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## The Past, Present and Future of Health Care Reform: Can It Happen?, 40 J. Marshall L. Rev. 767 (2007)

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# THE PAST, PRESENT AND FUTURE OF HEALTH CARE REFORM: CAN IT HAPPEN?

DAVID PRATT\*

## I. INTRODUCTION

The American health care system is in bad shape. The U.S. spends sixteen percent of its gross domestic product (GDP) on health, about twice the average for other rich countries, yet more than forty-six million Americans are uninsured, and another sixteen million are under-insured.<sup>1</sup> In a 2004 national survey, twenty-two percent of respondents listed health care as the most critical issue in America. Health care has ranked first or second in this survey since it began in 2000, with approximately two in ten respondents listing it first each year.<sup>2</sup>

In a 2006 survey, six in ten Americans rated the health care system as fair (twenty-eight percent), or poor (thirty-one percent).

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\* Professor of Law, Albany Law School. A portion of this Article first appeared, in somewhat different form, on the Hastings Center's Bioethics Forum. See Health Care Reform: A Guide to Current Events, by David Pratt and Alicia Ouellette, at <http://www.bioethicsforum.org>. Thanks to the Hastings Center and to my co-author, Alicia Ouellette.

1. See Paul Krugman, *A Healthy New Year*, N.Y. TIMES, Jan. 1, 2007, at A19 (noting that "[i]n 2005, almost 47 million Americans—including more than 8 million children—were uninsured, and many more had inadequate insurance."). Moreover, the United States "ha[s] the highest infant mortality and close to the lowest life expectancy of any wealthy nation." *Id.* See also C. Schoen, M.M. Doty, S.R. Collins & A.L. Holmgren, *Insured But Not Protected: How Many Adults Are Underinsured?* HEALTH AFFAIRS, Web Exclusive, June 14, 2005, [content.healthaffairs.org/cgi/reprint/hlthaff.w5.289v1.pdf](http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.289v1.pdf) (suggesting that underinsured Americans are almost as likely as the uninsured to not receive needed medical care). The problem is not new: "American medicine is in trouble. Its costs are staggering. Its record of performance—on access, effectiveness, and efficiency—is mixed. And its future worries millions of Americans." THEODORE R. MARMOR, UNDERSTANDING HEALTH CARE REFORM 107 (Yale University Press 1994).

2. Ruth Helman et al., *Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey*, 275 EBRI ISSUE BRIEF (2004), as cited in Edward J. Larson & Marc Dettmann, *The Impact Of HSAs On Health Care Reform: Preliminary Results After One Year*, 40 WAKE FOREST L. REV. 1087 (2005); see also Ruy Teixeira, *What the Public Really Wants on Health Care*, The Century Foundation, Center for American Progress, <http://tcf.org/publications/healthcare/wtprw.healthcare.pdf> (discussing public concerns with the lack of access to health care).

The percentage of individuals rating the system as poor has doubled since 1998 (fifteen percent).<sup>3</sup>

In March 2006, seventy-one percent of workers in private industry had access to employer-sponsored medical care plans, but only fifty-two percent were actually covered. Monthly employee premiums averaged \$296.88 for family coverage and \$76.05 for single coverage.<sup>4</sup> The states are struggling with Medicaid costs that consume more and more of their budgets. According to the National Association of State Budget Officers, twenty-three states spent more on Medicaid (after taking federal subsidies into account) than education in 2003.<sup>5</sup> Medicaid accounted for twenty-two percent of average state spending in fiscal year 2004. As a share of the states' own revenue (excluding federal funding), Medicaid increased from six percent in 1989 to thirteen percent in 2004.<sup>6</sup>

To date, the federal government has been woefully ineffective in improving the health care system.<sup>7</sup> In response, several states have acted on their own plans.<sup>8</sup> State programs go far beyond what is being given serious consideration in Washington,<sup>9</sup> but the plans are limited both in substance and in their geographical reach, and the more ambitious state plans are vulnerable to claims that they are preempted by ERISA.<sup>10</sup> Moreover, the possibility for state-level change is hampered by the same forces that control Washington: first, there are so many interested parties and the health care industry is such a colossus that any significant change

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3. Employee Benefit Research Institute, *2006 Health Confidence Survey: Dissatisfaction with Health Care Systems Doubles Since 1998*, EBRI NOTES, Nov. 2006, vol. 27, no. 11; see also Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 538 (2006) (stating that "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.").

4. Bureau of Labor Statistics, U.S. Department of Labor, *Employee Benefits In Private Industry, 2006*, <http://www.bls.gov/ncs/ebs/sp/ebism0004.pdf>.

5. National Association of State Budget Officers, *2003 State Expenditure Report*, <http://www.nasbo.org/publications/pdfs/2003expendreport.pdf>.

6. Alliance for Health Reform, *Covering Health Issues 2006*, Ch. 6: Medicaid, [http://www.allhealth.org/sourcebook2006/pdfs/chapter\\_6.pdf](http://www.allhealth.org/sourcebook2006/pdfs/chapter_6.pdf); see also National Association of State Budget Officers, *2004 State Expenditure Report*, <http://www.nasbo.org/Publications/PDFs/2004Expendreport.pdf> (showing how much states spend on Medicare).

7. See Susan J. Stabile, *State Law Health Care Initiatives*, 19 ST. THOMAS L. REV. 87 (2006) (discussing the health care crisis in America).

8. See *infra* Part VI.A (discussing development of state plans).

9. See *infra* Part VI.C (detailing federal reforms under consideration).

10. ERISA refers to the Employee Retirement Income Security Act of 1974, Pub. L. 93-406, codified (as frequently amended) in scattered sections of titles 26 U.S.C. and 29 U.S.C.

is difficult and controversial.<sup>11</sup> Second, our political leaders have short attention spans and do not like tackling controversial issues, so all of the current activity may lead to nothing.<sup>12</sup>

This Article will discuss the background of attempts to reform the health care system, the current problems, and the current proposals at both the state and federal levels.

## II. A LITTLE HISTORY

There is nothing new about a widespread desire for fundamental reform of the health care system and a perception that, finally, the time is nigh:

In the Progressive era, during the New Deal, under President Truman, and during the early 1970s, advocates thought universal health insurance was imminent and were bitterly disappointed. Now, as then, entrenched interests have tried to block national health insurance by skillfully manipulating our deepest fears to protect what they regard as their interests.<sup>13</sup>

In a 1970 survey, three people out of four agreed that the U.S. health care system was in crisis.<sup>14</sup> In a 1990 poll, ninety percent of those surveyed expressed the belief that the U.S. health care system required fundamental change or a complete rebuilding.<sup>15</sup>

Why is reform so difficult? According to Yale School of Management Professor Theodore R. Marmor:

The conventional account is this: On multiple occasions before World War I and after World War II, comprehensive national reform was on the public agenda, seriously debated legislatively, and, in 1973-74, appeared imminent. In all of these instances, reform coalitions fell short of the necessary political majorities in Congress. Each failure has its own peculiar history, but one essential fact remains: While commentators have persistently criticized the country's medical care arrangements, U.S. politics has defeated scores of universal health plans from the Murray-Wagner-Dingell

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11. See *infra* Part II (discussing the history of the health care reform movement).

12. Rep. Pete Stark's pessimistic assessment is probably correct: "What we are building up to is a year, 2007, in which a lot of people are willing to discuss the benefits and costs of universal coverage, but I don't think we're going to make legislative headway." Tom Hamburger & Ricardo Alonso-Zaldivar, *Unlikely Allies Push Expanded Health Care*, L.A. TIMES, Jan. 16, 2007, at 1.

13. MARMOR, *supra* note 1, at 6.

14. LAURENE A. GRAIG, *HEALTH OF NATIONS: AN INTERNATIONAL PERSPECTIVE ON U.S. HEALTH CARE REFORM* 20 (3d ed. 1999) (citing STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE*, (Basic Books 1982)). Graig comments that "[t]hrough the U.S. health care system has undergone profound changes over the past three decades, the one constant throughout this period has been a sense, real or perceived, of a crisis in the American health care system." *Id.*

15. *Id.*

schemes of the 1940s to the multiple proposals of the early 1970s, all the way to the wide range of legislative initiatives of the early Clinton presidency. It is worth remembering, as we approach the congressional elections of 2006, that news reports of a contemporary crisis in U.S. medicine are repeating in similar language what was feared in 1948, exclaimed in 1971-1974, and uttered almost without relief from 1986 to 1994, when the ambitious Clinton plan died of political asphyxiation. Mobilizing enough voter enthusiasm to produce a counterforce to the reform barriers—ideological hostility, institutional design, and group interests—has been enormously difficult for all reformers who have tried.<sup>16</sup>

Victor Fuchs, former president of the American Economics Association, and Ezekiel Emanuel, chairman of the Department of Clinical Bioethics at the National Institute of Health Clinical Center, cite the following obstacles to comprehensive reform: satisfaction with the status quo; single-issue constituencies that each want different changes in the system; the U.S. system of government, with its checks and balances and divided responsibilities, that are inherently resistant to radical change of any kind, economic, social, or political; the fact that “prospective losers are likely to be much more involved and effective in blocking change than prospective winners will be in promoting it”; and differences of opinion among those who favor comprehensive reform but differ over the changes they would like to see enacted.<sup>17</sup>

It is necessary to take seriously the vested interests of those who benefit from the current system and can be expected to launch a sophisticated and well-financed attack on reforms that threaten them.

The reason the system has been so resistant to change is that lots of powerful interests do very nicely with things just the way they are . . . . American doctors make a lot more money than doctors elsewhere—roughly twice as much . . . . While higher volume is the story behind higher physician costs in the United States, the culprit for spending on hospitals and drugs is higher prices.<sup>18</sup>

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16. Theodore R. Marmor, *U.S. Health Reform Failures: The Illusive Quest for Explanations*, HEALTH AFFAIRS, May/June 2006, at 872, available at <http://content.healthaffairs.org/cgi/content/full/25/3/872> (reviewing PHILIP J. FUNIGIELLO, CHRONIC POLITICS: HEALTH CARE SECURITY FROM FDR TO GEORGE W. BUSH (University of Kansas Press 2005)).

17. Ezekiel Emanuel & Victor Fuchs, *Beyond Health Care Band-Aids*, WASH. POST, Feb. 7, 2007, at A17; see also FUNIGIELLO, *supra* note 16, at 88 (quoting Machiavelli: “There is nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle, than to initiate a new order of things. For the reformer has enemies in all those who profit by the old order, and only lukewarm defenders in all those who would profit by the new order.”).

18. Steven Pearlstein, *Adding Up the Reasons for Expensive Health Care*, WASH. POST, Feb. 14, 2007, at D01. Another author stated,

It is our shared belief that a single-payer plan is unlikely to work well if

Also, the health insurance industry is very profitable:

While millions remain uninsured or underinsured, the industry's profits swell. Last year, the top six health insurance companies had combined profits of more than \$10 billion. What's amazing is that they netted so much after spending prodigious amounts on marketing and administration. In 2006 Wellpoint alone burned up nearly \$9 billion in such costs—nearly one quarter of what it paid out in actual benefits. By contrast, in Canada's government-run single-payer system, administration accounts for only about 3% of total costs.<sup>19</sup>

The most recent failure was the Clinton health care proposal of 1993-1994, which crashed spectacularly despite wide initial support for reform. According to health economist Sherry Glied:

The president's reform proposal . . . sought to exploit the strengths of the market in encouraging innovation while generating a more equal distribution of health care between the rich and the poor. Managed competition addressed the problems of bureaucracy-driven stagnation in health resource allocation that can occur in medicalist models when health care technologies change. The global budget addressed the problems of insufficient public funding that can occur in marketist models when health care costs rise. But rather than putting together the best of both world views, the Clinton plan was fundamentally flawed. Put simply, markets work only through prices, but global budgets regulate prices and limit the quantities of services that will be available. When health care changes as a result of the inevitable development of new and valued medical technology, the global budget becomes incompatible with managed competition.<sup>20</sup>

This failure haunts the debate today. Are today's reform efforts doomed to suffer a similar defeat? In 1995, Paul Starr argued for the need,

to rally around a smaller, defensible program perhaps focused on expanding subsidies to cover children and providing greater latitude for the states, particularly exemptions from ERISA, the federal law regulating employee benefit plans. The tobacco tax and employer

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managed within and according to existing government structures. What is needed is a strongly independent agency or government corporation set up—at a state or federal level—exclusively to manage the program, and well insulated from political pressures.

MARMOR *supra* note 1, at 138. The author continued, "[O]nly a single-payer plan means the virtual abolition of an entire industry as we know it. Politicians who are reluctant to take on established interests in Washington . . . and back home . . . are terrified by the anger that would result from putting health insurers out of business." *Id.* at 161.

19. Phil Mattera, *Private Health Insurance Is Not the Answer*, Corporate Research Project, Feb. 23, 2007, <http://www.alternet.org/story/48371> (click to page three of article) (last visited Apr. 27, 2007).

20. SHERRY GLIED, *CHRONIC CONDITION: WHY HEALTH REFORM FAILS* 210 (Harvard University Press 1997).

contributions should remain as preferred methods of financing broader coverage, although the employer mandate should be reconceived as an increase in the minimum wage—perhaps to \$4.25 plus a 50-cent-an-hour health insurance contribution. . . . The lesson for next time in health reform is faster, smaller. We made the error of trying to do too much at once, took too long, and ended up achieving nothing. Oh, yes, I was thrilled when President Clinton waved his pen before Congress and threatened to veto anything less than universal coverage. Like many others who supported reform, I failed to appreciate the risk of losing everything. We were too confident that reform was inevitable, just as some are now too certain that defeat was inevitable. Strategy and speed matter in politics as in sports. But, in both, new seasons bring new lineups and new opportunities.<sup>21</sup>

Fundamental redesign is a hard sell. Bowing to perceived political realities, some reformers advocate a more moderate approach:

Limits on public budgets, resistance to measures that might be seen as taking away what Americans already have, and the embedded realities of the present system all stand squarely in the path of grand policy redesigns—from single-payer national health insurance, to individual mandates requiring that everyone purchase private coverage, to a universe of individualized Health Savings Accounts. Instead, the most promising route forward is to build on the most popular elements of the present structure—Medicare and employment-based health insurance for well-compensated workers—through a series of large-scale changes that are straightforward, politically doable, self-reinforcing, and guaranteed to provide expanded health security.<sup>22</sup>

Fuchs and Emanuel identify some of the pros and cons of the incremental approach:

What has incremental reform achieved? Over the past decade, it has led to the State Children's Health Insurance Program (SCHIP) and expanded drug coverage for Medicare beneficiaries. Yet today we have an ever-declining proportion of people with employer-based insurance; more people uninsured than at any time since 1998, including more than 8.4 million uninsured children; and record-high and rising health care costs. Taken as an overall strategy, there is little evidence that incremental reform has improved U.S. health care. Also, given the current concerns about costs, adoption of new incremental reforms seems unlikely because any increase in coverage through incremental reform will result in greater health care spending. For example, to cover an additional twenty-seven million people, the proposal by presidential candidate John Kerry

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21. Paul Starr, *What Happened to Health Care Reform?* THE AMERICAN PROSPECT, no. 20, at 20-37 (Winter 1995).

22. Jacob S. Hacker, Health Care For America, Economic Policy Institute Briefing Paper # 180, Jan. 11, 2007, <http://www.sharedprosperity.org/p180/bp180.pdf>, at 2.

would have required \$653 billion over ten years; President Bush's more modest plan would have covered just 2.4 million uninsured Americans at a cost of \$90 billion over ten years. Political viability requires a plan to transform the inefficiencies of the current system into expanded coverage without increasing total outlays for health care.<sup>23</sup>

SCHIP was created in 1997, and has reduced the number of uninsured children by about twenty-five percent, to 8.3 million in 2003. Many states have expanded, or have proposals to expand, eligibility, but the President's recent budget would reduce payments to states for coverage of children with family incomes exceeding twice the poverty level.<sup>24</sup>

### III. THE CURRENT SITUATION

#### A. Access and Coverage

A U.S. Census Bureau report released in August, 2006, found that the number of U.S. residents without health insurance increased by 1.3 million in 2005 to 46.6 million. This represents 15.9 percent of the U.S. population, compared to 15.6 percent in 2004. About 961,000 of the 1.3 million increase in the number of people uninsured were full-time workers.<sup>25</sup> The percentage of U.S. residents with employer-sponsored health coverage decreased from 59.8 percent in 2004 to 59.5 percent in 2005, the lowest percentage since 1993. In 2001, 62.6 percent had employer-sponsored

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23. Victor R. Fuchs & Ezekiel J. Emanuel, *Health Care Reform: Why? What? When?; What It Might Take to Effect Comprehensive Change*, HEALTH AFFAIRS, Nov./Dec. 2005.

24. Robert Pear, *Governors Worry Over Money for Child Health Program*, N.Y. TIMES, Feb. 25, 2007, at 19; see also Robert Pear, *Child Health Care Splits White House and States*, N.Y. TIMES, Feb. 27, 2007, at A1; No Funds for Children's Insurance, Only for HSAs for the Rich, Statement of Robert Greenstein, Executive Director, Center on Budget and Policy Priorities (Dec. 7, 2006), [http://www.pnhp.org/news/2006/december/no\\_funds\\_for\\_childre.php](http://www.pnhp.org/news/2006/december/no_funds_for_childre.php). Mr. Greenstein contends,

It is stunning that as one of its final acts, Congress chose to attach to the tax extenders a provision making Health Savings Accounts more lucrative as tax shelters for wealthy individuals even as Congress refused to provide funds needed to ensure that up to 600,000 low-income children keep their health insurance through the State Children's Health Insurance Program in 2007).

*Id.*

25. Income, Poverty and Health Insurance Coverage in the United States, 2005, at 20-22, <http://www.census.gov/prod/2006pubs/p60-231.pdf>, [hereinafter Census Bureau Report]; see also Paul Fronstin, *Employment-Based Health Benefits: Trends in Access and Coverage*, Employee Benefit Research Institute Issue Brief, No. 284, Aug. 2005, [http://www.ebri.org/publications/ib/index.cfm?fa=ibDiscontent\\_id=3574](http://www.ebri.org/publications/ib/index.cfm?fa=ibDiscontent_id=3574) (specifying two main reasons that workers are uninsured: because their employer did not offer it or because they were ineligible).



coverage. "As the largest component of private health insurance coverage, this decline in employment-based coverage essentially explains the decrease in total private health insurance coverage, from 68.2 percent in 2004 to 67.7 percent in 2005."<sup>26</sup> According to another recent report, "The proportion of all firms offering health care benefits fell from sixty-nine percent in 2000 to sixty percent in 2005, causing five million employees to lose their insurance coverage."<sup>27</sup>

The likelihood of being covered by health insurance rises with income.<sup>28</sup>

In 2005, in households with annual incomes of less than \$25,000, 75.6% of people had health insurance. Health insurance coverage rates increased with higher household income levels to 91.5% for those in households with incomes of \$75,000 or more . . . . Among 18-to-64-year-olds in 2005, full-time workers were more likely to be covered by health insurance (82.3%) than part-time workers (76.5%) or nonworkers (72.7%) . . . . The number and the percentage of part-time workers who were uninsured remained statistically unchanged in 2005 at 5.9 million and 23.5%, respectively.<sup>29</sup>

26. *Id.* (Census Bureau Report & Fronstin).

27. David Blumenthal, *Employer-Sponsored Insurance- Riding the Health Care Tiger*, 355 N. ENG. J. MED. 195, 196 (2006) (citing Kaiser Family Foundation, Employer Health Benefits: 2005 Summary of Findings, <http://www.kff.org/insurance/7315/sections/upload/7316.pdf>); *see also* Daily Health Policy Report, Health Care Marketplace, Percentage of Workers Enrolled in Employer-Sponsored Health Plans at Large Companies Drops, New Government Data Show, Aug 25, 2006, [www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?hint=3&DR\\_ID=39448](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=39448) (noting the greatest decline in enrollment in employer-sponsored health plans occurs at large retailers).

28. Census Bureau Report, *supra* note 25, tbl.8; *see also* Sara R. Collins, Ph.D, Asst. V.P., Program for the Future on Health Insurance Program, Commonwealth Fund, NY, N.Y., Testimony Before House Committee on Ways & Means, June 28, 2006, (transcript available at <http://www.waysandmeans.house.gov/hearings.asp?formmode=printfriendly&id=5069>). Ms Collins stated,

Lack of insurance coverage continues to be highest among families with incomes under \$20,000, with more than half (53%) uninsured for at least part of 2005. But uninsured rates are climbing rapidly among adults in moderate-income families – those with incomes between \$20,000 and \$40,000 (under 200% of poverty for a family of four) – rising from 28% in 2001 to 41% in 2005. Young adults ages 19 to 29, meanwhile, are the fastest growing age group among the uninsured, a reflection of two factors: their loss of dependent coverage on their 19th birthday, or more importantly in terms of sheer numbers, their reclassification as adults at 19 by Medicaid and the State Children=s Health Insurance Program (SCHIP). Nearly 70% of uninsured young adults are in families with incomes under 200% of poverty.

*Id.*

29. Census Bureau Report, *supra* note 25, at 24 (footnote omitted).

Health care costs have increased at several times the rate of general inflation, and are expected to continue to outpace growth in the economy.<sup>30</sup> Many employers, particularly small companies, are passing on more of the cost to employees, or eliminating coverage.<sup>31</sup>

In addition to the forty-six million uninsured, another sixteen million people are “underinsured” as a result of high out-of-pocket costs relative to income.<sup>32</sup>

Americans already pay far more out-of-pocket for their health care than citizens do in any other industrialized country. Furthermore, real per capita out-of-pocket spending has been steadily rising since the late 1990s. Higher spending on health care, combined with sluggish growth in real incomes, also means that families are spending increasingly more of their earnings on medical costs. A Commonwealth Fund report by Mark Merlis found that the percentage of households spending 10% or more of their income on out-of-pocket costs rose from 8% during the years 1996–97 to 11% in 2001–02. Including premiums, 18% of all families spent more than 10% of income on health care.<sup>33</sup>

There has been a recent trend towards increased use by employers of high deductible health plans.<sup>34</sup> Proponents argue that by requiring consumers to pay more from their own funds in order to obtain health care, consumers become better informed and are less likely to over-spend. However, there is another side:

Other studies have shown that, instead of a decline in over-utilization of services, high out-of-pocket expenses lead to: delays in care, medical debt, and bankruptcy. One study found that half of those surveyed with an annual deductible of \$500 had problems with medical bills and medical debt (HSAs require an annual

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30. See, e.g., Stephen Heffler et al., *U.S. Health Spending Projections for 2004-2014*, HEALTH AFFAIRS, Web Exclusive, Feb. 23, 2005, <http://www.content.healthaffairs.org/cgi/reprint/hlthatt.w5.74v1.pdf> (outlining health care spending in the future with the introduction of Medicare part D (in 2006)); Cynthia Smith, et al., *National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending*, 25 HEALTH AFFAIRS 186 (2006).

31. See Jon Gabel et al., *Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode*, 24 HEALTH AFFAIRS 1273 (2005) (reporting findings on job-based health insurance in spring 2005 and how it has changed in recent years); David Pratt, *Healthy and Wealthy and Dead: Health Savings Accounts*, 19 ST. THOMAS L. REV. 7, 27 (2006).

32. Cathy Schoen et al., *Insured But Not Protected: How Many Adults Are Underinsured?*, 24 HEALTH AFFAIRS 272 (2005).

33. Health Savings Accounts: Why They Won't Cure What Ails U.S. Health Care: Hearing on Health Savings Accounts Before the Committee on Ways and Means, of the U.S. House of Representatives, June 28, 2006, available at [http://www.cmf.org/usr\\_doc/collins\\_waysandmeans\\_testimony\\_6-28-06.pdf](http://www.cmf.org/usr_doc/collins_waysandmeans_testimony_6-28-06.pdf) (invited testimony of Sara R. Collins, Ph.D., Assistant Vice President, The Commonwealth Fund) (footnotes omitted).

34. See generally, Pratt, *supra* note 31 (identifying the increase as jumping from five to twenty percent between 2003 and 2005).

deductible of \$1000 for individuals and \$2000 for families). In fact, medical bills are the leading cause of personal bankruptcies in the U.S.<sup>35</sup>

Higher out of pocket expenses also cause patients to forego needed care:

The RAND Health Insurance Experiment found that greater cost-sharing reduced the use of both essential and less-essential health care. Similarly, a study by Robyn Tamblyn and colleagues found that increased cost-sharing reduced the use of both essential and nonessential drugs, and it increased the risk of adverse health events. In addition, a review by Rice and Matsuoka of more than 20 studies examining the impact of cost-sharing on health care use and the health status of people 65 and older found that increases in cost-sharing nearly always reduced the health care use and/or the health status of this population. Cathy Schoen and colleagues, using data from the Commonwealth Fund Biennial Health Insurance Survey, found that insured people with out-of-pocket costs high relative to income were nearly as likely to report not accessing needed health care because of costs as were people without any coverage at all.<sup>36</sup>

The pattern in the U.S. is markedly different from European practice:

Most western European countries place little emphasis on cost sharing as a tool for either raising revenue or containing costs for physician and hospital services. About half use some form of cost sharing for first-contact care, and about half apply cost sharing to inpatient and specialty outpatient care. However, patient copayments tend to be nominal and often are accompanied by a set of categorical exemptions. Only a few countries rely on cost sharing as a significant source of health sector revenue, and most patients in these countries typically purchase supplementary private insurance to defray out-of-pocket spending. In France, for example, eighty-four percent of the population carries private supplemental coverage that reimburses them for copayments. The only exception to this general pattern is widespread cost sharing for pharmaceuticals, although here, too, cost sharing typically is buffered for pensioners, children, and the chronically ill. In CEE/CIS countries there is substantial real cost sharing, particularly in the inherited and as yet still unresolved problem of informal ("under-the-table")

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35. Mila Kofman, *HSAs: A Great Tax Shelter for Wealthy, Healthy People but Little Help to the Uninsured, Underinsured, and People with Medical Needs*, *Ethics Journal of the American Medical Association* (2005), <http://www.ama-assn.org/ama/pub/category/15234.html> (footnotes omitted).

36. Health Savings Accounts, *supra* note 33, at 6-7 (footnotes omitted); see also Mark Merlis et al., *The Commonwealth Fund, Rising Out-of-Pocket Spending for Medical Care: A Growing Strain on Family Budgets* (2006), [http://www.cmwf.org/publications\\_show.htm?doc\\_id=347500](http://www.cmwf.org/publications_show.htm?doc_id=347500) (discussing the struggles faced by families with high out-of-pocket costs).

payments made directly to doctors or, in some countries, to hospitals.<sup>37</sup>

In March, 2006, monthly employee premiums for employer plan coverage averaged \$296.88 for family coverage and \$76.05 for single coverage.<sup>38</sup> A recent report from the Center for Studying Health System Change suggests that companies could better contain costs if they fine-tuned the way they share the cost with employees:

the 25 experts interviewed for the report were most excited about two approaches to designing cost-sharing. One involves identifying the medical services that provide the most clinical value and the employees who would benefit from those services. This approach also entails reducing cost-sharing to encourage employees to use those services . . . . The second approach is to provide incentives for employees to use efficient providers.<sup>39</sup>

How can health coverage be increased?

Nations that provide universal coverage to their populations have accomplished this through a combination of compulsion and subsidization; individuals are required to have health insurance, insurers are required to cover everyone, and cross-subsidization across risk groups allows the entire population to have health insurance coverage. The United States has not yet reached this point because it does not accept compulsion and subsidization - the two basic premises of social insurance. Ideological factors come into play, as national health insurance is denounced by many Americans as a form of socialism - although national health insurance was introduced in Germany and Japan as an antidote to the spread of socialism.<sup>40</sup>

### *B. Health Care Cost Increases*

Premiums for employer-sponsored health insurance increased by 7.7 percent in 2006, the slowest rate of growth since 2000 and the third year of declining increases. Wages rose 3.8 percent and overall inflation was 3.5 percent. Over the past six years, premiums have increased by a total of eighty-seven percent. Since 2000, wages have risen by twenty percent but employees' share of the premiums has increased by eighty-four percent.<sup>41</sup> Premiums

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37. Richard B. Saltman & Josep Figueras, *Analyzing the Evidence on European Health Care Reforms*, 17 HEALTH AFFAIRS, Mar./Apr., 1998.

38. National Compensation Survey: Employee Benefits in Private Industry in the United States, Bureau of Labor Statistics, U.S. Department of Labor (Aug. 2006) available at <http://www.bls.gov/ncs/ebs/sp/ebsm0004.pdf>.

39. Susan Kelly, *Fixing Co-Pay Woes Promotes Cost Savings*, WORKFORCE MGMT., Mar. 13, 2007, available at <http://www.workforce.com>.

40. GRAIG, *supra* note 14, at 177.

41. Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2006 Annual Survey*,

for family coverage averaged \$11,480, more than the wages of a full-time minimum wage employee. Premiums for single coverage averaged \$4,242.<sup>42</sup>

In a recent article, actuaries from the Centers for Medicare & Medicaid Services (CMS) predicted that total health care expenditures will double by 2016, and will then constitute almost twenty percent of GDP.<sup>43</sup> Major factors include an aging population and greater spending for prescription medications.<sup>44</sup>

A recent Commonwealth Fund study listed six strategies that “have the potential to achieve savings, slow spending growth, and improve health system performance.” Those strategies are:

- 1) increasing the effectiveness of markets with better information and greater competition;
- 2) reducing high insurance administrative overhead and achieving more competitive prices;
- 3) providing incentives to promote efficient and effective care;
- 4) promoting patient-centered primary care;
- 5) investing in infrastructure such as health information technology; and
- 6) investing strategically to improve access, affordability, and equity.<sup>45</sup>

The stakes are very high:

Both strategies that achieve one-time savings as well as those that address cost trends could yield substantial cumulative gains over time. A policy option that has the effect of achieving a one-time reduction in the level of health care spending by 5% in 2007 would achieve cumulative savings over the eight-year period from 2007 to 2015 of \$1.31 trillion. A policy option that has the effect of lowering the average rate of increase in health care outlays by one percentage point a year would yield cumulative savings of \$1.39 trillion over the same period. In combination, one-time changes in spending levels plus even small changes in projected rates of increase interact to produce even more substantial long-term yields.<sup>46</sup>

Numerous studies have found that rates of coverage by employer-sponsored insurance are sensitive to changes in health insurance premiums:

Between 2001 and 2005 health insurance premiums grew by no less than nine percent each year, ranging between 9.2 and 13.9% annually for premiums for a family of four. The share of all businesses offering health benefits declined from 69% in 2000 to

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<http://www.kff.org/insurance/7527/upload/7527.pdf>.

42. *Id.* at 1.

43. Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact, Health Affairs, <http://www.healthaffairs.org>.

44. Susan Heavey, *Health Care Spending Seen Doubling in 10 Years*, REUTERS, Feb. 21, 2007.

45. K. Davis, C. Schoen, S. Guterman, T. Shih, S. C. Schoenbaum, & I. Weinbaum, *Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?*, The Commonwealth Fund, Jan. 2007.

46. *Id.*

60% by 2005, driven largely by decreases among small to mid-size firms (3 to 199 employees). Employees' earnings grew slowly between 2001 and 2005, ranging between 2.2% and 4.0% each year—mirroring the range of overall inflation rates of 1.6% to 3.5% annually—making health insurance even less affordable relative to their incomes. Family health insurance premiums averaged \$10,880 in 2005. The average share of a family premium employees were required to pay themselves stayed fairly flat between 2001 and 2005, around 27%. However, given the large increases in premiums, that share amounted to an increase of nearly \$1,000 over this period, from \$1,788 a year in 2001 to \$2,712 by 2005.<sup>47</sup>

Despite these large costs, the real question is not whether we can afford to provide universal health care, but whether we can afford not to. According to recent studies, the total cost of the Iraq war will be more than \$1 trillion, and perhaps more than \$2 trillion. “Just to put that \$2 trillion in perspective, it is four times the additional cost needed to provide health insurance for all uninsured Americans for the next decade.”<sup>48</sup>

### *C. Tax Benefits*<sup>49</sup>

Most insured Americans receive health care coverage through an employer-sponsored health plan, either as an employee, as the spouse or dependent of an employee, or as a retiree. The employer's contribution toward the cost of a health plan is deductible by the employer as a business expense,<sup>50</sup> and is excluded from the employee's income for both income and payroll tax purposes.<sup>51</sup> This exclusion for employer-provided health care represents a major departure from the general income tax rule that includes compensation for services (cash or non-cash) as gross income.<sup>52</sup> Employees participating in a cafeteria plan may pay their share of the health insurance premiums (and other medical expenses) on a pre-tax basis, through elective salary reduction; salary reduction contributions are treated as employer

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47. Kaiser Commission on Medicaid and the Uninsured, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005*, Dec. 2006.

48. Nicholas Kristof, *Iraq and Your Wallet*, N.Y. TIMES, Oct. 24, 2006, at A29.

49. See generally Joint Committee on Taxation, *Present Law and Analysis Relating to the Tax Treatment of Health Savings Accounts and Other Health Expenses*, JCX-27-06 (June 27, 2006); see also Paul Fronstin, *The Tax Treatment of Health Insurance and Employment-Based Health Benefits*, EBRI Issue Brief No. 294, June 2006, <http://www.ebri.org>; CRS Updates Report On Health Insurance Tax Benefits, *Tax Notes Today*, Jan. 29, 2007, 2007 TNT 19-60.

50. 26 U.S.C. § 162(a)(1) (2000 & Supp. 2006).

51. 26 U.S.C. §§ 106(a), 3121(a)(4) (2000 & Supp. 2006).

52. 26 U.S.C. § 61(a)(1) (2000 & Supp. 2006).

contributions and therefore are also excluded from income.<sup>53</sup> Reimbursements made by or under the employer plan, for medical expenses incurred by the employee and his or her covered spouse and dependents, are also generally excluded from gross income and wages.<sup>54</sup> There is no limit on the amount of employer-provided health coverage that is excludable, and there is no requirement that an insured health plan be nondiscriminatory.<sup>55</sup>

Self-employed individuals generally may deduct the cost of health insurance for themselves and their spouses and dependents. This deduction is not available for any month in which the self-employed individual is eligible to participate in an employer-subsidized health plan and it may not exceed the individual's net income from self-employment.<sup>56</sup>

An individual may claim an itemized deduction for unreimbursed medical expenses of the individual and his or her spouse and dependents, including health insurance premiums, but only if and to the extent that those expenses exceed 7.5 percent of adjusted gross income ("AGI").<sup>57</sup> Benefits received under personally purchased health insurance policies are also excluded from income.<sup>58</sup> Individuals who buy their own insurance are treated less favorably than those who receive coverage under an employer-sponsored plan: first, they receive no exclusion from payroll taxes; second, they receive a tax benefit only if they itemize deductions; third, they receive a tax benefit only if their unreimbursed expenses exceed 7.5 percent of AGI (even then, they receive no benefit on the expenses under the 7.5 percent threshold); and finally, the deductible medical expenses category is more narrowly defined<sup>59</sup> than it is for excludable reimbursements from an employer-sponsored plan.<sup>60</sup>

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53. 26 U.S.C. § 125(d)(1)(D) (2000 & Supp. 2006).

54. 26 U.S.C. § 105(b) (2000 & Supp. 2006). There is a limited exception, whereby certain reimbursements made to "highly compensated individuals" under a self-insured health plan are currently taxable to the recipients under section 105. 26 U.S.C. § 105(h) (2000 & Supp. 2006).

55. The Tax Reform Act of 1986 added section 89, which imposed nondiscrimination requirements for health plans and other employee welfare benefits, but the section was repealed before it went into effect. 26 U.S.C. § 89 (2000 & Supp. 2006).

56. 26 U.S.C. § 162(l) (2000 & Supp. 2006).

57. 26 U.S.C. § 213(a) (2000 & Supp. 2006). The threshold is ten percent (rather than 7.5 percent) for alternative minimum tax purposes. 26 U.S.C. § 56(b)(1)(B). The term "medical care" is defined in section 213. 26 U.S.C. § 213(d)(1)(A)-(D) (2000).

58. 26 U.S.C. § 104(a)(3) (2000). Unlike employer-paid insurance, the benefits are excluded even if they exceed the amount of medical care expenses incurred, but this is rarely the case.

59. See 26 U.S.C. § 213(d)(1) (2000) (defining the term "medical care").

60. The Joint Committee on Taxation said:

For purposes of the exclusions for reimbursements under employer

Certain individuals are eligible for a refundable income tax credit of sixty-five percent of the cost of qualified health insurance coverage, including some employer-sponsored insurance, state-based insurance, and insurance purchased in the individual market.<sup>61</sup>

A health savings account (“HSA”), like an IRA, is generally exempt from income taxation.<sup>62</sup> Any amount paid or distributed from an HSA which is used exclusively to pay qualified medical expenses is not includable in gross income.<sup>63</sup> Any such amount which is not used exclusively to pay qualified medical expenses is generally included in the gross income of the beneficiary, and is also generally subject to an additional income tax equal to ten percent of the amount includable.<sup>64</sup> If any amount paid or distributed from a HSA is rolled over to another HSA for the same beneficiary, the amount is not currently taxable.<sup>65</sup> This is limited to one rollover in any one year period, but this limitation does not apply to direct trustee-to-trustee transfers.<sup>66</sup> An interest in an HSA may be transferred tax-free to the beneficiary’s spouse or former spouse in connection with a divorce and, after the transfer, is treated as an HSA of the spouse.<sup>67</sup> An HSA can be established with or without any employer involvement.<sup>68</sup>

The tax-favored treatment of health benefits is one of the largest tax expenditures in the federal budget.<sup>69</sup> “Estimates for

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accident and health plans and distributions from HSAs, the limitation (applicable to the itemized deduction) that only prescription medicines or drugs and insulin are taken into account does not apply. Thus, for example, amounts paid from an FSA, HRA, or HSA to reimburse the employee for nonprescription medicines, such as sunscreen, nonprescription aspirin, allergy medicine, antacids, or pain relievers, are excludable from income; however, if the employee paid for such amounts directly (without such reimbursement), the expenses could not be taken into account in determining the itemized deduction for medical expenses.

Joint Committee on Taxation, *supra* note 50, at 11.

61. 26 U.S.C. § 35(a) (2000 & Supp. 2006); *see* 26 U.S.C. § 35(e) (2000 & Supp. 2006) (defining qualified health insurance).

62. 26 U.S.C. § 223(e)(1) (2000 & Supp. 2006).

63. 26 U.S.C. § 223(f)(1).

64. 26 U.S.C. § 223(f). In certain circumstances, taxation can be avoided if a mistaken distribution is timely repaid to the HSA. I.R.S. Notice 2004-50, 2004-33 C.B. 203 Q&A-37 (2004).

65. 26 U.S.C. § 223(f)(5) (2000 & Supp. 2006).

66. 26 U.S.C. § 223(f)(5)(A)-(B); *see also* I.R.S. Notice 2004-50, 2004-33 C.B. 205 Q&A-56 (2004) (answering that the limitation does not apply to direct trustee-to-trustee transfers).

67. 26 U.S.C. § 223(f)(7).

68. 26 U.S.C. § 223; *see also* Employer Comparable Contributions to Health Savings Accounts under Section 4980G, 71 Fed. Reg. 43,056, 43,057 (July 31, 2006) (to be codified at 26 C.F.R. pt. 54) (discussing employer contributions to HSAs).

69. *See generally* U.S. Government Accountability Office, Government



personal federal forgone tax revenue in 2006 related to the exclusion from individual income of employer contributions to health benefits range from \$91 billion (Joint Committee on Taxation) to \$133 billion (Office of Management and the Budget).<sup>70</sup> The Joint Committee on Taxation estimated that the Fiscal Year 2007 tax expenditure attributable to the exclusion for employer payments for health insurance and health care (for self-insured plans) will be \$99.7 billion.<sup>71</sup> This does not include the effect of the exclusion on employment taxes. These tax benefits “represent[s] a \$200 billion-a-year subsidy, with most of the benefits going to the well-to-do – a sum that could be much better spent on helping the uninsured.”<sup>72</sup>

In 2005, a presidential advisory panel recommended limiting the tax exclusion for health benefits to \$5,000 for individual coverage and \$11,500 for family coverage, indexed for future cost increases.<sup>73</sup>

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Performance and Accountability: Tax Expenditures Represent a Substantial Federal Commitment and Need to Be Reexamined, <http://www.gao.gov/new.items/d05690.pdf> (last visited Oct. 20, 2006) (describing how tax expenditures have changed over the past three decades).

70. Paul Fronstin & John MacDonald, Study Says Changing Tax Preferences for Health Benefits Involves Trade-Offs Requiring Thorough Understanding (June 15, 2006), [http://www.ebri.org/pdf/PR\\_741\\_15June06.pdf](http://www.ebri.org/pdf/PR_741_15June06.pdf) (last visited Oct. 20, 2006). “For Federal fiscal years 2006-2010, the tax expenditure for the exclusion of employer contributions for health care, health insurance premiums, and long-term care insurance premiums is estimated to be \$534 billion.” Joint Committee on Taxation, *supra* note 50, at n.22 (citing Joint Committee on Taxation, Estimates of Federal Tax Expenditures for Fiscal Years 2006-2010, JCS-2-06 (Apr. 25, 2006)).

71. CRS Updates Report On Health Insurance Tax Benefits, TAX NOTES TODAY, Jan. 29, 2007, at n.5. As the CRS notes, “[t]he FY2007 tax expenditure estimate from the Administration is considerably higher, \$146.8 billion. Analytical Perspectives, Budget of the United States Government, Fiscal Year 2007, p. 289. The difference is attributable to several factors, the most important of which is the JCT assumption that without the exclusion the itemized deduction for medical care would be higher.” *Id.*

72. David Broder, *Health Coverage's Momentum*, WASH. POST, Feb. 4, 2007, at B07; see also C. Eugene Steuerle, *Defining Our Long-Term Fiscal Challenges: Testimony Before the U.S. Senate Budget Committee*, Jan. 30, 2007, <http://www.urban.org/url.cfm?ID=901037>.

... [T]he employee exclusion for employer-provided health benefits is scheduled to grow continually faster than the economy. The additional amounts spent on this exclusion-over and above some base amount-likely lead to an increase in the number of uninsured because they add to spending on health, which, in turn, add to the cost of insurance. The higher cost insurance drives out some employers from offering insurance and drives away some consumers from buying it.

*Id.*

73. Report of the President's Advisory Panel on Federal Tax Reform, TAX NOTES TODAY, Nov. 1, 2005, at 211-14. The dollar limits are close to the average premium for health benefits in 2005: \$4,024 for employee-only coverage, and \$10,880 for family coverage. Fronstin & MacDonald, *supra* note

The Joint Committee on Taxation recently noted:

The appropriateness of the present-law Federal tax treatment of health expenses has been the subject of much debate . . . . The present . . . treatment of employer-provided health coverage has been justified on the grounds that it encourages employees to prefer health coverage over taxable compensation, thereby increasing health insurance coverage and reducing the number of uninsured. Proponents . . . also argue that the employer market provides a natural pooling mechanism which can result in more affordable coverage. However, others argue that the . . . rules are inequitable because they do not provide a consistent tax benefit for health coverage and that the exclusion may lead to over utilization of health care.<sup>74</sup>

The present tax rules *are* inequitable, because they do not provide the same level of tax benefits for everyone. Those who do not have employer-provided coverage—who are more likely to be low income employees—receive less favorable treatment than those who do, in several ways: they receive a tax benefit only if they itemize deductions, and even then only if their unreimbursed medical expenses exceed 7.5 percent of their AGI.<sup>75</sup> In addition, individual health insurance policies are typically more expensive and provide less comprehensive coverage than group policies. Even for those lower income individuals who do receive a tax benefit (an exclusion or a deduction) their tax subsidy is less valuable than it is to those in a higher income tax bracket.<sup>76</sup> As the Congressional Research Service recently noted:

Questions might be raised about the distribution of the tax incentives. Because as a practical matter they are not available to everyone, problems of horizontal equity arise. Workers without employment-based insurance generally cannot benefit from them, nor can many early retirees (people under 65, the age of Medicare eligibility). Even if these individuals itemize their deductions, they may deduct health insurance premiums only to the extent that they (and other health care expenditures) exceed 7.5% of AGI. In contrast, the exclusion for employer-paid insurance is unlimited.

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71, at 15 (citing Gabel et al., *Health Benefits In 2005: Premium Increases Slow Down, Coverage Continues to Erode*, 24 HEALTH AFFAIRS 5, 1273-80 (2005)).

74. Joint Committee on Taxation, *supra* note 50, at 2.

75. See generally 26 U.S.C. § 62 (2000 & Supp. 2006); I.R.C. § 62 (2006). Medical expenses are not deductible in determining “adjusted gross income.” See 26 U.S.C. § 213(a) (2000 & Supp. 2004) (stating what can and cannot be deducted).

76. See Joint Committee on Taxation, *supra* note 50 (noting the refundable tax credit provides a greater tax benefit than the exclusion). “However, the credit is available to only limited classes of taxpayers. Less than one-half million taxpayers per year are estimated to be eligible for the credit.” *Id.* at 12, n.24.

Even if everyone could benefit from the tax incentives, there would be questions of vertical equity. Tax savings from the exclusions and deductions described above generally are determined by taxpayers' marginal tax rate. Thus, taxpayers in the 15% tax bracket would save \$600 in income taxes from a \$4,000 exclusion (i.e., \$4,000 x 0.15) for an employer-paid premium, whereas taxpayers in the 35% bracket would save \$1,400 (i.e., \$4,000 x 0.35). If health insurance is considered a form of personal consumption like food or clothing, this pattern of benefits would strike many people as unfair. It is unlikely that a government grant program would be designed in this manner. However, to the extent that health insurance is considered a way of spreading an individual's catastrophic economic risk over multiple years, basing tax savings on marginal tax rates might be justified. Under a progressive income tax system, economic losses ought to be deducted at applicable marginal rates, just as economic gains are taxed at those rates.

Assessing the equity of tax incentives for health insurance is complicated by uncertainty as to who pays for employer subsidies. In the long run, the cost of these subsidies presumably is passed on to the workers in the form of reductions to wages and other benefits. But whether these reductions are shared equally by all workers is unclear given differences in their preferences for insurance, their attachment to particular employers, and broader labor market forces.<sup>77</sup>

President Bush's proposal to change the taxation of health insurance is discussed below.<sup>78</sup>

#### D. Employer Plans

For many years, most Americans with health insurance have received their coverage through an employer-sponsored plan.<sup>79</sup> In 2005, 63.1 percent of workers were covered by a plan from their own employer, 14.9 percent had coverage through an employer as a dependent, and seventeen percent were uninsured. Among workers eligible for health benefits, 84.2 percent were covered by their employer, 9.8 percent had coverage through an employer as a dependent, and 4.8 percent were uninsured.<sup>80</sup>

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77. Bob Lyke, *CRS Updates Report On Health Insurance Tax Benefits*, TAX NOTES TODAY, Jan. 29, 2007, 2007 TNT 19-60.

78. See *infra* Part VI.C.

79. See, e.g., David Blumenthal, *Employer-Sponsored Health Insurance in the United States - Origins and Implications*, 355 NEW. ENG. J. MED. 82 (2006); Sherry A. Glied & Phyllis C. Borzi, *The Current State of Employment-Based Health Coverage*, 32 J.L. MED. & ETHICS 404, 405 (2004); Catherine Hoffman et al., *Holes in the Health Insurance System - Who Lacks Coverage and Why*, 32 J.L. MED. & ETHICS 390 (2004) (discussing most Americans get insurance from employers).

80. Paul Fronstin, *Employment-Based Health Benefits: Access and Coverage, 1988-2005*, EBRI Issue Brief No. 303, March 2007, available at <http://www.ebri.org> (last visited March 30, 2007).

The percentage of workers who take health benefits that are offered (the take-up rate) was 83.5 percent in 2005, down from 87.9 percent in 1988. Workers who decline health coverage are more likely to have coverage elsewhere (e.g., from an employed family member); from 1995-2005, only about four percent of workers eligible for coverage were uninsured.<sup>81</sup>

According to the U.S. Chamber of Commerce's annual Employee Benefits Study, medically related expenses cost employers \$5,924 per employee in 2006, 14.5 percent of payroll, up from 11.9 percent cited in last year's Study.<sup>82</sup> Employer health care costs last year increased by eight percent; companies expect the same rate of growth this year and in 2008, according to a survey released in February, 2007, by Watson Wyatt Worldwide.<sup>83</sup> The ever-increasing cost of health care has caused many employers to reconsider their commitment to providing comprehensive health care coverage.

Health care costs at current levels override the incentives that have historically supported employer-based health insurance. Now that health costs loom so large, companies that provide generous benefits are in effect paying some of their workers much more than the going wage—or, more to the point, more than competitors pay similar workers. Inevitably, this creates pressure to reduce or eliminate health benefits. And companies that can't cut benefits enough to stay competitive—such as GM—find their very existence at risk.<sup>84</sup>

A U.S. Census Bureau report released in August, 2006, found that the percentage of U.S. residents with employer-sponsored health coverage decreased from 59.8 percent in 2004 to 59.5 percent in 2005, the lowest percentage since 1993.<sup>85</sup> In 2001, 62.6 percent had employer-sponsored coverage.<sup>86</sup> "As the largest component of private health insurance coverage, this decline in employment-based coverage essentially explains the decrease in total private health insurance coverage, from 68.2 percent in 2004 to 67.7

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81. *Id.*

82. *U.S. Chamber Study: Employee Benefit Costs Continue to Rise*, BUSINESS WIRE, Feb. 22, 2007.

83. Kaiser Family Foundation, *Daily Health Policy Report, Employers Expect 8% Increase in Health Care Costs This Year, Survey Finds*, Feb 22, 2007, available at <http://www.kff.org> (last visited March 30, 2007).

84. Paul Krugman & Robin Wells, *The Health Care Crisis and What to Do About It*, THE N.Y. REVIEW OF BOOKS 38, 39 (Mar. 23, 2006) (reviewing HENRY J. AARON ET AL., *CAN WE SAY NO?* (2005); JULIUS RICHMOND & RASHI FEIN, *THE HEALTH CARE MESS* (2006); JOHN F. COGAN ET AL., *HEALTHY, WEALTHY, AND WISE* (2005)), available at <http://www.NYBooks.com> (last visited March 30, 2006).

85. Census Bureau Report, *supra* note 25, at 21.

86. Julie Appleby, *Ranks of Uninsured Americans Grow*, USA TODAY, Aug. 29, 2006, available at [http://www.usatoday.com/money/industries/health/2006-08-29-health-insurance-coverage\\_x.htm?POE=NEWISVA](http://www.usatoday.com/money/industries/health/2006-08-29-health-insurance-coverage_x.htm?POE=NEWISVA) (last visited Oct. 20, 2006).

percent in 2005.”<sup>87</sup> According to another recent report, “[t]he proportion of all firms offering health care benefits fell from sixty-nine percent in 2000 to sixty percent in 2005, causing five million employees to lose their insurance coverage.”<sup>88</sup>

Most employees covered by employer plans are in plans requiring employee contributions for both single coverage and family coverage. In March, 2006, employee contributions to medical care premiums averaged \$296.88 per month for family coverage and \$76.05 per month for single coverage. Employer premiums for medical care plans averaged \$617.18 a month per participant for family coverage and \$266.50 a month for single coverage. Employer contributions were higher for those employees who were not required to contribute than for those who were.<sup>89</sup> Not surprisingly, “Take-up rates are substantially lower at lower levels of family income and differences in take-up rates across income levels grew dramatically between 2001 and 2005.”<sup>90</sup> Since 2000, the percentage of workers covered by employer-sponsored health benefits in firms with fewer than two-hundred workers has decreased from fifty-seven percent to fifty percent.<sup>91</sup>

One significant effect of a decline in employer-sponsored coverage is that people with health problems may find it significantly more difficult to obtain comparable coverage in the non-group market.<sup>92</sup>

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87. Census Bureau Report, *supra* note 25, at 23.

88. David Blumenthal, *Employer-Sponsored Health Insurance Riding the Health Care Tiger*, 355 *NEW ENG. J. MED.* 195 (2006); Kaiser Daily Health Policy Report, *Percentage of Workers Enrolled in Employer-Sponsored Health Plans at Large Companies Drops, New Government Data Show* (Aug. 25, 2006), [http://www.kaisernetwork.org/daily\\_reports/print\\_report.cfm?DR\\_ID=39448&dr\\_cat=3](http://www.kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=39448&dr_cat=3) (last visited Oct. 20, 2006).

89. Commonwealth Fund, *Public Views on Shaping the Future of the U.S. Health Care System*, <http://www.cmwf.org>.

90. Kaiser Commission on Medicaid and the Uninsured, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005*, Dec. 2006.

91. Kaiser Family Foundation, *Employer Health Benefits, 2005 Annual Survey*, [www.kff.org](http://www.kff.org).

92. *See, e.g.*, Kaiser Family Foundation, *How Accessible Is Individual Health Insurance for Consumers in Less-Than Perfect Health?*, June 2001, available at <http://www.kff.org/insurance/upload/How-Accessible-is-Individual-Health-Insurance-for-Consumers-in-Less-Than-Perfect-Health-Executive-Summary-June-2001.pdf>.

### *E. ERISA and Preemption*<sup>93</sup>

As its name indicates, the primary focus of ERISA is the regulation of *retirement* plans. However, the employee benefit plans subject to ERISA include both retirement plans and health and welfare plans.<sup>94</sup> As Susan Stabile has noted,

The decision that ERISA would cover both pension plans and welfare benefit plans itself is not problematic. What is problematic is that ERISA contains extensive regulation of pension plans but, with limited exception, it subjects welfare benefit plans only to its fiduciary, disclosure and reporting provisions. At the same time, ERISA broadly preempts any and all state laws that “relate to” an employee benefit plan, limiting the ability of states to regulate such plans.<sup>95</sup>

The language of the statute is very sweeping: subject to specified exceptions, the most important of which exempts state laws regulating insurance, the provisions of Titles I and IV of ERISA “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) and not exempt under section 1003(b).”<sup>96</sup> The early Supreme Court decisions interpreted ERISA preemption very broadly:<sup>97</sup> however, beginning with its 1995

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93. Helpful materials are available at the web sites of the National Academy for State Health Policy, <http://www.nashp.org> (including Revisiting Pay or Play: How States Could Expand Employer-based Coverage Within ERISA Constraints (May 2002); ERISA Preemption Manual for State Health Policy Makers: Update – Jan. 2001; and ERISA Preemption Primer and Manual for State Health Policy Makers) and the Robert Wood Johnson Foundation’s State Coverage Initiatives program, <http://www.statecoverage.net> (including ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland “Fair Share Act” Court Decision (Nov. 2006); and ERISA Update: Federal Court of Appeals Agrees Feb. 2007)). See also Rebecca A.D. O’Reilly, *Is ERISA Ready for a New Generation of State Health Care Reform? Preemption, Innovation, and Expanding Access to Health Care Coverage*, 8 U. PA. J. LAB. & EMP. L. 387, Winter, 2006; Amy B. Monahan, *Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55 KAN. L. REV. (forthcoming 2007).

94. See ERISA § 3(3), 29 U.S.C. § 1002(3) (defining the term “employee benefit plan”).

95. Stabile, *supra* note 7.

96. 29 U.S.C. § 1144(a).

97. See, e.g., *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983) (holding that for purposes of preemption the state laws “related to” employee benefit plans under 514(a) of ERISA because they had a connection with or reference to such plans); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) (stating “a state law may ‘relate to’ a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans, or the effect is only indirect; Pre-emption is also not precluded simply because a state law is consistent with ERISA’s substantive requirements.”).

decision in *Travelers*,<sup>98</sup> the Court began to take a narrower approach.

The immediate question is whether, and what types of, State laws relating to health care can survive ERISA preemption. Shortly after ERISA was enacted, the Hawaii law requiring employers to offer and pay for health coverage was held to be preempted,<sup>99</sup> but it was restored by a 1983 amendment to ERISA.<sup>100</sup>

According to one expert on preemption, a state law is likely to withstand an ERISA challenge if (1) the State is neutral regarding whether employers offer coverage or pay tax [i.e., the law is not a disguised mandate]; and (2) the State does not set standards to qualify for a tax credit or otherwise refer to ERISA plans.<sup>101</sup> The most relevant Supreme Court precedent is *Travelers*,<sup>102</sup> where the Court upheld New York surcharges on commercial health insurers and HMOs. The Court held that a State law that did not require an employer to provide benefits, or specify the types of benefits to be provided, was not preempted merely because it had an indirect economic effect on an ERISA-covered plan. In addition, the Court noted that regulation of health care was a traditional area of state, rather than federal, concern.

In the most recent appellate decision, the Fourth Circuit Court of Appeals invalidated a Maryland law requiring large employers to spend at least eight percent of payroll on health coverage or to pay the shortfall to the state Medicaid program.<sup>103</sup>

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98. *NYS Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *Cal. Div. Of Labor Standards Enforcement v. Dillingham Constr. N.A., Inc.*, 519 U.S. 316 (1997); *De Buono v. NYS-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997); *Boggs v. Boggs*, 520 U.S. 833 (1997); *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999); *Egelhoff v. Egelhoff*, 121 S. Ct. 1322 (2001); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003); *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488 (2004).

99. *Standard Oil v. Agsalud*, 633 F.2d 760 (9th Cir. 1980).

100. 29 U.S.C. § 1144(b)(5)(A) (2000).

101. Patricia A. Butler, ERISA'S IMPLICATIONS FOR STATE HEALTH CARE ACCESS INITIATIVES (2005), <http://www.statecoverage.net/SCINASHP.pdf>. A cyber seminar sponsored by the Robert Wood Johnson Foundation's State Coverage Initiatives Program and the National Academy for State Health Policy is available at <http://www.nashp.org>.

102. *Travelers*, 514 U.S. at 645.

103. *Retail Indus. Leaders Ass'n v. Fielder* 475 F.3d 180 (4th Cir. 2007). Note that the employer taxes in Massachusetts and Vermont, discussed in Part VI.A below, are much smaller. Judge Motz, the trial judge in the Maryland case said:

Of course, I am expressing no opinion on whether legislative approaches taken by other States to the problems of health care delivery and its attendant costs would be preempted by ERISA. For example, the Commonwealth of Massachusetts has recently enacted legislation that addresses health care issues comprehensively and in a manner that

The decision was clearly influenced by the fact that, in practice, the law only affected one employer, Wal-Mart.<sup>104</sup>

The majority held, “[b]ecause Maryland’s Fair Share Health Care Fund Act effectively requires employers in Maryland covered by the Act to restructure their employee health insurance plans, it conflicts with ERISA’s goal of permitting uniform nationwide administration of these plans. We conclude therefore that the Maryland Act is preempted by ERISA and accordingly affirm.”<sup>105</sup>

The majority viewed the Act as giving employers no real choice:

In effect, the only rational choice employers have under the Fair Share Act is to structure their ERISA health care benefit plans so as to meet the minimum spending threshold. The Act thus falls squarely under Shaw’s prohibition of state mandates on how employers structure their ERISA plans.<sup>106</sup> Because the Fair Share Act effectively mandates that employers structure their employee health care plans to provide a certain level of benefits, the Act has an obvious “connection with” employee benefit plans and so is preempted by ERISA.<sup>107</sup>

In his dissent, Judge Michael disagreed:

The Act offers a covered employer the option to pay an assessment into a state fund that will support Maryland’s Medicaid program. Thus, the Act offers a means of compliance that does not impact ERISA plans, and it is not preempted.

...

... The Act does not force a covered employer to make a choice that impacts an employee benefit plan. An employer can comply with the Act either by paying assessments into the special fund or by increasing spending on employee health insurance. The Act expresses no preference for one method of Medicaid support or the other. As a result, the Act is not preempted by ERISA.

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arguably has only incidental effects upon ERISA plans. In light of what is generally perceived as a national health care crisis, it would seem that to the extent ERISA allows, it is strongly in the public interest to permit states to perform their traditional role of serving as laboratories for experiment in controlling the costs and increasing the quality of health care for all citizens.

*Retail Indus. Leaders Ass’n v. Fielder*, 435 F. Supp. 2d at 186 n.15 (D. Md. 2006).

104. See *Retail Indus. Leaders Ass’n*, 475 F.3d at 183 (stating in the majority opinion that “the Act’s minimum spending provision was crafted to cover just Wal-Mart.”).

105. *Id.*

106. See *Shaw*, 463 U.S. at 96-97.

107. *Retail Indus. Leaders Ass’n*, 475 F.3d at 193-94.



... The assessment does not amount to an exorbitant fee that leaves a large employer with no choice but to alter its ERISA plan offerings. According to Wal-Mart estimates, the company faces, at most, a potential assessment of one percent of its Maryland payroll. Paying the assessment would thus not be a financial burden that leaves Wal-Mart with a Hobson's choice, that is, no real choice but to increase health insurance benefits. Wal-Mart contends that it would never choose to pay the assessment when given the option of gaining employee goodwill through increased benefits. To begin with, Wal-Mart's bald claim that it would increase benefits appears dubious. Wal-Mart has not seen fit thus far to use comprehensive health insurance as a means of generating employee goodwill. More important, Wal-Mart's claim that it would increase benefits rather than pay the fee is irrelevant because the choice to increase benefits is not compelled by the Act. That choice would simply be a business judgment that Wal-Mart is free to make. Indeed, an employer close to the required statutory percentage, such as Wal-Mart, may find it easier to pay the assessment than to increase health insurance spending. So long as the assessment is not so high as to make its selection financially untenable, an employer may freely evaluate whether the ability to maintain current levels of health insurance spending is worth the price of the assessment.<sup>108</sup>

He also rejected the majority's attempt to distinguish *Travelers* and *Dillingham*:

the statutes in *Travelers* and *Dillingham* were permissible regulations of ERISA plans primarily because they did not mandate a particular level of benefits or impact plan administration, not because of the non-ERISA targets of the regulations. We must similarly focus our inquiry on any threat the Maryland Act poses to the purposes of the ERISA preemption provision rather than on hazy distinctions between direct and indirect regulations. Congress generally does not intend to preempt acts in traditional areas of state regulation, such as health and safety. The purpose of the Act, to relieve state Medicaid burdens and improve health care for low income residents, falls into this category. *Travelers* and *Dillingham* demonstrate that so long as the regulation impacts a traditional area of state concern, and employers are left with an effective choice that avoids ERISA implications, the regulation may stand.<sup>109</sup>

It is hard to reconcile the Fourth Circuit's decision with the reasoning of the Court in *Travelers*. In commenting on the district court decision, Susan Stabile said "[t]here is much to be criticized in the district court's opinion, including the fact the court gives little more than lip service to recent Supreme Court decisions that seem to signal a more narrow approach to ERISA preemption than

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108. *Id.* at 198-203; see also *Retail Indus. Leaders Ass'n*, 435 F. Supp. 2d at 497 (Michael, J., dissenting) (stating that "[t]he 'choice' here is a Hobson's choice"); see also *Travelers*, 514 U.S. at 664 (finding that a Hobson's choice would "impose a substantive mandate").

109. *Retail Indus. Leaders Ass'n*, 475 F.3d at 203 (citations omitted).

did earlier cases.”<sup>110</sup> Most commentators have expressed a negative view of the decision. According to Marc Machiz, “[t]he preemption test is fair enough, but the law does no such thing. It gives employers a choice between increasing health care spending to a certain level or paying the state—a real choice as far as the dissent was concerned—hardly a ‘requirement.’”<sup>111</sup> He also said that “nothing in the law requires (either literally or effectively) a change in the terms or administration of an existing employee benefit plan.”<sup>112</sup>

According to Patricia Butler:

It should still be possible to argue that much lower fees, such as those in Massachusetts or Vermont, not only apply to a broad array of employers but also are not “irresistible incentives” to expand employee benefits. Proposals with somewhat higher fee levels, such as California Governor Schwarzenegger’s proposed 4% payroll assessment also can be defended if they are not so high as to look like a coverage mandate.

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Furthermore, although the Court of Appeals opinion did not include the helpful footnote in the Maryland lower court’s decision that suggested it might reach a different result in the case of a “comprehensive” state reform law, including an employer assessment in such a broad-based law should make it easier to defend because health care access is a long-standing area of primary state authority.<sup>113</sup>

#### IV. SOME POLICY ISSUES

Many advocates of reform would do so by essentially extending Medicare to all Americans. For instance, Jacob Hacker proposes “Health Care for America”, which would enable every legal resident of the U.S. who lacks access to Medicare or good employer coverage to buy into a new public insurance pool modeled after Medicare. The employer contribution would be six percent of payroll.

This new program would team up with Medicare to bargain for lower prices and upgrade the quality of care so that every enrollee

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110. Stabile, *supra* note 7, at 95.

111. Marc Machiz, State Based Health Care Reform – Getting Out from Under Preemption (2007), available at [http://phlog.bna.com/penben/2007/02/state\\_based\\_heal](http://phlog.bna.com/penben/2007/02/state_based_heal).

112. Practitioners Debate Impact of Ruling That Maryland’s ‘Wal-Mart Law’ Is Preempted, BNA PENSION & BENEFITS REPORTER 284, Jan. 30, 2007.

113. Patricia A. Butler, FEDERAL COURT OF APPEALS AGREES ERISA PREEMPTS MARYLAND’S “FAIR SHARE ACT” (2007), <http://www.statecoverage.net/SCINASHP2.pdf>, Feb. 2007, available at <http://www.nashp.org>. The footnote is set out *supra* in note 104.

would have access to either an affordable Medicare-like plan with free choice of providers or to a selection of comprehensive private plans.

At the same time, employers would be asked to either provide coverage as good as this new plan or, failing that, make a relatively modest payroll-based contribution to the Health Care for America plan to help finance coverage for their workers . . . . The self-employed could buy into the plan by paying the same payroll-based contribution; those without workplace ties would be able to buy into Health Care for America by paying an income-related premium. The states would be given powerful incentives to enroll any remaining uninsured.<sup>114</sup>

Real reform will require policymakers to break away from multi-insurer plans funded by employers and loaded with budget busting administrative costs.<sup>115</sup> Most unbiased observers agree that meaningful reform can be achieved only by eliminating the incredibly wasteful, unfair and inefficient multi-insurer system that we have today. As Robert Reich noted,

a single payer . . . would avoid the current insanity by which private insurers spend hundreds of millions of dollars a year advertising and marketing to younger and healthier beneficiaries, and seeking to discourage older and riskier ones, or people with pre-existing medical conditions. America now has the only health-insurance system in the world designed to avoid sick people.<sup>116</sup>

Many of the current reform proposals fall short in this respect: as two California advocates noted wryly, “[a] strange thing happened on the way to health-care security—the goal of universal health care morphed into the cause of mandatory health insurance purchases.”<sup>117</sup>

Ezekiel Emanuel and Victor Fuchs suggest that there are five essential changes:

114. Jacob S. Hacker, *HEALTH CARE FOR AMERICA*, *Economic Policy Institute Briefing Paper # 180* (2007), [http://www.agingsociety.org/agingsociety/publications/public\\_policy/Hacker.pdf](http://www.agingsociety.org/agingsociety/publications/public_policy/Hacker.pdf).

115. See, e.g., Paul Krugman: *The Health Care Racket*, N.Y. TIMES, Feb. 16, 2007 (noting that “McKinsey estimates the cost of providing full medical care to all of America’s uninsured at \$77 billion a year.”). Mr. Krugman continues, “Either eliminating the excess administrative costs of private health insurers, or paying what the rest of the world pays for drugs and medical devices, would by itself more or less pay the cost of covering all the uninsured. And that doesn’t count the many other costs imposed by the fragmentation of our health care system.” *Id.*

116. Robert B. Reich, *Bush’s Health Care Plan Deserves One Cheer, but One Cheer Only*, MARKETPLACE, Jan. 24, 2007, <http://www.robertreich.org/reich/20070124.asp>.

117. Jamie Court & Judy Dugan, *Beware What the Medical-Industrial Complex Loves*, S.F. CHRON., Feb. 22, 2007, at B-9.

- Get businesses out of health care . . .
- Guarantee every American an essential benefits package . . . modeled on what members of Congress get . . .
- The universal basic package should be financed by a dedicated tax that everyone pays, such as a value-added tax.
- Administer the program through an independent National Health Board and regional boards modeled on the Federal Reserve System.
- Establish an independent Institute for Technology and Outcomes Assessment to evaluate new technologies and quantify their health benefits in relation to their costs.<sup>118</sup>

According to Robert Reich:

The President's health-care proposal deserves one cheer for the following reason: It potentially de-couples health care from employment. The President's plan to de-couple health insurance from employment merits only one cheer, though, because it's only the first step. Two cheers for the President or any politician who comes up with a way to get health insurance to lower-income people who can't afford it on their own even with a tax deduction. It's called universal health care. Every advanced nation has it except the United States . . . . Finally, three cheers for the politician who bypasses America's inefficient private insurance market and establishes a single payer that provides all Americans with health insurance just as good as the health insurance their representatives in Congress receive free of charge. Note I said single payer, not single provider. Americans want to keep their choice of doctor and hospital.<sup>119</sup>

According to a recent New York Times/CBS News poll, a majority of Americans say the federal government should guarantee health insurance to every American, especially children, and are willing to pay higher taxes to do it. Access to affordable health care is at the top of the public's domestic agenda, ranked far more important than immigration, cutting taxes or promoting traditional values. However, "Americans remain divided, largely along party lines, over whether the government should require everyone to participate in a national health care plan, and over whether the government would do a better job than the private insurance industry in providing coverage."<sup>120</sup> In addition, some

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118. Ezekiel J. Emanuel & Victor R. Fuchs, *Beyond Health-Care Band-Aids*, WASH. POST, Feb. 7, 2007, at A17; see also Fuchs & Emanuel, *supra* note 23 (describing the principal features of alternative reform proposals, and showing the relation between the goals of reform and the alternative proposals).

119. Reich, *supra* note 116.

120. Robin Toner and Janet Elder, *Most Support U.S. Guarantee of Health Care*, N.Y. TIMES, March 2, 2007, § A, Col. 5, 1.

doubt whether we are philosophically ready for universal health care:

The large and growing uninsured population in the United States is a direct byproduct of U.S. inability to come to agreement over whether health care is a right to which all are entitled regardless of income level or a private consumer good available only to those who can afford to purchase it or receive it as a benefit of employment. . . . The issue of universal coverage surfaces at regular intervals; the United States has started down the road to national health insurance (or at least looked at the maps and plotted a trip) numerous times over the course of the past century.<sup>121</sup>

Finally, it is necessary to consider the likely economic effects of any significant reform:

The results of this paper suggest that while the employer mandate may provide the largest drop in the number of uninsured, it does so at the highest cost in terms of lost jobs, foregone wages, and increased employer spending. A Medicaid expansion, on the other hand, will actually increase employment at roughly the same cost per newly insured individual as the employer mandate. Tax credits represent the least effective way to expand health insurance coverage of the three alternatives. Although they are expected to have negligible labor market effects, their impact on newly insured

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121. Graig, *supra* note 14, at 17 (citing Uwe Reinhardt, *Economics*, J. AM. MED. ASS'N. 275, no. 23 (1996); Uwe Reinhardt, *Wanted: A Clearly Articulated Social Ethic for American Health Care*, J. AM. MED. ASS'N. 278, no. 17 (1997)). She also notes,

The United States, unlike the other nations in this study, has a marked ambivalence about whether health care is a right to which all Americans are entitled . . . . One should not blame the delivery system - managed care - for the failure of the U.S. society to reach the consensus that most other industrialized nations have managed to achieve. Uwe Reinhardt has referred to such a consensus as a "clearly articulated social ethic" that health care is a social good that should be made available to all. Any systemic reform process to address the plight of the uninsured is doomed without such consensus.

GRAIG, *supra* note 14, at 184. J.P. Ruger makes a moral claim:

This article offers an alternative moral framework for analyzing [sic] health insurance: that universal health insurance is essential for human flourishing. The central ethical aims of universal health insurance coverage are to keep people healthy, and to enhance their security by protecting them from both ill health and its economic consequences, issues not adequately considered to date. Universal health insurance coverage requires redistribution through taxation, and so individuals in societies providing this entitlement must voluntarily embrace sharing these costs. This redistribution is another ethical aim of universal health insurance unaddressed by other frameworks.

J.P. Ruger, *The Moral Foundations of Health Insurance*, 100 Q.J. MED. 1, 53-57 (2007).

individuals is lower than the other alternatives and comes at a higher public cost.<sup>122</sup>

## V. WHAT CAN WE LEARN FROM OTHER COUNTRIES?

One of the ironies of the recent debates over health care reform and Social Security privatization has been that, while proponents of individual accounts under Social Security point to Chile as a shining example, they are unwilling to accept that the United States has anything to learn from other countries' health systems, even that of Canada, a country with which we have far more in common than we do with Chile.

The U.S. spends sixteen percent of its gross domestic product (GDP) on health, about twice the average for other rich countries.<sup>123</sup> Not only does the U.S. spend more per capita on health care, it has one of the highest growth rates and does not achieve better outcomes on many important health measures. In the U.S., the share of GDP spent on health care increased from 8.8 percent in 1980 to 15.2 percent in 2003. The next highest were Switzerland at 11.6 percent and Germany at 10.8 percent.<sup>124</sup> In Organization for Economic Cooperation and Development (OECD) countries with above average per capita income, spending in 2003 ranged from \$2,104 in Finland to \$5,711 in the U.S. The next highest were Luxembourg at \$4,611 and Switzerland at \$3,847. Canada spent \$2,998.<sup>125</sup>

The United States cannot simply copy the health care system of another country. One major difference, that cannot be ignored, is that "[t]he United States places greater emphasis on individual responsibility, free choice, and pluralism, whereas other industrialized nations focus on preserving equitable access to health care for the entire population."<sup>126</sup> In addition, as Laurene Graig pointed out in 1999, "[t]hough the share of U.S. health expenditures covered by public financing has increased from forty-two percent in 1990 to forty-six percent today, it is still below the average of nearly seventy-five percent in the other nations analyzed in this book."<sup>127</sup>

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122. Comparing The Effects of Health Insurance Reform Proposals: Employer Mandates, Medicaid Expansions, and Tax Credits, [www.epionline.org/studies/meara\\_06-2007.pdf](http://www.epionline.org/studies/meara_06-2007.pdf).

123. Kaiser Family Foundation, *Health Care Spending in the United States and OECD Countries* (Jan. 2007), <http://www.kff.org/insurance/snapshot/chcm0103070tn.cfm>.

124. *Id.*

125. *Id.*; see also Organization for Economic Cooperation and Development, *OECD Health Data 2006*, <http://www.oecd.org/health/healthdata> (describing health care spending in different countries).

126. GRAIG, *supra* note 14, at 7.

127. *Id.* at 178-79. The government's share is expected to approach fifty percent within the next ten years. Jane Zhang & Vanessa Furmans,

However, we *can* learn from other countries: “[t]he point is that by examining other people’s experiences you can extend your range of perceptions of what is possible.”<sup>128</sup> The country from which the United States can learn most is Canada:

If it is possible, in a society not identical but roughly comparable to ours, to provide comprehensive medical care at two percent less of GNP than we now spend, there would appear to be a very good basis for believing that we are spending more than necessary. . . . There is a third way between the British example of severe service rationing in some areas and the American way of continued high spending on medical care. That third way is the Canadian route to cost containment – compatible with decent access to medical care. . . . The central lesson of the Canadian experiment is that the balance among cost, quality, and access is relatively easy to evaluate. What Canada illustrates clearly is that a sensibly organized national health insurance system can work in a political community like that in the United States; that universal coverage, coherent financial responsibility, and clear political accountability are the central ingredients of success; and that a population accustomed to the same standard of medical care as the United States can take pride in what in essence are ten provincial Blue Cross/Blue Shield plans with comprehensive benefits to which everyone belongs as a matter of right.<sup>129</sup>

## VI. RECENT REFORM PROPOSALS<sup>130</sup>

Ideally, any significant health care reform should take place at the federal level, as only the federal government has the ability and resources to introduce uniform, comprehensive reform. As Paul Krugman has pointed out, “[i]n the end health care should be a federal responsibility. State-level plans should be seen as pilot projects, not substitutes for a national system. Otherwise, some states just won’t do the right thing. Remember, almost twenty-five percent of Texans are uninsured.”<sup>131</sup> In addition, federal legislation would avoid the problem of ERISA preemption, discussed above.<sup>132</sup> However, it appears highly unlikely that any such reform will happen under the current administration, so the

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*Government Pays Growing Share of Health Costs*, WALL ST. J., Feb. 21, 2007, at A1.

128. Robert Evans, *The Spurious Dilemma: Reconciling Medical Progress and Cost Control*, 4 HEALTH MATRIX 1, at 26.

129. MARMOR, *supra* note 1, at 118, 194; *see also* GREGORY P. MARHILDON, *HEALTH SYSTEMS IN TRANSITION: CANADA* (Univ. of Toronto Press 2006) (describing the Canadian system).

130. *See* International Foundation of Employee Benefit Plans, *The U.S. Health Care Dilemma: Who Has the Answer?* (providing a good summary of all of the recent state and federal proposals).

131. Paul Krugman, *Golden State Gamble*, N.Y. TIMES, Jan 12, 2007, at A21.

132. *See supra* Part III.E.

federal government should at least clarify the preemption issue to allow individual states to enact the reforms which they consider appropriate. Representative Robert E. Andrews, chairman of the House Education and Labor Health Subcommittee, said on March 15, 2007, that he does not rule out the idea of employer health insurance mandates through the amendment of ERISA. He said that he would consider amending ERISA to “facilitate covering the uninsured and reduce costs,” but he also said that mandates are a “last resort, not a first option.” The ranking subcommittee member, Representative John Kline, said that he is “strongly opposed to mandates.”<sup>133</sup> At present,

the states appear to be on a collision course with the Bush administration, whose latest budget proposals create a huge potential obstacle to their efforts to expand coverage. While offering to work with states by waiving requirements of federal law, the Bush administration has balked at state initiatives that increase costs to the federal government.<sup>134</sup>

Any reform should, however, allow for local variations; what is appropriate in New York City will not necessarily work in rural Texas, particularly given the differences in available health care resources. One of the strengths of the Canadian system is allowing for such variations:

Wholly administered and largely funded by the provincial governments, Canada’s universal health insurance permits a good deal of local variation. The federal government does not prescribe the details of provincial administration, but merely requires that provincial programs embody the five basic principles of the Canada Health Act to receive federal funding. These principles are as follows: programs must be universal (covering all citizens), comprehensive (insuring all “medically necessary” care), accessible to all (imposing no significant deductibles or copayment obligations on individuals), portable (each province recognizing the other’s coverage), and publicly administered (under the control of a public, nonprofit organization).<sup>135</sup>

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133. Michael W. Wyand, *Health Care Policy: Chairman Does Not Rule Out Mandates for Employer-Provided Health Insurance*, PENSION & BENEFITS DAILY (BNA), March 16, 2007; see also <http://www.edworkforce.house.gov/committee/schedule.shtml> (supplying more information on the hearing).

134. Robert Pear & Raymond Hernandez, *States and U.S. at Odds on Aid For Uninsured*, N.Y. TIMES, Feb. 13, 2007, at A1.

135. MARMOR, *supra* note 1, at 126.



### A. Recent State Legislation<sup>136</sup>

Four states—Maine, Maryland, Massachusetts, and Vermont—have already enacted health care reform statutes. Other states, including California and New York, appear poised to pass some kind of health reform law. All of the state plans rely on employer contributions, and none would eliminate the inefficient multi-insurer system that is the current model for American health care.

#### 1. Maine

The Maine statute, The “Dirigo Health Act,” was enacted in 2003 and revised in 2005.<sup>137</sup> The Act created the Dirigo Health Agency, an independent executive agency responsible for monitoring and improving the quality of health care in the state and arranging for the provision of comprehensive, affordable health care coverage to small employers, self-employed persons, and other individuals on a voluntary basis. DirigoChoice, the state-designed and taxpayer-subsidized health insurance plan, provides taxpayer-financed subsidies to employees with household incomes under three hundred percent of the federal poverty level (FPL), to reduce employees’ costs for their share of employer-provided insurance premiums. DirigoChoice requires participating employers to pay at least sixty percent of the premiums for employee-only coverage; there is no minimum employer contribution for dependent coverage. To date, only 15,800 people are enrolled in DirigoChoice; the goal was to cover all of the State’s 130,000 uninsured by 2009.<sup>138</sup>

Even with its limited enrollment, the program is experiencing financial problems. The State paid \$53 million to launch the program.<sup>139</sup> The plan was to obtain further funding from cost savings expected to be enjoyed by Maine’s hospitals and insurance

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136. For a list of states in which bills have been proposed that would provide universal or near universal coverage and additional resources on state health care reform initiatives, see generally Access to Health Care and the Uninsured, National Conference of State Legislatures, <http://www.ncsl.org/programs/health/h-primary.htm>; 2006-2007 Fair Share Health Care Fund or “Pay or Play” Bills, National Conference of State Legislatures, <http://www.ncsl.org/programs/health/payorplay2006.htm>; State of the States 2007 – State Coverage Initiatives, Robert Wood Johnson Foundation, <http://www.statecoverage.net/pdf/stateofstates2007.pdf>; The Century Forum, Universal Health Insurance and the States, *available at* [forum@tcf.org](mailto:forum@tcf.org); Stabile, *supra* note 7.

137. ME. REV. STAT. ANN. Tit. 24-A, § 6901 (2005).

138. Bioethics Forum: Health Care Reform: A Guide to Current Events [hereinafter Bioethics Forum], <http://www.bioethicsforum.org/health-care-reform-state-and-federal.asp> (last visited Apr. 25, 2007).

139. *Id.*

companies.<sup>140</sup> The plan called for an evaluation of those savings and for the insurers to pay the savings back to the Dirigo system. Maine's insurance commissioner evaluated the program in 2006 and calculated that \$43.7 million had been saved since the program started.<sup>141</sup>

The Governor contends that those savings benefited the insurance industry and the state has billed insurers for that amount.<sup>142</sup> The insurance industry contends that the assessment is erroneous and that, if they are made to pay the \$43.7 million bill, they will pass the costs on through higher premiums for consumers—constituting what the plan's opponents call "The Dirigo Tax".<sup>143</sup> The Maine Association of Health Plans has filed lawsuits challenging the assessment, contending that it is "arbitrary or capricious," and that any savings they have seen are outweighed by the fees associated with the program.

Given its low enrollment and the controversy over the Dirigo Tax, the Maine reform plan is hardly a model to emulate.

## 2. *Maryland*<sup>144</sup>

In 2005, the Maryland legislature enacted the Fair Share Health Care Fund Act, which requires very large employers (generally, 10,000 or more Maryland employees) to spend at least eight percent of their total payrolls on employee health insurance, or to pay the amount of the shortfall to the State. The Governor vetoed the bill, but the legislature overrode the veto in January, 2006.<sup>145</sup> The only employer that would have been immediately affected by the Act was Wal-Mart. In January, 2007, as discussed above, the federal Fourth Circuit Court of Appeals held by a 2-1 majority that the Act is preempted by ERISA.<sup>146</sup> This decision, if followed, may pose problems for any state that, like Massachusetts, requires employer contributions as part of its reform package.<sup>147</sup>

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140. Private Public Partnerships: Strategies for Reaching the Uninsured, <http://www.hsph.harvard.edu/uninsured/files/summary.pdf>.

141. Bioethics Forum, *supra* note 139.

142. *Id.*

143. *Id.*

144. See generally Julia Contreras & Orly Lobel, *Wal-Martization and the Fair Share Health Care Acts*, 19 ST. THOMAS L. REV. 105 (2006).

145. The Fair Share Health Care Fund Act (H.B. 1284), available at <http://www.mlis.state.md.us/2005rs/billfile/hb1284.htm>. The Governor's veto message is available at [http://www.mlis.state.md.us/2005rs/veto\\_letters/hb1284.htm](http://www.mlis.state.md.us/2005rs/veto_letters/hb1284.htm).

146. *Retail Indus. Leaders Ass'n*, 475 F.3d at 191-92.

147. See discussion *supra* Part III.E.

### 3. Massachusetts

In 2006, the legislature enacted An Act Further Regulating Health Care Access.<sup>148</sup> The aim was to cover ninety-five percent of the state's 500,000 uninsured within three years. Massachusetts has already enrolled more than half of the poorest people who are eligible, but it will be more difficult to enroll the working poor, who will receive a state-subsidized rate, but must pay a monthly premium depending on income.<sup>149</sup>

The law requires an employer with eleven or more employees that does not provide health insurance to pay \$295 annually per full time employee, pro-rated for part-time and temporary workers. There is no absolute mandate on individuals to buy insurance, but people will face financial penalties if they choose not to enroll in an eligible plan that is available to them. For 2007, they would forfeit their personal state income tax exemption, costing them about \$200. In 2008, they would be fined half of the average premium for the minimal plan. Is this enough of an incentive? "Without a big drop in cost, healthy people living just above the poverty line may forego insurance because paying the penalty is cheaper," said William Walczak, who runs Codman Square Health Center in Boston's Dorchester neighborhood. "The penalty in the first year is the loss of your personal tax exemption. For a working poor person that can range from nothing to \$150 a year. Why would you buy health insurance at a cost upwards of \$3,000 a year if you're relatively healthy and the penalty is likely to be \$150?" he said.<sup>150</sup>

In January, 2007, the state agency, the Commonwealth Connector board, outlined the minimum requirements: the estimated average cost was \$380 a month, more than \$100 above previous estimates.<sup>151</sup> In addition, more than 200,000 Massachusetts residents with health insurance would need to buy additional coverage to satisfy the minimum standards.<sup>152</sup> A less

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148. 2006 Mass. Adv. Legis. Serv. 58 (Lexis Nexis), available at <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>.

149. Pam Belluck, *Massachusetts Could Serve as Guide in California's Health Insurance Bid*, N.Y. TIMES, Jan. 10, 2007, at A1. For a description of recent developments, see Sibson Consulting, *Massachusetts Moves Forward in Implementing Landmark Health Care Reform Act* (Feb. 22, 2007), <http://www.sibson.com/publications/capitalcheckup/index.html>.

150. Reuters, *Massachusetts Spurs Health-Care Debate*, Feb. 22, 2007, <http://www.reuters.com/article/healthnews/idUSN2016859420070222>.

151. Alice Dembner, *Sticker Shock for State Care Plan*, BOSTON GLOBE, Jan. 20, 2007, at A1.

152. Alice Dembner, *200,000 May Need to Get More Insurance*, BOSTON GLOBE, Jan. 30, 2007, at A1.

expensive minimal plan design would provide less coverage.<sup>153</sup> Subsequently, state officials said that the average uninsured Massachusetts resident could obtain health care coverage for as little as \$175 a month.<sup>154</sup> On March 8, 2007, the board approved seven health insurance plans that will offer relatively inexpensive coverage. Officials also said that they would consider exempting some people from the penalties for not buying insurance. However, advocates are still concerned about the effect of large deductibles and other out-of-pocket expenses on low-income families.<sup>155</sup> Jonathan Gruber, a professor of economics at M.I.T., and a member of the Connector Board, disagrees:

the structure of the minimum creditable coverage plans that are being discussed makes a lot of sense. All of the plans being considered provide some up front medical care that individuals can use to get preventative care and be evaluated for more serious medical disease. If individuals are found to be chronically ill, they can then buy up to more generous plans that are more appropriate to their health status.<sup>156</sup>

Don McCanne, MD, of Physicians for a National Health Plan, disagrees:

Rather than compounding the nightmare of administrative inefficiencies, it would be much simpler to combine everyone into a single risk pool that is equitably funded and therefore affordable for everyone. Single payer would do it. But in his efforts to make the antiquated private plans work, Dr. Gruber states, ' . . . we can't insist everyone who has no insurance get the policy that optimizes their health.' Further, "Let's get them into the system and get them real insurance, and then maybe they'll be interested in buying something better." (The Boston Globe, March 5) Why don't we start out with something better? Real insurance. Single payer.<sup>157</sup>

From the outset, critics have questioned the financial viability of the plan. "The ongoing commitment of state and federal funds is critical. The plan projects that more than \$200 million over three years will be raised from employer contributions and this funding is also essential. In addition, the employer contribution requirement could be subject to a legal challenge."<sup>158</sup>

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153. Alice Dembner, *Universal Plan Can Cost Under \$300, Insurers Say Monthly Price Is Closer to Goal*, BOSTON GLOBE, Feb. 5, 2007, at A1.

154. Steve LeBlanc, *Massachusetts Health Care Plan Moving Forward*, Associated Press, March 4, 2007.

155. Jeffrey Krasner, *State OK's 7 Low-Cost Health Plans for Uninsured*, BOSTON GLOBE, March 9, 2007, at C1.

156. Jonathan Gruber, *What Is Insurance*, <http://www.wbur.org> (last visited March 9, 2007).

157. Posting of Don McCanne, MD to commonwealth weblogs, <http://www.blogs.wbur.org/commonhealth/?p=23#comments> (March 9, 2007).

158. Community Catalyst, *Massachusetts Health Reform*, [http://www.communitycatalyst.org/resource.php?base\\_id=1023](http://www.communitycatalyst.org/resource.php?base_id=1023) (April 2006)

#### 4. Vermont

Vermont enacted its program, Catamount Health, in May 2006.<sup>159</sup> Catamount Health will require private insurers to offer coverage for the uninsured, starting in October 2007. Employers who do not offer health insurance must pay \$365 annually per employee, and cigarette taxes will increase. The law also creates a subsidized insurance product. The law is much more specific than the Massachusetts law, which left many issues to regulation. Unlike Massachusetts, Vermont did not make participation mandatory.<sup>160</sup> Reform should be easier in Vermont than in most other states. In Vermont, only eleven percent of state residents are uninsured. The state has the lowest rate of uninsured children (six percent) and one of the lowest rates of poverty or near-poverty.<sup>161</sup>

#### B. Reform Proposals in other States

Health care reform has been discussed recently in many other states.<sup>162</sup> However, the two states in which the proposals have

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(including a good summary of the law); *see also* Leif Wellington Haase, Century Foundation, *Pumping Up the Universal Coverage Debate*, Jan. 10, 2007, <http://www.tcf.org/list.asp?type=nc&pubid=1476>, (stating, “The Massachusetts universal coverage plan is probably more artful politically than California’s but less likely to succeed in practice.”).

Big questions remain about whether the Massachusetts plan can be paid for over time or whether insurers will actually offer decent insurance products at a reasonable price. But California, unlike Massachusetts, has many more uninsured residents and lower rates of existing employer coverage. There is some question whether the success of other states in achieving universal coverage would be a national model. But if universal coverage can work in California, it can happen anywhere.

*Id.*

159. The text of the 2006 Health Care Affordability Act is available at <http://www.leg.state.vt.us/HealthCare/2006LegAction.htm>.

160. “While many activists (the pragmatists) supported the compromise (albeit with reservations) as step forward and as a foundation for future reform, some felt that no bill was better than a compromise and that there was an opportunity to get better legislation after the next election.” Community Catalyst, *Understanding Health Reform in Vermont*, Dec. 2006, <http://www.communitycatalyst.org/resources/vermontFinal.pdf>.

161. *See id.* (providing Vermont statistics).

162. *See State Watch – Kaiser Daily Health Policy Report Rounds Up Health Issues in State of the State Addresses*, Jan. 22, 2007, [http://www.ikaiser.network.org/daily\\_reports/rep\\_index.cfm?hint=3&DR\\_ID=42394](http://www.ikaiser.network.org/daily_reports/rep_index.cfm?hint=3&DR_ID=42394); *Access to Health Care and the Uninsured*, National Conference of State Legislatures, <http://www.ncsl.org/programs/health/h-primary.htm> (listing states in which bills have been proposed that would provide universal or near universal coverage, and additional resources on state health care reform initiatives); 2006-2007 Fair Share Health Care Fund or “Pay or Play” Bills, National Conference of State Legislatures, <http://www.ncsl.org/programs/health/payorplay2006.htm>; State of the States 2007 – State Coverage Initiatives, Robert Wood Johnson Foundation, <http://www.statecoverage.net/pdf/>

attracted the most attention, because of their size and their large uninsured populations, are California and New York.

### 1. *California*

In California, 6.5 million (including at least one million illegal immigrants) of the thirty-six million residents are uninsured.<sup>163</sup> Last summer, the legislature passed a single payer bill, which Governor Schwarzenegger vetoed.<sup>164</sup> Schwarzenegger has now unveiled his own proposal. Businesses (with ten or more employees) that do not offer coverage would pay four percent of Social Security wages to a state fund, to subsidize the purchase of coverage by the working uninsured. The cost to the individual would be based on a sliding scale determined by earnings.<sup>165</sup>

The minimum coverage would be a \$5,000 deductible plan with maximum out of pocket limits of \$7,500 per person and \$10,000 per family. Schwarzenegger claimed that for the majority of uninsured individuals, such coverage could be purchased for \$100 or less per month for an individual and \$200 or less for two persons. According to Physicians for a National Health Program, however,

[c]onsidering that this proposal requires guaranteed issue and community rating, the premiums likely will be at least five or six times that much. And maximum out-of-pocket limits are a fiction since they ignore non-covered and out-of-network services- often unavoidable. The total costs to individuals or families with significant health care needs can be in the tens of thousands of dollars. An insurance product that does not protect average-income Americans cannot serve as the foundation of an affordable, efficient

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stateofstates2007.pdf; see also *The Century Forum: Universal Health Insurance and the States*, <http://www.tcf.org/list.asp?type=PB&pubid=601> (discussing prospects for universal coverage); Stabile, *supra* note 7.

163. Jennifer Steinhauer, *California Plan for Health Care Would Cover All*, N.Y. TIMES, Jan. 8, 2007, at A1.

164. "As a result, he came up with a plan that, like the failed Clinton health care plan of the early 1990s, is best described as a Rube Goldberg device -- a complicated, indirect way of achieving what a single-payer system would accomplish simply and directly." Paul Krugman, *Golden State Gamble*, N.Y. TIMES, Jan. 12, 2007, at A21; see also Sheila Kuehl, *A Second, Third and Fourth Opinion on Health Care*, L.A. TIMES, Jan. 9, 2007, at A13 (opining that Schwarzenegger's new plan does not address coverage for unemployed people and only creates new problems).

165. See [http://gov.ca.gov/pdf/press/Governors\\_HC\\_Proposal.pdf](http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf) (detailing the text of the health care reform proposal); <http://gov.ca.gov/index.php?fact-sheet/5190> (listing facts of reform plan); <http://gov.ca.gov/index.php?press-release/5057> (detailing the Governor's press release); see also comment by Don McCanne, *Gov. Schwarzenegger's Health Care Proposal*, <http://www.phhp.org/news/2007/january/gov.schwarzenegger.php> (opining on Schwarzenegger's health care proposal).

health care system for all. This alone destroys the credibility of Gov. Schwarzenegger's model.<sup>166</sup>

As with Massachusetts, one basic concern is whether the cost would be as affordable as Schwarzenegger has claimed. Legislative Analyst Elizabeth Hill warned that the proposal could leave the state with \$3.2 billion in unanticipated costs.<sup>167</sup>

In addition, Medicaid eligibility would be extended and doctors would pay two percent, and hospitals four percent, of their revenues to help cover higher reimbursements for those who treat Medicaid patients.<sup>168</sup>

## 2. New York

At his inauguration, Governor Eliot Spitzer promised to make health insurance available to all children and to enroll all eligible adults in Medicaid. "If carried out fully, his pledges would cut the number of uninsured New Yorkers in half. Almost fourteen percent of New Yorkers are uninsured, according to the Census Bureau, below the national average of nearly sixteen percent but well above Minnesota, with the lowest rate, less than nine percent."<sup>169</sup> On January 26, 2007, Governor Spitzer said that New York should move toward a system of universal health coverage as part of a multi-year strategy to fundamentally reform the state's health care system.<sup>170</sup>

In December 2006, two influential organizations, the United Hospital Fund and the Commonwealth Fund, issued a detailed report and recommendations.<sup>171</sup> According to the report, New York has an estimated 2.8 million uninsured. Of these 2.8 million, forty-one percent are already eligible for an existing public health insurance program; another thirty-six percent have low-to-moderate incomes (below three hundred percent of the FPL) but are ineligible for public coverage; and the remaining twenty-three percent have incomes above three hundred percent FPL.<sup>172</sup>

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166. *Id.*

167. Evan Halper, *State Budget Short Fall Is Predicted*, L.A. TIMES, Feb. 22, 2007, at B1.

168. *See supra* note 163.

169. Richard Perez-Pena, *Spitzer's Health Care Pledge Focuses on Easing the Way for Those Entitled*, N.Y. TIMES, Jan. 4, 2007, at B1.

170. Gov. Eliot Spitzer, Remarks at the Nelson A. Rockefeller Institute, Albany, N.Y. (Jan. 26, 2007), available at [http://www.ny.gov/governor/keydocs/0126071\\_speech.html](http://www.ny.gov/governor/keydocs/0126071_speech.html).

171. The United Hospital Fund and the Commonwealth Fund, *A Blueprint for Universal Health Insurance Coverage in New York*, available at [www.cmwf.org/usr\\_doc/blueprint\\_for\\_universal\\_coverage.pdf](http://www.cmwf.org/usr_doc/blueprint_for_universal_coverage.pdf).

172. *Id.*

The report advocates a building block approach:

First, reform public programs to increase participation rates and make affordable coverage available to a greater share of low and moderate income persons. Simplify rules to enroll those who are eligible but uninsured; expand Family Health Plus eligibility for childless adults; allow low to moderate income New Yorkers to buy into FHP with income-related premium assistance. A new statewide purchasing mechanism would provide a choice of additional coverage options at group rates.<sup>173</sup>

The report describes two variations of assessments on employers with ten or more employees that do not offer health insurance: an assessment of \$400 per worker per year; or a pay-or-play assessment of eight percent of payroll, with a credit for coverage offered. The average would be \$3,200 per worker. All residents would be required to buy health insurance, with income-related premium assistance.<sup>174</sup>

### C. Federal Proposals<sup>175</sup>

In September 2006, a federal advisory panel appointed by the comptroller general, the Citizens' Health Care Working Group, said that Congress should take steps to ensure that all Americans have access to affordable health care by 2012.<sup>176</sup> President Bush recently refused to support the proposal.<sup>177</sup> Numerous bills have been introduced in Congress, and Sen. Kennedy and Rep. Conyers have advocated Medicare for All, a concept endorsed by the AFL-CIO.<sup>178</sup> John Edwards began his presidential campaign with a call for universal health care,<sup>179</sup> and Sen. Wyden has introduced a plan

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173. *Id.*

174. *Id.*

175. See generally Martin A. Sullivan, *Economic Analysis: Why the Bush Health Insurance Plan Matters* TAX NOTES TODAY, Feb. 13, 2007, at 3, 2007 TNT 30-3 (discussing state and federal proposals for health care reform).

176. Robert Pear, *Panel Urges Basic Coverage on Health Care*, N.Y. TIMES, Sept. 26, 2006, at A17.

177. Matthew Dobias, *Bush Won't Budge; Citizens' Group Report on Improving Coverage Rejected*, MODERN HEALTHCARE, Mar. 19, 2007, at 8.

178. Kevin Freking, *Kennedy Calls on U.S. to Enact Universal Health Care*, THE BUFFALO NEWS, Jan. 11, 2007, available at <http://www.aflcio.org/aboutus/thisistheafficio/ecouncil/ec03062007.cfm>; *Kennedy Seeks Universal Health Plan*, N.Y. TIMES, Jan. 11, 2007; AFL-CIO Executive Council Statement, March 6, 2007.

179.

[Edwards'] plan would require every U.S. resident to get health insurance after several initiatives which make coverage more affordable have been implemented. These initiatives include an expansion of Medicaid and the State Children's Health Insurance Plan, new sliding scale tax credits and health insurance reform including guaranteed issue requirements. The plan would require employers to provide substantial health care coverage to their employees or contribute to the



similar to the one introduced in Massachusetts.<sup>180</sup> In March, 2007, Sen. Wyden said that lawmakers were on the “cusp of a very big breakthrough” in the debate over health care reform,<sup>181</sup> but Rep. Pete Stark’s pessimistic assessment is probably correct: “What we are building up to is a year, 2007, in which a lot of people are willing to discuss the benefits and costs of universal coverage, but I don’t think we’re going to make legislative headway.”<sup>182</sup>

In his 2007 State of the Union address, President Bush proposed counting employer-provided health insurance as taxable income, and creating a standard deduction for health insurance beginning in 2009.<sup>183</sup> The deduction would initially be \$15,000 for

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cost of providing coverage through “health markets.” These health markets would be regional non-profit purchasing pools which allow individuals and businesses [to] increase their bargaining power for health insurance and have a choice of plans. The plan would be funded by a tax increase.

International Foundation of Employee Benefit Plans, Health Care Reform Discussion, The U.S. Health Care Dilemma: Who Has the Answer?, <http://www.ifebp.org>; see also Universal Health Care Through Shared Responsibility, John Edwards 2008 Campaign Website, <http://www.johndwards.com/about/issues/health-care-overview.pdf> (last visited Mar. 30, 2007) (discussing details of Edwards’ plan to provide greater access to universal health insurance); Paul Krugman, *Edwards Gets It Right*, N.Y. TIMES, Feb. 9, 2007, at A19. Mr. Krugman stated:

[T]his is a smart, serious proposal. It addresses both the problem of the uninsured and the waste and inefficiency of our fragmented insurance system. And every candidate should be pressed to come up with something comparable. Yes, that includes Barack Obama and Hillary Clinton. So far, all we have from Mr. Obama is inspiring rhetoric about universal care – that’s great, but how do we get there? And how do we know whether Mrs. Clinton, who says that she’s “not ready to be specific,” and that she wants to “build the consensus first,” will really be willing to take on this issue again?).

180. In Feb. 2007, Sen. Wyden introduced S. 334, the Healthy Americans Act, which would offer “affordable, guaranteed” health care coverage that “can never be taken away.” *S. 334 Would Provide ‘Affordable, Guaranteed’ Health Care Coverage*, TAX NOTES TODAY, Feb. 27, 2007, at 29, 2007 TNT 39-29.

181. Meg Shreve, *Wyden Sees Health Care Reform on the Horizon*, TAX NOTES TODAY, Mar. 7, 2007, at 2, 2007 TNT 45-2.

182. Tom Hamburger, *Unlikely Allies Push Expanded Health Care*, L.A. TIMES, Jan. 16, 2007, at 1.

183. *White House Issues Fact Sheet on Health Insurance Affordability*, TAX NOTES TODAY, Feb. 26, 2007, at 136, 2007 TNT 38-136; see also Press Release, U.S. Treasury Department Office of Public Affairs, Making Health Insurance Affordable for More Americans (Jan. 29, 2007) (showing how President Bush’s Standard Deduction Health Insurance Plan would work in a variety of scenarios), available at [www.treas.gov/press/releases/hp238.htm](http://www.treas.gov/press/releases/hp238.htm). According to a preliminary estimate from the Joint Committee on Taxation, President Bush’s health insurance proposals would cost taxpayers \$526 billion through 2017. Kevin Freking, *Advisers: Bush Plan Would Cost Taxpayers*, Associated Press, Feb. 28, 2007. By contrast, the White House says the changes the President seeks are revenue-neutral over ten years. *Id.*

family coverage and \$7,500 for individuals. According to a January 23, 2007 Associated Press article,<sup>184</sup>

Diane Rowland, executive vice president of the Kaiser Family Foundation, noted that some individuals with high health insurance premiums don't necessarily have "gold-plated insurance," as the Bush administration has called plans with premiums above \$15,000. She pointed out that insurance premiums vary by geographic location, size of employer and the age and health of the employers' workforce.<sup>185</sup>

On March 14, 2007, the Senate Finance Committee held a hearing on health care reform and the White House proposal.<sup>186</sup>

Critics assert that the changes would encourage employers to stop providing health insurance.<sup>187</sup> Also, as a *New York Times*

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184. Kevin Freking, *Bush Health Insurance Tax Break a Hard Sell*, Associated Press, Jan. 23, 2007.

185. *Id.*; see also K. DAVIS ET AL, *Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?*, THE COMMONWEALTH FUND (2007) (explaining, "Health care costs vary substantially across the United States."). "For example, the Dartmouth Atlas of Health Care shows that Medicare outlays per beneficiary adjusted for area wage costs ranged from \$4,530 in Hawaii to \$8,080 in New Jersey in 2003." *Id.*

186. *Finance Committee Examines Healthcare Reform*, TAX NOTES TODAY, Mar. 15, 2007, at 4, 2007 TNT 51-4. Member and witness statements, <http://www.senate.gov/~finance/sitepages/hearing031407.htm>.

187. For example, "Rep. Pete Stark said . . . that the tax changes would encourage employers to stop providing health insurance. 'Under the guise of tax breaks, the president is pursuing a policy designed to destroy the employer-based health care system through which 160 million people receive coverage.'" Freking, *supra* note 184; see also Statement by Robert Greenstein, Executive Director, Center on Budget and Policy Priorities (Jan. 24, 2007) (discussing flaws in President Bush's budget and health care proposals), available at <http://www.cbpp.org/1-23-07bud-stmt.pdf>.

On the subject of health insurance, by contrast, the president has shown leadership in placing the tax treatment of employer-based coverage on the table as part of health care reform, and by implicitly acknowledging that more revenues will be needed over time to help address the problem of the uninsured. But the president has undermined his initiative by tying it to an ill-designed proposal that would erode incentives for employer-based coverage — the primary means of pooling healthier and sicker Americans together to keep insurance affordable — without providing an alternative way of effectively pooling risk. The president's plan would drive more Americans into the deeply flawed individual health insurance market, where people with health conditions are often refused coverage or can get it only at exorbitant cost.

*Id.*; see also Robert Pear, *Experts See Peril in Bush Health Proposal*, N.Y. TIMES, Jan. 28, 2007, at 20. Mr. Pear quoted Paul Fronstin, director of health research at the Employee Benefit Research Institute, as saying, "The president's proposal would mean the end of employer-based benefits as we know them. It gives employers a way out of providing the benefits because their employees could get the same tax break on their own." See also Paper by Leonard E. Burman et al., Tax Policy Center, *The President's Proposed Standard Deduction for Health Insurance: An Evaluation* (Feb. 15, 2007)

editorial pointed out:

The new standard deduction would almost certainly entice some people to buy health insurance who had previously elected not to. But a tax deduction is of little value to people so poor that they pay little or no income tax. And unfortunately, it is those people who account for the vast majority of the nation's uninsured.

The editorial goes on to state that the proposal to offer a tax deduction, as opposed to a tax credit, will primarily benefit high-income taxpayers, as low-income people do not pay income taxes.<sup>188</sup> The Tax Policy Center commented that "In some respects, the plan is very innovative and a step in the right direction" and noted that it could be improved by several recommended changes, including (1) The deduction could be replaced with a refundable tax credit or a voucher that provides as much (or more) assistance to low-income families as it does to those with higher incomes; (2) eligibility for the voucher or credit in the individual non-group market could be made conditional on insurers offering community-

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available at <http://www.taxpolicycenter.org/publications/urlprint.cfm?ID=10028>.

A more fundamental concern about the plan, as proposed, is that the standard deduction would be available to all who obtained qualifying insurance, whether through an employer or as an individual. That would level the playing field between employer-sponsored insurance and insurance purchased in the individual market. But removing the existing advantage for employment-based plans would lead some employers, especially small and medium-sized businesses, to stop offering health insurance to their employees, exacerbating a trend that is already well underway. Assuming that employers raise wages when they stop offering health insurance, healthy employees will often be able to use their wage boost to purchase inexpensive health insurance in the individual nongroup market, but many who have health problems, especially those with low incomes, will find health insurance unaffordable. Mitigating or remedying these problems would require some combination of expanded public programs, new pooling arrangements, fundamental reform of the individual market, or additional subsidies for targeted groups, such as small employers that offer health insurance, people with chronic health conditions, and low-income households.

*Id.*; see also Reid Says Bush's Health Care Proposals Would Increase Number of Uninsured, TAX NOTES TODAY, Feb. 22 2007, at 38, 2007 TNT 36-38 (reporting on a Feb. 21 Release by Senate Majority Leader Harry Reid criticizing Bush's plan).

188. Editorial, *The President's Risky Health Plan*, N.Y. TIMES, Jan. 26, 2007, at A20; see also Gene Steuerle, *Prescribing Better Under Bush's Health Plan*, TAX NOTES TODAY, Jan. 30, 2007, 2007 TNT 20-56 (arguing that "[a] properly designed voucher is a much better vehicle for addressing many of those problems"). This is because "[a voucher] can be extended to people who pay little or no tax; it can be integrated with state Medicaid and related children's insurance for the poor; and, if it were worth the same amount per person, it would be much easier to administer by employers and insurance companies alike." *Id.*

rated premiums or some other mechanism that guarantees that people who are continually insured can purchase insurance at the same low rate as everyone else, even if they develop chronic health conditions; (3) additional funds could be dedicated to complementary programs; (4) the mandate for coverage could be made more explicit; and (5) tax subsidies for health savings accounts should be eliminated.<sup>189</sup>

The pithiest comment on the President's proposal comes from Stephen Colbert:

It's so simple. Most people who can't afford health insurance also are too poor to owe taxes. But if you give them a deduction from the taxes they don't owe, they can use the money they're not getting back from what they haven't given to buy the health care they can't afford.<sup>190</sup>

The proposal also ignores the realities of the individual insurance market: in her 2001 study, Karen Pollitz found that roughly ninety percent of applicants in less-than-perfect health were unable to buy individual policies at standard rates, while thirty-seven percent were rejected outright.<sup>191</sup>

## VII. CONCLUSION

Health care is again the subject of intense national debate, and there appears to be strong support for major reforms and a significant expansion of coverage. However, we must remember that similar public sentiments have failed many times in the past to produce real reform. The outcome will almost certainly depend on the results of the 2008 presidential and congressional elections.

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189. Len Burman et al., *Tax Policy Center Reviews Bush Healthcare Plan*, TAX NOTES TODAY, Jan. 24, 2007, TNT 16-52.

190. See Robert H. Frank, *A Health Care Plan So Simple, Even Stephen Colbert Couldn't Simplify It*, N.Y. TIMES, Feb. 15, 2007, at C3 (quoting Stephen Colbert's Comedy Central Show).

191. See also Kaiser Family Foundation, *How Accessible Is Individual Health Insurance for Consumers in Less-Than Perfect Health?* June 2001, available at <http://www.kff.org/insurance/upload/How-Accessible-is-Individual-Health-Insurance-for-Consumers-in-Less-Than-Perfect-Health-Executive-Summary-June-2001.pdf>.

