discourage care where lack of that care may seriously threaten health or increase costs later. One approach might be, therefore, to cap total cost-sharing obligations, as is done in a number of other countries,³⁸⁶ but it also might be appropriate to

WASH. SCH. OF PUB. HEALTH, INFO. UPDATE 1 (2004), *available at* http://depts.washington.edu/hpap/pdf_reports/cost_of_underinsurance_summary.pdf. This figure is also a good benchmark for defining the maximum a family should have to spend on cost sharing and insurance premiums.

384. See Brenda Motheral & Kathleen A. Fairman, *Effect of a Three-Tier Prescription Copay on Pharmaceutical and Other Medical Utilization*, 39 MED. CARE 1293, 1299 (2001).

385. A possible exception here would be where a procedure can be performed equally well and safely on an outpatient or inpatient basis, in which case financial incentives might be appropriate to encourage the patient to use the less expensive approach. The RAND study did find that cost-sharing reduced hospitalization, but also found that it reduced appropriate hospitalizations to the same extent as inappropriate, suggesting that a better tool needs to be found to encourage appropriate use of hospital care. See NEWHOUSE, *supra* note 76, at 172-76.

386. See BUSSE & RIESBERG, *supra* note 254, at 75-77 (describing exemption in Germany).

exclude certain maintenance drugs from cost-sharing.

The approach described above would in fact assure that all Americans had health insurance. It would accomplish this by addressing both the problems of risk and of affordability, and by doing so while still preserving a role for private initiative and for consumer responsibility. It would also have great promise for controlling costs.

The government catastrophic care program would be dealing primarily with institutional providers, which it could pay on an administered price basis, as they are paid now by Medicare and Medicaid. Alternatively, it could negotiate budgets with providers, as payers do in the German system,³⁸⁷ or purchase blocks of services from providers who provide care most efficiently or who provide the highest quality care.³⁸⁸ The government preventive care program could also negotiate prices, perhaps through a competitive bidding process. Vaccines and screening tests, for example, could be bought in quantity from the lowest bidder or from the provider who provided the highest quality services. The government acute care insurance company would probably pay for services on an administered price basis, as Medicare now does. Private providers would not be required to participate in the public program, however, and prices would have to be set at a high enough level to assure provider participation.

The proposal does not simply rely on the government to control costs, however, but also takes advantage of both managed competition and consumer-driven purchasing strategies. The government program would be competing for business with private insurers, and if it set the prices it paid providers too high, or was unable to control fraud and abuse, it would have to raise premiums and would lose members to the private plans. Alternatively, if the government program set the prices it paid providers too low, and was unable to attract high quality providers, it would also lose market share to private insurers.³⁸⁹ If, as I predict, it was able to underprice private insurers, it would set an example for the private sector to follow. Competition between the public and private

387. See Jost, *supra* note 33, at 243-48.

388. In the English National Health Care Service, local purchasing authorities, called primary care trusts, negotiate contracts with providers for the purchase of services for their residents. See Timothy Stoltzfus Jost et al., *The British Health Care Reforms, The American Health Care Revolution, and Purchaser/Provider Contracts*, 20 J. HEALTH POL. POL'Y & L. 885, 887 (1995).

389. If there were two competing government insurers, the performance of the more successful might set a benchmark for and call attention to the underperformance of the other.

insurance programs would keep the prices of both programs in check.

The private insurers could develop provider networks to save cost or encourage quality. Both private and public insurers, however, would cover the same menu of services, and each would be subject to prompt internal and external review if it refused to cover services.³⁹⁰ New products and services, as well as questionable existing products and services, would be subject to rigorous technology assessment.³⁹¹ Products and services found ineffective, or to be seriously inferior in terms of cost-effectiveness, would not be covered by the public program. Private programs could cover them, but this would be reflected in higher premiums.

The products and services that consumers are able to, in fact, judge comparatively and that are affordable to most consumers, such as eyeglasses, contact lenses, routine dental care, and some primary medical care, would be purchased directly by consumers. Optometrists, opticians, and purveyors of over-the-counter drugs already advertise their prices, and dentists and primary care physicians would follow suit.³⁹² All professionals and providers would be required to list their prices on a publicly provided Internet site for a set list of routine services that are the private responsibility of patients to allow easy price comparison shopping.³⁹³ As insurers would pay no more for professional services than these published prices,³⁹⁴ competition for direct patient purchasing might also bring down insurance prices as well (though it is likely that insurers would continue to be able to get better prices from providers than private individuals because they can offer volume). Competition among health care professionals would begin to look more like current competition among lawyers for providing routine services, such as bankruptcies, divorces, or real estate closings.

390. See Leatrice Berman-Sandler, *Independent Medical Review: Expanding Legal Remedies to Achieve Managed Care Accountability*, 13 ANNALS HEALTH L. 233, 237-75 (2004) (reviewing current state of managed care external review statutes).

391. See Symposium, *Putting Evidence into Practice*, HEALTH AFF., Jan./Feb. 2005, at 7 (discussing the state of evidence-based technology assessment in the United States). See generally INTERNATIONAL COMPARATIVE STUDY, *supra* note 63 (discussing international experience with the use of technology assessment for coverage determinations).

392. The Supreme Court's decision in *California Dental Ass'n v. F.T.C.*, 526 U.S. 756, 778 (1999), unfortunately gives private professional associations considerable discretion in limiting professional advertising.

393. Since laboratory tests and diagnostic imaging would be covered by insurance, professionals would only need to set and publish prices for their consultation services.

394. They could, of course, negotiate lower prices.

To the extent that cost control is effective, it will make a number of powerful interests very unhappy. One person's cost is another's income or profit. If health care cost containment were ever successfully implemented in the United States, doctors, hospitals, health insurers, and drug companies can be counted on to whine about their loss of income and about the threat that this would pose to the nation's health.³⁹⁵ But in other countries, health care professionals earn far less than they do in the United States when compared to the income of the average worker, and somehow manage to get by.³⁹⁶ There is no reason why health care providers, as opposed to other providers of goods and services, should be entitled to income protection not extended to others in the economy.

Actually limiting growth in health care costs, moreover, would likely have an impact on the nation's economy. Health care is one of the few things that is still predominantly produced domestically in the United States, and growth in the health care sector has been one of the primary drivers of job creation in our country.³⁹⁷ Imposing serious constraints on the growth of health care would likely take a toll on job growth. But, because we pay excessively high prices for health care, controlling those prices could allow us to move investment to sectors of the economy where that money could be used more productively. And cutting the costs paid by employers for health insurance would be likely to promote job growth elsewhere in the economy. In any event, we should not allow health care to consume an ever-greater share of our national income unless we actually prefer to spend money on it rather than on other goods and services.³⁹⁸ The plan proposed here would allow us both to make

395. See Robert G. Evans, *Tension, Compression, and Shear: Directions, Stresses, and Outcomes of Health Care Cost Control*, 15 J. HEALTH POL. POL'Y & L. 101, 117 (1990).

396. Physician incomes are much higher in the United States than they are in other OECD countries. In 1996, for example, the average U.S. physician income was \$199,000, while the OECD median physician income was \$70,324. The ratio of the average income of U.S. physicians to average employee compensation for the United States as a whole was about 5.5, compared to Germany at 3.4, Canada at 3.2, Switzerland at 2.1, France at 1.9, and the United Kingdom at 1.4. Uwe E. Reinhardt, Peter S. Hussey & Gerard F. Anderson, *Cross-National Comparisons of Health Systems Using OECD Data, 1999*, HEALTH AFF., May/June 2002, at 169, 175.

397. The Bureau of Labor Statistics, for example, identifies the "education and health services industry" as the industry sector that will experience the fastest growth in employment from 2004 to 2014, while six of the "ten fastest growing occupations" it identifies for 2004-2014 are health care occupations. See BUREAU OF LAB. STATS., ECON. AND EMP. PROJECTIONS, 5 tbl.1, 7 tbl.3c (2005), available at <http://www.bls.gov/news.release/pdf/ecopro.pdf>.

398. See Mark V. Pauly, *Should We Be Worried About High Real Medical*

political decisions as to how much we want to spend as a nation and personal decisions as to how much we want to spend as individuals on health care.

To facilitate that political choice, and also to assure that the costs of health care are borne broadly and progressively, the cost of the government programs should be financed through a broad-based tax such as the income tax, rather than by a narrow and regressive payroll tax.³⁹⁹ The tax, however, should be earmarked for health care (as the Medicare tax is now), possibly through a percentage surcharge on income tax, to make the health care spending visible and transparent. Polls show that Americans support the government spending more money if necessary to make high-quality care available to all; many even support substantial tax increases for this purpose.⁴⁰⁰ It should be possible, therefore, to raise enough money in this way to fund the program.

The proposed program could also be structured to address our problems of quality of care and medical error. Current licensing, accreditation, certification, institutional regulation, and drug and device approval and monitoring programs should continue in place, and be continually improved, until better means of assuring institutional competence are discovered. Both public and private insurers should be encouraged to experiment with pay-for-performance approaches to provider payment. Maintaining a diversity of payers for most services should facilitate experimentation in this area. The creation of information that might permit competition on the basis of quality should be encouraged to allow comparative shopping for services, and reliable comparative information on quality, as it emerges, should be made available on the Internet sites where providers post price information. This competition should encourage providers to specialize and to become better at doing what they do best. On the other hand, a national and uniform system of health insurance should be used to facilitate the adoption of electronic patient records and reminder systems. Most importantly, the federal government should devote significant funding toward identifying the best clinical practices and should publish information developed through this funding on internet sites to which the public and all providers have access.

Finally, a thoroughgoing reform of the health care system could

Spending Growth in the United States?, HEALTH AFF.-WEB EXCLUSIVE, Jan. 8, 2003, at W3-315, W3-318, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.15v1.pdf>.

399. JOST, *supra* note 34, at 272.

400. Blendon et al., *supra* note 363, at W3-410.

open the door for real malpractice reform that goes beyond efforts to disadvantage malpractice plaintiffs and punish plaintiff's attorneys. If the government was responsible for catastrophic medical expenses—caring for brain-damaged children, for example—there would be much less need to litigate responsibility for the damage.⁴⁰¹ If the government was the primary source of payment for hospitals, nursing homes, and some specialists, the government could take responsibility for providing affordable malpractice insurance.⁴⁰² National legislation could set up a workers' compensation type system to compensate injury, increasing the availability of payment for smaller medical negligence claims. The entity administering the claims could use information gained through the compensation program to identify and devise responses to underlying problems that result in medical errors. In some instances, this might lead to taking corrective action against providers. In others, problems in larger systems could be identified, and appropriate responses could be devised. Because the government would be paying for the majority of health care in the new system, it would have even more of an incentive than it now has to assure that it was getting its money's worth in terms of quality from the system.

VI. THE LEGAL INFRASTRUCTURE OF THE NEW SYSTEM

Most of the statutory and regulatory law necessary to implement this new system would have to be federal law. Our experience with Medicaid should have taught us that there is little to be gained by creating fifty different programs to deal with what is essentially a national problem.⁴⁰³ Diseases and accidents are the same in every state, and the services and products necessary to treat them do not change when one crosses state lines.⁴⁰⁴ Federally subsidized state health care programs, like Medicaid, lead to

401. In Germany, for example, damages in medical negligence litigation are much lower than in the United States because medical costs are largely covered by insurance. See Timothy Stoltzfus Jost, *Schlichtungsstellen and Gutachterkommissionen: The German Approach to Extrajudicial Malpractice Claims Resolution*, 11 OHIO ST. J. ON DISP. RESOL. 81, 102 (1996).

402. See William M. Sage, *The Forgotten Third: Liability Insurance and the Medical Malpractice Crisis*, HEALTH AFF., July/Aug. 2004, at 10, 20 (recommending that Medicare take the lead in resolving the malpractice insurance crisis).

403. See JOST, *supra* note 34, at 172-78.

404. There is, of course, considerable variation as to how medical conditions are treated in different regions of the country. See THE DARTMOUTH ATLAS OF HEALTH CARE IN THE UNITED STATES 1999, THE QUALITY OF MEDICAL CARE IN THE UNITED STATES: A REPORT ON THE MEDICARE PROGRAM (John E. Wennberg et al. eds., 1999), available at <http://www.dartmouthatlas.org/atlases/99Atlas.pdf>. This variation, however, is generally viewed as a problem rather than a virtue.

undesirable gaming of the system by the states to capture federal money,⁴⁰⁵ and create the risk that a person's health coverage could change significantly just because he or she moved across the state line. While there may at one point have been reasons why the financing of health care was considered a state or local responsibility, they no longer exist.

Legislation of this scope should be enacted as a single piece of legislation (though in fact it may need to be adopted incrementally for political reasons). Like the Health Insurance Portability and Accountability Act of 1996, it would have to amend the Social Security Act,⁴⁰⁶ ERISA, and the tax code. The legislation would probably also have to create a new title to the Social Security Act to cover the new programs it would include, as well as to repeal or completely rewrite Titles XVIII and XIX of the Social Security Act. The legislation would be massive, but so was the Medicare Modernization Act,⁴⁰⁷ the Balanced Budget Act of 1997,⁴⁰⁸ the Health Insurance Portability and Accountability Act, and any number of recent budget reconciliation acts. Though Clinton's Health Security Act⁴⁰⁹ was held up to ridicule because of its complexity,⁴¹⁰ it is the unfortunate fact that in health care complex problems require complex solutions, and that simple solutions are simplistic and ineffective.⁴¹¹

The proposed program should be substituted for the current Medicare program, bringing us in line with most of the rest of the countries of the world where there is not a special public insurance program for the elderly. It would, however, be unwise simply to abolish the Medicare program without providing for its former beneficiaries. Though poorer Medicare beneficiaries would probably be better off under the proposed program, some wealthier people may have to pay more. Medicare, like Social Security, has always been sold as a social contract, and current beneficiaries and persons

405. See SCHNEIDER ET AL., *supra* note 134, at 106-15 (describing state attempts to manipulate federal financial participation to maximize Medicaid revenue).

406. Pub. L. 74-271, 49 Stat. 620 (1935).

407. Pub. L. 108-173, 117 Stat. 2066 (2003).

408. Pub. L. 105-33, 111 Stat. 251 (1997).

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

410. See Manish C. Shah & Judith M. Rosenberg, Essay, *Health Care Reform in the 103d Congress: A Congressional Analysis*, 33 HARV. J. ON LEGIS. 585, 610 (1996).

411. It should also be noted, however, that part of the complexity of the Clinton health care reform was attributable to the lengths to which it went to appease all possible political constituencies. Legislation that was more courageous politically could have been simpler, and left more to subsequent administrative rulemaking.

nearing retirement would feel cheated if they thought that they were losing what they might well have perceived as vested rights under the program.⁴¹² Therefore, all current Medicare beneficiaries, as well as persons who will become eligible for Medicare over the next twenty years, would be enrolled in the government acute care insurance program and would not have to pay premiums that exceed what they would otherwise have to pay for Part B coverage.

Medicaid, on the other hand, would be wholly replaced by the program, and few would mourn its passing. Medicaid eligibility rules have become impossibly complex and irrational, and in many states Medicaid provider payments are so low that Medicaid's promise of access for the poor to mainstream medicine is a mockery. Medicaid has provided for many poor people an essential federal right to health care and has been a dramatic success story in terms of its impact on the health of the poor,⁴¹³ but the proposed program would afford more solid federal rights, and finally provide the poor with true equal access to health care.

Tax subsidies for employment-related insurance would not survive the reforms. Though employment-related insurance tax subsidies have been relatively easy to administer, they have operated capriciously, benefiting the wealthy and offering little to the poor.⁴¹⁴ There will also be less need for tax subsidies for non-profit health care facilities under the new law, as the facilities will now be paid when they provide services to the poor, but these subsidies may still be justified if these facilities continue to sponsor education and research and offer other community benefits.

Some of the basic provisions of HIPAA could continue in force—for example, its provisions prohibiting discrimination against persons covered by group policies⁴¹⁵—but others, such as those assuring small groups access to health insurance,⁴¹⁶ would no longer be necessary. HIPAA's prohibition against preexisting conditions clauses should become universal.⁴¹⁷ But with universal insurance coverage, the adverse selection problem that preexisting conditions clauses address would become moot. COBRA would also no longer serve a useful purpose, as individuals would have direct access to insurance without needing coverage under employment-related plans.

412. See JOST, *supra* note 34, at 50-51.

413. See Diane Rowland & James R. Tallon, Jr., *Medicaid: Lessons from a Decade*, HEALTH AFF., Jan./Feb. 2003, at 138, 139.

414. See Sheils & Haught, *supra* note 148, at W4-109-10.

415. 42 U.S.C. § 300gg-1(b) (2000).

416. *Id.* § 300gg-11(a).

417. *Id.* § 300gg.

Most of the ad hoc legal infrastructure that has been constructed at the state level to facilitate access to health care could be dispensed with under the proposed plan. Basic state regulation of insurance would need to be continued to assure plan solvency and honest marketing and claims practices, but state benefit and provider coverage mandates would be replaced by uniform federal coverage rules, while state laws intended to expand access would become superfluous.

The legal requirements of ERISA could also be folded into the new program. Once again, a comprehensive reform of the health care system would provide an opportunity to revisit some of the intractable problems that ERISA has posed. Included among these is the question of the damages that should be available when a health plan's negligent denial of coverage results in serious injury to an insured. Current ERISA jurisprudence denies recovery of extracontractual damages against a health plan under these circumstances.⁴¹⁸ A couple of Supreme Court Justices, however, along with distinguished legal scholars, have questioned this result.⁴¹⁹ The new program would significantly reduce the saliency of this issue, as it would assure coverage for catastrophic health care costs, make coverage determinations more uniform across plans, and afford prompt internal and external review where coverage questions arose.

One body of access-promoting federal and state law that would not become superfluous in a reformed health care system would be the civil rights laws that prohibit discrimination on the basis of race, color, religion, national origin, gender, or disability.⁴²⁰ The United States health care system has a long history of racial segregation,⁴²¹ and unequal treatment on the basis of race continues to this day.⁴²² Discrimination on the basis of disabling medical conditions, such as AIDS, also continues.⁴²³ One would hope that removing financial barriers to access would improve access to care for minorities and

418. See *Aetna Health Inc. v. Davila*, 542 U.S. 200, 212-14 (2004); *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256-58 (1993); *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985).

419. See *Davila*, 542 U.S. at 222 (Ginsburg, J., concurring); see also John H. Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens, and Great-West*, 103 COLUM. L. REV. 1317, 1365 (2003) (suggesting the Supreme Court has made errors in ERISA remedy law).

420. §§ 2000d, 12182.

421. See DAVID BARTON SMITH, *HEALTH CARE DIVIDED: RACE AND HEALING A NATION* 3-31 (1999).

422. IOM, *UNEQUAL TREATMENT*, *supra* note 361, at 38-79.

423. See, e.g., *Bragdon v. Abbott*, 524 U.S. 624, 629 (1998); *Howe v. Hull*, 874 F. Supp. 779, 782 (N.D. Ohio 1994).

for the disabled. But disparities in health care access are not solely the result of financial barriers to access, but also of institutional, organizational, and systemic barriers, as well as of provider attitudes and behavior.⁴²⁴ The civil rights laws should remain in place to address these issues. To date, enforcement of Title VI⁴²⁵ has been largely ineffective, but Title VI should at least remain as an expression of an aspiration, and creative approaches to bring its values to fruition should be explored.⁴²⁶ EMTALA should also continue in force. Even though hospitals would be paid for emergency care under the new program, and would have little economic reason to deny emergency treatment, they might still refuse treatment for discriminatory reasons.⁴²⁷

The proposal would have less effect on laws that are currently in place to address health care cost concerns. Coverage of the civil and criminal false claims laws⁴²⁸ should be extended to include all public and private insurers in the system, and should be vigorously enforced in both the private and public sector.⁴²⁹ The bribe and kickback⁴³⁰ and self-referral laws⁴³¹ should be extended to the private sector, but they should also be simplified. Because the acute care program would continue to operate largely on a fee-for-service basis, the tendency of bribes and kickbacks to generate unnecessary care in a fee-for-service environment would continue to be a concern. Nevertheless, the creation of a new program could provide an opportunity to review some of the more intrusive applications of the bribe and kickback and self-referral laws to determine whether they continue to be needed.

The antitrust laws⁴³² should continue to be enforced so as to encourage active competition among providers. The remaining state CON laws, on the other hand, would no longer be necessary once the federal government took over compensating long-term care facilities and hospitals, the primary target of state CON programs, as the

424. IOM, UNEQUAL TREATMENT, *supra* note 361, at 140-59, 162-74.

425. § 200d.

426. *See, e.g.*, Timothy Stoltzfus Jost, *Racial and Ethnic Disparities in Medicare: What the Department of Health and Human Services and the Centers for Medicare and Medicaid Services Can, and Should, Do*, 8 DEPAUL J. HEALTH CARE L. (forthcoming 2006).

427. *See, e.g.*, *Howe*, 874 F. Supp. at 782 (EMTALA case against hospital that refused to treat person with AIDS).

428. 31 U.S.C. § 3729 (2000) (civil); 18 U.S.C. § 287 (2000) (criminal).

429. In an earlier article I have explained why fraud and abuse enforcement is important for controlling health care utilization and cost. Jost & Davies, *supra* note 195, at 239.

430. 42 U.S.C. § 1320a-7(b)(1)(A) (2000).

431. *Id.* §§ 1395nn, 1396b(s).

432. 15 U.S.C. §§ 1-12 (2000).

financial incentives that drive construction of excess capacity could be limited.

In general, the new program will need to be implemented through administrative agencies governed by administrative law. In this sense, it will resemble much of existing health law.⁴³³ The program will, however, like Medicare, involve the private sector extensively both in management and in administration. It is important that private sector institutions be used where they bring flexibility and innovation (or where their use might co-opt opposition to the law), but that their role be constrained where it could result in inequity or inefficiency.⁴³⁴ Advisory committees, like the MEDPAC, should also be used to bring nongovernmental expertise to the policy-making and rate-setting processes, and to bridge between Congress and the Executive.⁴³⁵

VII. POLITICAL FEASIBILITY: HOW DO WE GET THERE FROM HERE?

Now comes the hard part: getting the proposal adopted into law. It is difficult to interpret the 2004 election as an endorsement of a national health insurance program. In fact, it is likely that over the next few years our health care system will continue to deteriorate in all respects. We are likely to see an expansion of consumer-driven health plans, as employers, ever more frustrated with their inability to control health insurance premium increases, try to shift more of the problem to employees.⁴³⁶ These plans may well include HSAs, health reimbursement accounts, or some yet-to-be-designed mechanism for providing tax subsidies for health benefit plans with high cost-sharing obligations.⁴³⁷ Additional tax credit schemes will probably make it through Congress, possibly aimed at relatively low-income uninsureds, like those proposed by President Bush.⁴³⁸

433. See Jost, *supra* note 9, at 1.

434. For a sample of recent articles addressing the appropriate role of private institutions in administrative governance, see Jack M. Beermann, *Administrative-Law-Like Obligations of Private(ized) Entities*, 49 UCLA L. REV. 1717 (2002); Jody Freeman, *Extending Public Law Norms Through Privatization*, 116 HARV. L. REV. 1285 (2003); Jody Freeman, *The Private Role In Public Governance*, 75 N.Y.U. L. REV. 543 (2000); Symposium, *Public Values in an Era of Privatization*, 116 HARV. L. REV. 1212 (2003).

435. See Jost, *supra* note 133, at 71 (describing the role of MedPAC's predecessor institutions).

436. See Jon R. Gabel et al., *Employers' Contradictory Views About Consumer-Driven Health Care: Results from a National Survey*, HEALTH AFF.-WEB EXCLUSIVE, Apr. 21, 2004, at W4-210, W4-215-17.

437. For a description of the current mechanisms for achieving this, see FURROW ET AL., *supra* note 161, at 642.

438. See Press Release, *supra* note 239.

The amount of these credits will probably be too low to offer much help to those who are really poor, and they may well aggravate the situation of the uninsured if they result in even more employers dropping coverage.⁴³⁹ In a rush to adopt tax credits and to facilitate consumer-driven health care, Congress is likely to do serious damage to our employment-based health insurance system, which has made our lack of a universal public health insurance system tolerable. As this is happening, however, our public insurance system is also likely to deteriorate. The President and Congress are likely to try to block-grant Medicaid, and the states might accept this if Congress eliminates the right of Medicaid recipients to sue the states in federal court to enforce their Medicaid entitlement.⁴⁴⁰ As the states cut back on their increasingly unaffordable Medicaid benefits, the number of uninsured will continue to increase. Hospitals may for a time be able to continue to care for the uninsured through their uncompensated care programs, but this cannot go on forever. Pressure will mount on Congress to repeal EMTALA, to which it may at some point succumb.

In the meantime, health care costs will continue to soar, as a new Medicare drug program comes on line, as billions of dollars are dumped into the Medicare Advantage program,⁴⁴¹ as employers continue to try to get out of the business of controlling costs, and as “consumer-driven” health plans result in consumers paying retail rather than wholesale prices for provider services. Congress may, after years of political battles, adopt caps on malpractice judgments and perhaps limits on contingent fees, but this will have no perceptible effect on limiting health care costs or expanding access.⁴⁴² By the next election, we will, in all likelihood, have several million more Americans uninsured and health care costs that

439. *See id.*

440. *See, e.g.,* Robert Pear, *Health Secretary Calls for Medicaid Changes*, N.Y. TIMES, Feb. 2, 2005, at A12. The 2005 Deficit Reduction Act passed after this Essay was completed takes us far in this direction. *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, DEFICIT REDUCTION ACT OF 2005: IMPLICATIONS FOR MEDICAID, <http://www.kff.org/medicaid/upload/7465.pdf> (last visited April 8, 2006).

441. *See* BRIAN BILES, LAUREN HERSCH NICHOLAS & BARBARA S. COOPER, THE COMMONWEALTH FUND, THE COST OF PRIVATIZATION: EXTRA PAYMENTS TO MEDICARE ADVANTAGE PLANS, 2005 UPDATE 4 (2004), available at http://www.cmf.org/usr_doc/750_Biles_costofprivatization_update_ib_pdf.pdf. (Medicare Advantage is projected to cost the Medicare program in 2005 \$2.72 billion more than the cost Medicare would have incurred had beneficiaries in the MA program been covered by traditional Medicare).

442. *See* CONG. BUDGET OFF., ECON. & BUDGET ISSUE BRIEF: LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE 1 (2004), available at <http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf>.

consume more of the gross domestic product than they do now.⁴⁴³

When all else fails, we might try the obvious, that is, learning from the experience of other nations. Of course, that experience is mixed, but it tends to show that in this one particular corner of the economy, government often outperforms the private sector. We could, and should, join the rest of the world in making public health insurance available to all.

In the meantime several things need to happen. First, a way must be found to get the media to pay attention to a progressive voice on health policy. For years, right-wing advocacy centers—the Heritage Foundation, the Galen Institute, Cato, and others—have steadily and loudly beat the drum for their market-oriented solutions to our health care problems.⁴⁴⁴ The media have been hearing this drum beat for so long that they have begun to march to it, either accepting the positions of the right wing as truth or at least seeing them as valid positions that at most need to be balanced occasionally with progressive perspectives. The media also often present negative and misleading caricatures of the health care systems of other nations.⁴⁴⁵ Few Americans realize, for example, that other nations offer quicker access to primary care than does the United States,⁴⁴⁶ or have more sophisticated health IT systems.⁴⁴⁷ Progressive voices need to be loud and insistent. They need to get out accurate information on how health care systems in fact function in other nations and why market-based solutions are not the answer to all of our problems.

When the times comes, perhaps in two years, perhaps in six, to again move forward on health reform, progress may need to be made incrementally. The Medicare drug bill demonstrates that America still has a commitment to insuring the elderly, just as the SCHIP program, established in 1997, showed that we have a commitment to

443. It is projected that by 2008, health care costs will grow to over \$2.35 billion dollars and consume 16.4% of the GDP. See Stephen Heffler et al., *Health Spending Projections for 2002-2012*, HEALTH AFF.-WEB EXCLUSIVE, Feb. 7, 2003, at W3-54, W3-55. It is difficult to find recent projections on growth in the number of uninsured, but older sources projected growth to between forty-eight and sixty-one million people by 2009. WILLIAM S. CUSTER & PAT KETSCHKE, *THE CHANGING SOURCES OF HEALTH INSURANCE* 18-19 (2000).

444. See LIEBERMAN, *supra* note 229, at 117-48 (recounting the Heritage Foundation's campaign to privatize Medicare).

445. This is often seen, for example, in the negative press that the Canadian health care system gets in the United States. See Theodore R. Marmor et al., *Fact & Fiction: The Medicare "Crisis" Seen from the United States*, in WHITHER HEALTH CARE POLICY?: U.S., CANADIAN, AND EUROPEAN PERSPECTIVES 4-9 (2002).

446. See generally Jost, Dawson & den Exter, *supra* note 89.

447. See Jost, *supra* note 33, at 443-48 (Chilean system).

covering poor children.⁴⁴⁸ Perhaps catastrophic coverage for all can come next, or comprehensive coverage for the poor. Alternatively, there may come a point when so many middle-class Americans (or their adult children) are uninsured, that the “path dependency” that has kept us from embracing national health insurance will lose its grip.

One barrier that will have to be overcome will be the opposition of interest groups that profit from the current system—insurers, the pharmaceutical companies, and organized medicine. It is these interests that were largely responsible for killing the Clinton plan.⁴⁴⁹ As the situation of the health care system becomes more dire, however, these interests may conclude that they have more to gain than lose by supporting a national health program. Accommodating these interests within the program, as Medicare did in using insurers to process claims, might make the reform more palatable to them. But if interest groups continue to oppose reform, members of Congress may ultimately have to listen to their constituents rather than to these obstructionist interest groups.

One of the biggest problems that we will face when the time comes to adopt a new program will be the problem of cost. The program proposed in this Essay will certainly require billions of additional public dollars. How many is difficult to say, though the catastrophic coverage program proposed here would have covered the \$45.2 billion that the private sector spent on nursing home care in 2004, and some of the \$249.7 billion spent by the private sector on hospital care in that year.⁴⁵⁰ Senator Kerry’s plan for extending federal catastrophic coverage to employees, giving individuals access to the Federal Employees Health Benefits Plan, and extending Medicaid and SCHIP, was priced at \$653 billion over ten years.⁴⁵¹

It is important to understand, however, that government money spent on the program would not all be new money; indeed most of it might not be. The government currently spends over \$200 billion dollars a year in tax subsidies for private insurance, and Congress seems eager to spend more by creating new tax subsidies. The Medicaid program spends close to \$300 billion on caring for the poor,

448. State Coverage Initiatives, Matrix Glossary, State Children’s Health Insurance Program (SCHIP), <http://www.statecoverage.net/pdf/brochure.pdf> (last visited Apr. 19, 2006).

449. NICHOLAS LAHAM, A LOST CAUSE: BILL CLINTON’S CAMPAIGN FOR NATIONAL HEALTH INSURANCE 208-10 (1996); Jacob S. Hacker & Theda Skocpol, *The New Politics of U.S. Health Policy*, in *THE NATION’S HEALTH*, 186, 189 (Philip R. Lee et al. eds., 6th ed. 2001).

450. Smith et al., *supra* note 3, at 191 exh.5.

451. Jeanne M. Lambrew, *Numbers Matter: A Guide to Cost and Coverage Estimates in Health Reform Debates*, 32 J.L. MED. & ETHICS 446, 447 (2004).

much of which already goes for nursing home care and the care of the chronically ill.⁴⁵² The Medicare and Medicaid programs already spend billions of dollars to cover the costs of the uninsured through disproportionate-share hospital payments and medical education cost subsidies.⁴⁵³ Bankruptcies shift yet more of the cost of the poor to uncompensated providers, who try to shift those costs on ultimately to their patients and insurers.⁴⁵⁴ All of these subsidies and cost shifting would be eliminated by universal coverage.

A careful study by the Institute of Medicine concluded that extending coverage to the uninsured would only cost from \$34 to \$69 billion per year in actual new money, depending on the plan design.⁴⁵⁵ This compares favorably to the \$99 billion per year cost of making President Bush's tax cut permanent, mostly for the benefit of the wealthiest Americans, or to the \$137 billion that U.S. health care costs increased between 2003 and 2004.⁴⁵⁶

Moreover, the cost to government of the new program would not even all be tax money. Much of the cost of the acute care government insurance program would be financed by premiums collected from persons who chose to participate in the program. Only the subsidies that would cover the premiums for low income enrollees in the government plan (or in private plans) would be covered through taxes. And many of these would be persons currently receiving government funds through Medicaid or SCHIP.

The plan would also result in significant savings. A recent Institute of Medicine report on the cost of uninsurance in America concluded that "the aggregate, annualized cost of the diminished health and shorter life spans of Americans who lack health insurance is between \$65 and \$130 billion for each year of health insurance foregone."⁴⁵⁷ The cost control provisions of the proposed plan should also reduce its cost. A recent study, for example, estimated that the implementation of fully standardized health care information exchange and interoperability could save our health

452. In 2004, Medicaid spent \$292.7 billion, including \$99.1 billion on hospital care and \$64.8 billion on long term care. Smith et al., *supra* note 3, at 191 exh.5.

453. \$16.2 billion in 2001. IOM, HIDDEN COSTS, VALUE LOST, *supra* note 142, at 54.

454. See Himmelstein, *supra* note 41, at W5-71.

455. IOM, HIDDEN COSTS, VALUE LOST, *supra* note 142, at 9, tbl. ES.1.

456. See Lambrew, *supra* note 451, at 450; Smith et al., *supra* note 3, at 187 exh.1.

457. INST. OF MED., INSURING AMERICA'S HEALTH: PRINCIPLES AND RECOMMENDATIONS (2004), available at <http://darwin.nap.edu/books/0309091055/html/1.html>.

care system \$77.8 billion a year.⁴⁵⁸ It would be much easier to implement such a system with the rationalization of our health insurance system that this Essay proposes.

It cannot be denied, however, that the total cost of health care will continue to rise for the foreseeable future, and under this proposal, the proportion of the cost of that system borne by Americans as taxpayers rather than as by private citizens would grow as well. But this is a cost we can in fact bear. Assuming that our national productivity continues to increase as it has over much of the past century, we are essentially looking at devoting to health care a growing share of an ever-expanding pie. Between 1970 and 2004, the proportion of the GDP spent on health care grew from 7.2% to 16%.⁴⁵⁹ But over that same period of time, the GDP grew from \$1 trillion to \$11.7 trillion in constant dollars.⁴⁶⁰ Even if the proportion of GDP we spend on health care keeps growing, and more of this money is tax money, we will still have on average far more private money two or three decades from now than we do currently to spend on the then-equivalent of SUVs, exotic coffees, video games, or whatever happens to be in fashion at the time, and still be able to pay for health care.⁴⁶¹

The question is ultimately not whether we can afford to provide health care for all. The question is not even, as I hope this Essay has demonstrated, whether it is possible to find a way to do this. The question is, rather, whether we want to do it. If we want to, we can.

458. Jan Walker et al., *The Value of Health Care Information Exchange and Interoperability*, HEALTH AFF.-WEB EXCLUSIVE, Jan. 19, 2005, at W5-10, W5-10, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.10v1.pdf>.

459. Smith et al., *supra* note 3, at 187 exh.1.

460. *Id.*

461. If we simply project increased worker productivity forward at 1.1% per year, as compared to historic increases of 1.5% per year over the past fifty years, per worker productivity will expand from \$67,473 in 2000, to \$105,982 in 2035 in 2002 dollars. MARLIYN MOON & MATTHEW STOREYGUARD, KAISER FAMILY FOUND., SOLVENCY OR AFFORDABILITY? WAYS TO MEASURE MEDICARE'S FINANCIAL HEALTH 16, FIGURE 2 (2002), <http://www.kff.org/medicare/upload/Solvency-or-Affordability-Ways-to-Measure-Medicare-s-Financial-Health-Report.pdf>. Even if per American health care costs double during that time in constant dollars, Americans would still have a great deal of discretionary money left over.