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Will Americans Embrace Single-Payer Health Insurance: The Intractable Barriers of Inertia, Free Market and Culture

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Introduction

Lately, I have been having flashes of déjà vu. Here it is, a decade into the new millennium, and it is the 1990s all over again. A Clinton was running for president, O.J. Simpson, the media's darling, was in court and constantly on television news, and health care was (and still is) United States' number one domestic concern. I feel a little like Rip Van Winkle, falling asleep in 1995 and waking up at the end of 2009. What has happened in the past fourteen years? This Article does not theorize about either the possibility of a Clinton II presidency (no longer a possibility for the 2008 election)[1] or discuss the O.J. II felony trial (Simpson was convicted of armed robbery and kidnapping and sentenced to fifteen years in prison, thirteen years to the day after a jury acquitted him of killing Nicole Brown Simpson and Ron Goldman).[2] This Article does, however, hope to deconstruct the salient features of health care in the United States as the second decade of the new millennium approaches.

Health care in the United States is in a crisis, or at least heading towards one. At least 46.4 million, or approximately 17.9% of Americans under the age of sixty-five, are completely uninsured,[3] and millions more are underinsured.[4] Even the

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1. Adam Nagourney, *Obama: Racial Barrier Falls in Decisive Victory*, N.Y. TIMES, Nov. 5, 2008, at A1.

2. Ashley Powers, *Simpson Guilty on All Counts: He Faces Life in Prison for Kidnapping and Armed Robbery at a Las Vegas Hotel. He Will Be Sentenced Dec. 5*, L.A. TIMES, Oct. 4, 2008, at A1.

3. The Employee Benefit Research Institute, in a report released on October 4, 2007, found that in 2006

> [m]ore than 25% of self-employed workers were uninsured, while almost 20% of all workers lacked insurance . . . . Self-employed people and

approximately eighty-two percent of nonelderly Americans who have health insurance—through their employers, as part of a public program, or individually[5]—are paying significantly more out-of-pocket than ever before.[6] Moreover, many employers are either dropping health insurance benefits altogether or shifting the cost of health insurance to their employees.[7] Health care is also an issue for global companies because the cost of their goods increases with the cost of their employees' health insurance, making it harder to compete in the global market.[8] Health care is big business. In 2009, the United States is expected to spend $2.5 trillion, or 17.6% of the gross domestic product (GDP), on health care,[9] more than it will spend in any other sector of the economy.[10] The Congressional Budget Office projects that by 2016, the percentage of GDP consumed by health care will reach nearly 20%.[11]

> workers at private-sector firms with fewer than 100 employees made up 63% of the working uninsured . . . . About 33% of the uninsured were in families with annual incomes less than $20,000, compared with about 7% of people in families with annual incomes of $75,000 or more.

Uninsured Nonelderly U.S. Residents Up 17.9% in 2006, CAL. HEALTHLINE, Oct. 5, 2007, http://www.californiahealthline.org/Articles/2007/10/5/Uninsured-Nonelderly-US-Residents-Up-179-in-2006.aspx [hereinafter *Uninsured Residents*].

4. Cathy Schoen et al., *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, 27 HEALTH AFF. w298, w298, June 10, 2008, http://content.healthaffairs.org/cgi/reprint/27/4/w298.

5. *Uninsured Residents*, *supra* note 3.

6. MICHAEL HALLE ET AL., HIDDEN COSTS OF HEALTH CARE: WHY AMERICANS ARE PAYING MORE BUT GETTING LESS 1–2 (2009), *available at* http://www.healthreform.gov/reports/hiddencosts/hiddencosts.pdf.

7. David S. Hilzenrath, *Many Employers to Raise Cost of Health Benefits, Survey Finds*, WASH. POST, Sept. 16, 2009, at A8.

8. The current CEO of General Motors, Rick Wagoner, says that the cost of employer-sponsored "[h]ealth care raises the price of each GM car by $1,500." While that figure may be arguable because it is offset by federal government tax subsidies to employers, the point is not without merit. Susan Froetschel, *Globalization Forces a Health-Check of US Auto Industry*, YALEGLOBAL ONLINE, Feb. 19, 2007, http://www.yaleglobal.yale.edu/content/globalization-forces-health-check-us-auto-industry; *see also* Geoffrey Colvin, *Detroit's Health-Care Crisis—And Ours*, FORTUNE, Sept. 29, 2003, at 50 (arguing that Chrysler and General Motors are "HMOs with wheels" and are struggling to compete with Toyota because of their insurance costs for retirees).

9. NAT'L COAL. ON HEALTH CARE, HEALTH INSURANCE COST 1 (2009), *available at* http://nchc.org/sites/default/files/resources/Fact%20Sheet%20-%20Cost.pdf.

10. Posting of Jim Cooper, Representative of Tennessee, to Health Affairs Blog, http://healthaffairs.org/blog/2008/02/26/health-spending-a-growing-economic-crisis/ (Feb. 26, 2008, 6:45 EST).

11. *Research on the Comparative Effectiveness of Medical Treatments: Options for an Expanded Federal Role Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 110th Cong. 3 (2007) (statement of Peter R. Orszag, Director, Cong. Budget Office), *available at* http://www.cbo.gov/ftpdocs/82xx/doc8209/Comparative_Testimony.pdf.

In 2008, the beginning of a national election cycle, each presidential candidate had health care reform on his or her agenda.[12] In the face of federal inaction, many states, such as Maine, Massachusetts, and California, have attempted to fill the vacuum with innovative health care legislation.[13] All of these proposals, both federal and state, have one goal in mind: to provide affordable and universal health insurance. The challenge for policy makers is to unpack the proposals and look behind the language to evaluate the real effects of each. Health insurance for all is a laudable goal, but trying to implement universal health coverage without breaking the bank is essential. In the end, policy and its ensuing legislation has to be palatable both to the voters, who have the power to oust unsatisfactory legislators, and to the legislators themselves, who are often beholden to special interest groups formed by health care's key players.

As a law professor, I focus primarily on health care law. Due to my interest in accessible health coverage and financing health care, my classes discuss these issues as social policy. How have Americans come to accept the twin norms in health care of enormous annual cost (over two trillion) and the exclusion of almost forty-seven million uninsured Americans under the age of sixty-five?[14] When I put this dilemma to my students, they are universally appalled. Yet, when I posit that the fairest and least socially burdensome solution might be to require the explicit cross-subsidization of the poorest and least healthy sector by the wealthiest and healthiest sector, even the most socially-oriented students balk. With two notable exceptions, providing even a modicum of health insurance to everyone, regardless of ability to pay, is anathema to most Americans.[15] The exceptions to this rule

12. *See generally* SARA R. COLLINS ET AL., THE 2008 PRESIDENTIAL CANDIDATES' HEALTH REFORM PROPOSALS: CHOICES FOR AMERICA (2008), *available at* http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2008/Oct/The-2008-Presidential-Candidates-Health-Reform-Proposals--Choices-for-America.aspx (follow "Fund Report" hyperlink) (describing and evaluating presidential candidates' health reform proposals and examining their differences).

13. Library of Congress, State Legislation on Comprehensive Health Care Coverage, http://www.loc.gov/law/help/statehealthplans/ (last visited Sept. 23, 2009).

14. *Uninsured Residents*, *supra* note 3.

15. Joseph M. Schwartz, *From Domestic to Global Solidarity: The Dialectic of the Particular and Universal in the Building of Social Solidarity*, 38 J. SOC. PHIL. 131, 132 (2007). *But see* MICHAEL WALZER, SPHERES OF JUSTICE: A DEFENSE OF PLURALISM AND EQUALITY 84–90 (1983). Schwartz summarizes Walzer's argument as follows: "[T]he American willingness to provide guaranteed health insurance for the poor and elderly indicates a latent commitment to a universal right to health care." Schwartz, *supra* note 15, at 135.

are Medicare—the health insurance program for the elderly, which (at least until recently) has been as close to true social insurance as the United States has[16]—and the State Children's Health Insurance Program (SCHIP)—which insures a relatively large percentage of lower and middle-income children who are not covered by either Medicaid or private insurance.[17] Yet in all other first-world countries, social solidarity with respect to health care—the belief that bad health is predominantly outside an individual's control and thus the cost should be shouldered by society—makes health care a fully integrated value available to all citizens (and indeed non-citizens).[18]

The highly skewed nature of health care costs, where a small percentage of the general population accounts for a disproportionately high percentage of costs,[19] further exacerbates the access-financing problem. Insuring large groups has generally been the solution to the skewing problem. Large group insurance smoothes out the costs of unexpected health risks which, in countries like the United States with ever-increasing costs of medical technology,[20] are high. Fee-for-service Medicare is the single best U.S. example of social insurance, as the federal government is the only payer and the cost of use is delinked from the cost of contribution.[21] Thus, why not expand the social principles of Medicare to everyone? In a country that prides itself on equality of opportunity, why is there so little equality when it

16. Charles Katzenberg, *Medicare System Offers Model for Health Reform*, ARIZ. DAILY STAR, June 9, 2009, *available at* http://www.azstarnet.com/sn/related/296194.

17. CONG. BUDGET OFFICE, THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM 5 (2007), *available at* http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf.

18. "Political sociologists have long analyzed why social solidarity and the welfare state have been weaker in the United States than in continental Europe . . . ." Schwartz, *supra* note 15, at 137. In the United States, "even our social insurance programs are couched as individually earned benefits with no redistributive elements." *Id.* at 138. *See also* Posting of Uwe E. Reinhardt to New York Times Economix, http://economix.blogs.nytimes.com/tag/principle-of-social-solidarity/ (Apr. 17, 2009, 7:02 EST) (identifying social solidarity as crucial to the German health care system).

19. This is often referred to as the "80-20 rule." *See "47 Million and Counting: Why the Health Care Marketplace is Broken:" Hearing Before the S. Comm. on Finance,* 110th Cong. 4 (2008) (statement of Mark A. Hall, J.D., Wake Forest Univ.), *available at* http://finance.senate.gov/hearings/testimony/2008test/061008MHTest.pdf.

20. *See* Chana Joffe-Walt, *A Medical Mystery: Why Health Care Is So Expensive*, NPR, Sept. 4, 2009, http://www.npr.org/templates/story/story.php?storyId=112522353 (examining why a single arterial stent costs $2000).

21. *See* Katzenberg, *supra* note 16.

comes to healthcare? Why does the value of equality of opportunity not translate into social solidarity?

This Article seeks answers to these questions. Risking the label of socialist,[22] I posit that the most cost-effective, efficacious, and efficient solution to the health care mess[23] that the United States is in is universal single-payer reform with the federal government as that payer. The probability of the United States adopting single-payer health care reform, notwithstanding the real likelihood that a single-payer system may offer the lowest cost solution, is concededly unlikely.[24] The reasons for my conclusion, while certainly historical and political, are even more so cultural and economic. If eighty-five percent of Americans currently have health insurance and access to health care,[25] what are the incentives to provide the same for the remaining fifteen percent who have been left outside of the system?

Part I examines the United States' current climate as it affects health care reform. In Part II, this Article scrutinizes recent state health care reform legislation, specifically in California and Massachusetts. Part III evaluates current national reform efforts, while Part IV argues that though the barriers to implementing single-payer health insurance may be insurmountable at this time, it is the best answer to our health care crisis.

I. The National Climate for Reform

Since President Clinton's unsuccessful attempt to bring everyone into a national health care system fifteen years ago, there have been virtually no federal attempts to create access for all Americans. The health care picture at the end of 2009 is significantly worse than it was in 1994,[26] the year that Clinton's

22. Mayor Giuliani criticized Senator Clinton's health reform plan as the "Clinton-Moore" plan after filmmaker Michael Moore, while Governor Romney branded the plan "European socialism." Richard Wolf, *Clinton Health Plan Calls for Mandatory Coverage*, USA TODAY, Sept. 18, 2007, at 5A.

23. *See* JULIUS B. RICHMOND & RASHI FEIN, THE HEALTH CARE MESS: HOW WE GOT INTO IT AND WHAT IT WILL TAKE TO GET OUT (2005) (describing the current health care predicament and potential solutions).

24. Lawrence R. Jacobs, *1994 All Over Again? Public Opinion and Health Care*, 358 NEW ENG. J. MED. 1881, 1881–83 (2008).

25. CARMEN DENAVAS-WALT ET AL., INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2008 27 (2009), *available at* http://www.census.gov/prod/2009pubs/p60-236.pdf.

26. "Personal health expenditures in the U.S. totaled over $782 billion in 1993, more than triple the total in 1980," and about one-third of the 2007 cost of $2.2 trillion. National Center for Health Statistics, Monitoring Health Care in America,

Health Security Act (HSA) failed.[27] In addition to the general malaise of the Bush administration and the concurrent Congress to effectuate reform at the federal level, political and policy momentum seems to be driven by the apparent success of private markets in other sectors.[28] The state-led reform movements, as well as the presidential candidates' health reform proposals, rely heavily on the status quo of multiple payers competing in an employer-sponsored health insurance (ESI) environment.[29] Employers, who in earlier and less expensive times were satisfied with ESI because of its federal tax subsidy,[30] have grown more dissatisfied as their costs for health care have risen dramatically.[31] Employers' continuous attempts to escape the financial burden of providing health insurance to their employees exacerbate the growth of the uninsured population.[32] Until a good alternative exists, however, dismantling the private system that still keeps at least sixty percent of Americans insured would be unwise.[33]

Quarterly Fact Sheet, September 1995, http://www.cdc.gov/nchs/pressroom/95facts/fs_qtr99.htm (last visited Nov. 16, 2009); *see* KAISER FAMILY FOUNDATION, TRENDS IN HEALTH CARE COSTS AND SPENDING 1 (2007), *available at* http://www.kff.org/insurance/upload/7692.pdf.

27. Jonathan Oberlander, *Learning from Failure in Health Care Reform*, 357 NEW ENG. J. MED. 1677, 1677 (2007).

28. Matt Ryan, Workers' Compensation Reform Shows Power of Privatization, http://westvirginiapolicy.com/Columns/Workers.pdf (last visited Nov. 16, 2009) (commenting on how the privatization of workers' compensation succeeded in West Virgina).

29. *See generally* LEWIN GROUP, MCCAIN AND OBAMA HEALTH CARE POLICIES: COST AND COVERAGE COMPARED (2008), *available at* http://www.lewin.com/content/publications/TheLewinGroupMcCain-ObamaHealthReformAnalysisRev10-15-08.pdf (comparing the health plans of the presidential candidates). Both Massachusetts' health reform and President Obama's plan reach universal insurance by continuing the use of the private insurance market and the already existing employer-subsidized health insurance. The Obama plan calls for the creation of "a 'National Exchange,' offering a selection of private health insurance options comparable to those now offered to members of Congress and federal workers." *Id.* at ES-2. The Lewin Group estimates that the number of people with ESI would increase by 4.7 million under the Obama health plan, primarily due to the requirement for medium and large employers to contribute to the cost of worker coverage. *Id. See infra* Part II.

30. John Sheils & Randall Haught, *The Cost of Tax-Exempt Health Benefits in 2004*, 23 HEALTH AFF. w4-106, w4-106, Feb. 25, 2004, http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1.

31. NAT'L COAL. ON HEALTH CARE, *supra* note 9, at 1–2.

32. ELLEN MONTZ ET. AL., INSURANCE INSECURITY: FAMILIES ARE LOSING EMPLOYER-SPONSORED INSURANCE COVERAGE 1, (2009) *available at* http://www.healthreform.gov/reports/insurance/insuranceinsecuritypdf.pdf.

33. CTR. ON BUDGET AND POLICY PRIORITIES, THE NUMBER OF UNINSURED AMERICANS IS AT AN ALL-TIME HIGH 3 (2006), *available at* http://www.cbpp.org/files/8-29-06health.pdf.

Even in the waning days of the Bush administration, in the interregnum before President Obama took office, there was a stirring of interest in a federal solution to the clear failure of the current health care system. The first indication something was afoot was the late Senator Ted Kennedy's caucus with other legislators interested in health care reform.[34] The senator, who was gravely ill, gave up his post on the powerful Senate Judiciary Committee to focus on reforming health care "to guarantee affordable health care, at long last, for every American."[35] In addition, Senator Max Baucus,[36] the chair of the Senate Finance Committee, issued a white paper on health care reform that called for Congress to "act on meaningful health reform legislation that achieves coverage for every American while also addressing the underlying problems in our health system."[37] In 2009, President Obama made health reform a clear priority for his administration. The President stated that "health costs are forcing small businesses to lay off employees or close their doors . . . creat[ing] a disadvantage for a U.S. auto industry competing against foreign competitors 'unburdened by these costs.'"[38] President Obama made these comments in advance of U.S. businesses shedding jobs by the hundreds of thousands.[39]

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34. Before his death, Senator Edward M. Kennedy (D-MA), had been quietly orchestrating "meetings with lobbyists and lawmakers from both parties to craft legislation that would . . . provide affordable medical coverage to all Americans." His goal was universal coverage. Jeffrey H. Birnbaum, *Kennedy Secretly Crafts Health Care Plan*, WASH. TIMES, Oct. 24, 2008, http://www.washingtontimes.com/news/2008/oct/24/kennedy-secretly-crafts-health-care-plan/. "[T]his is the cause of my life—new hope that we will break the old gridlock and guarantee that every American—North, South, East, West, young, old—will have decent, quality health care as a fundamental right and not a privilege." Senator Ted Kennedy, The Dream Lives On, Address at the Democratic National Convention (Aug. 5, 2008), *in* NEWSWEEK, Aug. 27, 2009, *available at* http://www.newsweek.com/id/213874/page/1.

35. "Kennedy, who also chair[ed] the Senate's Health Committee said that he was . . . tak[ing] advantage of a rare and important opportunity to get 47 million uninsured Americans covered." Posting of Jonathan D. Rockoff to Wall Street Journal Health Blog, http://blogs.wsj.com/health/2008/12/08/ted-kennedy-drops-judiciary-post-to-focus-on-health-reform/ (Dec. 8, 2008, 10:41 EST).

36. Max Baucus has represented Montana in the United States Senate since 1978. Baucus, Max Sieben, Biographical Directory of the United States Congress, http://bioguide.congress.gov/scripts/biodisplay.pl?index=B000243 (last visited Dec. 3, 2009).

37. Max BAUCUS, CALL TO ACTION: HEALTH REFORM 2009 2 (2008), *available at* http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf.

38. Posting of Sarah Rubenstein to Wall Street Journal Health Blog, http://blogs.wsj.com/health/2008/12/11/in-naming-daschle-for-hhs-obama-pushes-health-reform/ (Dec. 11, 2008, 1:41 EST) (summarizing the President's comments).

39. In December 2008 alone, "[t]he nation's employers shed 524,000 jobs." Job Losses in 2008, http://www.nytimes.com/interactive/2009/01/09/business/

President Obama also indicated his serious intentions regarding health care reform by naming former Senate majority leader Tom Daschle as Secretary of the Department of Health and Human Services (HHS).[40] Senator Daschle was also to "get a second charge overseeing a new White House Office of Health Reform."[41] The Obama administration planned for the deputy director of the new office to be Jeanne Lambrew,[42] who co-authored Senator Daschle's recent book about health care reform[43] and was a senior fellow at the think tank Center for American Progress.[44] All of the above activity indicates that President Obama is serious about health care reform at the federal level and, in spite of the state of the economy, has begun striving toward universal access to affordable, high-quality health care.[45]

This activity is a profound change from the previous administration's subscription to President Reagan's belief that "government is not the solution to our problem" but rather part of the problem.[46] During an attempt by Congress to expand SCHIP, former President Bush said it was unnecessary because emergency

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20080109_jobs_graphic.html (last visited Sept. 25, 2009).

40. Rubenstein, *supra* note 38.

41. Posting of Sarah Rubenstein to Wall Street Journal Health Blog, http://blogs.wsj.com/health/2008/12/11/besides-hhs-daschle-to-oversee-health-reform-office/ (Dec. 11, 2008, 8:44 EST).

42. Jeanne Lambrew, a former senior fellow at the Center for American Progress, focuses her research on the uninsured, Medicaid, Medicare, and long-term care. She worked on health policy in the Clinton White House and, among other things, focused on SCHIP. *Id.* She currently holds the position of Director of the Health and Human Services Office of Health Reform. Press Release, Dep't of Health and Human Servs., Secretary Sebelius Announces HHS Office of Health Reform Personnel, (May 11, 2009), *available at* http://www.hhs.gov/news/press/2009pres/05/20090511a.html.

43. *See generally* TOM DASCHLE ET AL., CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH-CARE CRISIS (2008) (offering solutions for health care reform).

44. Rubenstein, *supra* note 41. Although Lambrew was initially selected to work as deputy to Daschle in the White House Office of Health Reform, after Daschle withdrew as nominee Lambrew ended up at the Health Reform Office within the U.S. Department of Health and Human Services. Profiles: Jeanne Lambrew, http://www.whorunsgov.com/Profiles/Jeanne_Lambrew (last visited Sept. 24, 2009).

45. President Obama intended to move toward universal coverage by building on ESI with an employer pay-or-play mandate, an expansion of Medicaid and SCHIP, and a choice of competitive private or public plans. Salynn Boyles, *Obama Wins: What it Means for Health Care*, WEBMD, Nov. 5, 2008, http://www.webmd.com/news/20081104/obama-wins-what-it-means-for-health-care?page=2.

46. Ronald Reagan, President of the United States, First Inaugural Address (Jan. 20, 1981), *in* INAUGURAL ADDRESSES OF THE PRESIDENTS OF THE UNITED STATES 332 (U.S. Govt. Printing Office, 1989).

rooms are always available to sick children who do not have health insurance.[47] President Bush continued:

> [Congress is] going to increase the number of folks eligible through SCHIP; some want to lower the age for Medicare. And then all of a sudden, you begin to see a—I wouldn't call it a plot, just a strategy—to get more people to be a part of the federalization of health care.[48]

Paul Krugman, Princeton economist and recent recipient of the Nobel Prize in Economics, explained President Bush's rationale for his veto of the bipartisan SCHIP expansion—if government can be successful at expanding health care access, Americans will be more easily persuaded that government indeed can be the answer.[49] Since the Bush administration was opposed to the federal government as the answer to social issues, President Bush's veto of SCHIP expansion was quite predictable.

II. States' Solutions to Universal Coverage

Before considering the future of federal plans for universal health coverage, it is illuminating to examine some of the states' efforts at health care reform. The popular wisdom has, for some time, been that solutions to health care access, funding, and cost containment were more likely to occur in the so-called "laboratories" of the states.[50] With a dearth of federal solutions to the problems created by the uninsured and underinsured, states have stepped into the vacuum with proposals for insuring more of their citizens. Much of the burden of providing for the uninsured falls on states, which often end up being the payers of last resort for a population that is more costly to treat than the insured.[51] States should be incentivized to create new solutions,[52] and

47. President Bush twice vetoed the expanded legislation. Paul Krugman, *An Immoral Philosophy*, N.Y. TIMES, July 30, 2007, at A17.

48. *Id.*

49. *Id.*

50. IND. EMPLOYERS QUALITY HEALTH ALLIANCE, UNDERSTANDING AND RESPONDING TO THE HEALTH CARE CRISIS 14 (2006), *available at* http://www.qualityhealthalliance.org/files/Health_Care_Crisis_White_Paper_02-21-06_.pdf.

51. The Institute of Medicine of the National Academy of Science has published six reports since 2003 on the effects of uninsurance on personal health, families, and communities. *See* Institute of Medicine of the National Academies Reports Index, http://www.iom.edu/en/Reports.aspx (last visited Nov. 21, 2009).

52. Approximately forty-six percent of the uninsured "reside in just five states—California, Texas, New York, Florida and Illinois—which represent 36.5% of the nation's population." Lisa Dubay et. al., *Advancing Toward Universal Coverage: Are States Able to Take the Lead?*, 7 J. HEALTH CARE L. & POL'Y 1, 18–19 (2004).

indeed, some appear to be. The newest iteration of universal health insurance, the so-called "individual mandate," is the basis for health care reform in both Massachusetts and California.[53] These programs seek to ensure that everyone will have access to health insurance, the financing of which will be the shared responsibility of individuals and employers, as well as state and federal government. In California, health care providers were also expected to contribute quid pro quo for higher Medi-Cal reimbursement.[54] Each individual is required to obtain and pay for insurance.[55] Low-income individuals in both Massachusetts and California can receive premium subsidies to make purchasing health insurance policies feasible.[56] Both states plan to modify their Medicaid programs to provide expanded coverage for low-income children and adults.[57]

Ironically, the success of the existing health insurance paradigm—the partnership between the private sector and public health insurance programs such as Medicare and Medicaid that insures some eighty-five percent of the population—acts as a barrier to health care reform. Unless the United States is prepared to spend more of its GDP to insure currently uninsured populations, the insured population will inevitably have to give up something to cover the uninsured. "The primary political and policy problems are that it is almost impossible to insure the 'have-

53. Merrill Matthews, *Is Romney's Healthcare Plan Conservative?*, COUNCIL FOR AFFORDABLE HEALTH INS., Dec. 27, 2007, http://www.cahi.org/article.asp?id=915. California's health reform proposal, ABX1 1, which incorporated individual mandates and was supported by Gov. Schwarzenegger, Speaker Fabian Nunez, and Senate President Pro Tempore Don Perata, was defeated in early 2008. *Proponents of Defeated Health Reform Bill Remain Steadfast*, CAL. HEALTHLINE, Jan. 30, 2008, http://www.californiahealthline.org/Articles/2008/1/30/Proponents-of-Defeated-Health-Reform-Bill-Remain-Steadfast.aspx [hereinafter *Proponents Steadfast*]. See *infra* notes 226–238 and accompanying text for a description of the defeat of the California legislation.

54. Rick Curtis & Ed Neuschler, *Designing Health Insurance Market Constructs for Shared Responsibility: Insights from California*, 28 HEALTH AFF. w431, w441, Mar. 24, 2009, http://content.healthaffairs.org/cgi/content/abstract/28/3/w431.

55. KAISER COMM. ON MEDICAID AND THE UNINSURED, KEY FACTS: MASSACHUSETTS HEALTH CARE REFORM PLAN: AN UPDATE 1 (2007), *available at* http://www.grassrootsnetroots.org/materials/kaiserMA.pdf (describing the Massachusetts health plan) [hereinafter KAISER COMM.]; *Proponents Steadfast*, *supra* note 53.

56. KAISER COMM., *supra* note 55, at 1; Curtis & Neuschler, *supra* note 54, at 436.

57. KAISER COMM., *supra* note 55, at 1; Marian R. Mulkey & Mark D. Smith, *The Long and Winding Road: Reflections on California's 'Year of Health Reform,'* 28 HEALTH AFF. w446, w446, Mar. 24, 2009, http://content.healthaffairs.org/cgi/content/abstract/28/3/w446.

nots' without in some way disrupting the status quo of the 'haves.'"[58] With redistribution always a hard sell and the perception by the "insured haves" that universal health insurance will make them worse off, the probability of explicit social solidarity or cross-subsidization seems dim.

To avoid resistance from the currently insured, neither Massachusetts' plan nor California Governor Schwarzenegger's individual mandate plan seeks to supplant or supersede the private or public programs already in place that insure the lion's share of their populations.[59] The model with respect to almost all reform plans is to leave the status quo alone, make incremental adjustments to already existing programs such as Medicaid and SCHIP in order to be more inclusive, and then add programs in order to cover those who remain uninsured.[60] For example, the federal tax advantage that has traditionally been available to employers who offer and then subsidize their employees' health insurance remains intact, and is further incentivized by a possible employer mandate to either pay or play.[61] In this round of health

58. Judith Feder & Donald W. Moran, *Cost Containment and the Politics of Health Care Reform*, *in* RESTORING FISCAL SANITY 2007: THE HEALTH SPENDING CHALLENGE 176 (Alice M. Rivlin & Joseph R. Antos eds., 2007).

59. *See* STATE COVERAGE INITIATIVES, STATE OF THE STATES, CHARTING A COURSE: PREPARING FOR THE FUTURE, LEARNING FROM THE PAST 21 (2009), *available at* http://www.idph.state.ia.us/hcr_committees/common/pdf/prevention_chronic_care_mgmt/states_report_2009.pdf.

60. *See id.* John McCain's health reform plan was an exception to the ESI status quo paradigm. *See* David Blumenthal, *Primum Non Nocere—The McCain Plan for Health Insecurity*, 359 NEW ENG. J. MED. 1645, 1646–47 (2008). Senator McCain's health reform plan consisted of dismantling tax-subsidized ESI and using the tax savings to give each individual a $2500 tax credit and each family a $5000 tax credit with which to shop around and purchase any preferred and affordable health insurance policy. *Id.* at 46. Senator McCain touted his plan as giving Americans freedom of choice and the financial wherewithal to purchase individual policies that are designed to meet their health care needs. The plan was flawed for a number of reasons, not the least of which is that the average family health insurance policy costs about $12,000 to which the average employer contributes seventy-five percent. *Id.* Senator McCain's plan would have created a much larger liability for many Americans, potentially causing them to forego health insurance and increasing the rolls of the uninsured. *Id.* at 45–47.

61. Stephen Morrissey et al., *Health of the Nation—Coverage for All Americans*, 359 NEW ENG. J. MED. 855, 855 (2008). In Massachusetts, the penalty for failing to play is $295 per employee. DAVID A. HYMAN, THE MASSACHUSETTS HEALTH PLAN: THE GOOD, THE BAD, AND THE UGLY 2 (2007), *available at* http://www.cato.org/pub_display.php?pub_id=8431. Governor Schwarzenegger's plan calls for an employer mandate of four percent of payroll. CalHealthReform.org, Summary of the Proposal's Features: ABX1 2: Governor Schwarzenegger's Plan, http://www.calhealthreform.org/content/view/25/32/ (last visited Nov. 22, 2009). The more aggressive pay-or-play state health insurance reform legislation, AB 8, ups the employer mandate ante to 7.5%. CalHealthReform.org, Summary of the Proposal's Features: AB 8: "Health Care

care reform, neither the states nor the federal government have heeded the argument that it is not smart, fair, or efficient for corporate America to subsidize the cost of health care.[62]

Whether states can succeed in improving health care access and health status remains an open question. On a bright note, according to a poll conducted by the Kaiser Family Foundation, the Harvard School of Public Health, and Blue Cross Blue Shield, the Massachusetts Health Care Reform, implemented on July 1, 2007, seems to be gaining approval with state residents.[63] Of the 1003 Massachusetts residents polled, sixty-seven percent of state residents who have heard of the law support it.[64] Interestingly, ninety percent of supporters believe "it is the right thing to do" and that broader coverage will ultimately keep costs down by providing more incentives for preventive care.[65] It seems worth the effort to analyze why the Massachusetts plan currently has resident approval. How does the fairly broad agreement among Massachusetts residents that providing health care to everyone is "the right thing to do" coincide with the fact that redistributive social solidarity has traditionally been a non-starter in the United States?

Is there something unique about Massachusetts that drives this result, or can the Massachusetts experience be recreated in other venues? What accounts for the positive feedback on the individual mandate health insurance legislation? First, Massachusetts has always been known as a progressive state, accustomed to both unusually high taxes to fund programs for the

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Coverage," http://www.calhealthreform.org/content/view/26/27/ (last visited Oct. 8, 2009).

62. *See generally* ROBERT B. REICH, SUPERCAPITALISM: THE TRANSFORMATION OF BUSINESS, DEMOCRACY, AND EVERYDAY LIFE (2007) (arguing that one of the solutions to the United States' current problems is to separate capitalism from democracy to help stem the growing inequalities and shrinking safety nets facing U.S. citizens). Secretary Hillary Clinton, who has scars from her last go-around with health care reform and knows well the pitfalls of threatening the interests of the vested insured population, endorsed a federal version of the individual-employer mandates, an expansion of the existing Medicaid and SCHIP programs, and subsidies for those who are neither covered by public programs nor can afford private insurance. Laura Meckler, *Why Clinton Embraced Employer-Based Insurance,* WALL ST. J., Sept. 19, 2007, at A12.

63. Press Release, Harvard Sch. of Pub. Health, Poll Finds Most Mass. Residents Support New Health Reform Law, Including Individual Mandate, as Initial Deadline Nears (Jun. 27, 2007), *available at* http://www.hsph.harvard.edu/news/press-releases/2007-releases/press06272007.html.

64. *Id.*

65. *Id.*

poor and underserved,[66] as well as what many perceive as overregulation of health insurance by the state.[67] For example, as of 2007, Massachusetts' uninsured population was 7.9% of the total population, compared with 18.5% in California and 15.3% in the United States as a whole.[68] Second, the individual mandate model for universal health insurance is much less traditionally progressive than a single-payer universal health insurance model.[69] A Republican governor designed and supported the model,[70] and it is not regarded by most as typical liberal Massachusetts legislation. As Stuart Altman, current dean of the Heller School of Social Policy and Management at Brandeis University and well-respected health care guru, states, it "is not a typical Massachusetts-Taxachusetts, oh-just-crazy-liberal plan . . . . It is a pretty moderate approach, and that's what's impressive about it. It tried to borrow and blend a lot of different pieces."[71] However, individuals from both sides of the political aisle have criticized the plan, and its success still remains to be seen.[72] Third, Massachusetts is a relatively small state with a population of approximately 6,434,343, of whom ten percent, or 650,000 people, were estimated to be uninsured prior to the effective date of the Massachusetts Health Care Reform Plan.[73] California, another state considering universal health insurance through the individual mandate model, has a population of 36,398,000, of whom 18.5%, or 6,742,000, were uninsured as of

66. *Cf.* John E. McDonough et al., *The Third Wave of Massachusetts Health Care Access Reform*, 25 HEALTH AFF. w420, w421, Sept. 14, 2006, http://content.healthaffairs.org/cgi/content/abstract/25/6/w420 (stating that Massachusetts has long had adequate health coverage for underinsured).

67. HYMAN, *supra* note 61, at 1, 8 (stating that Massachusetts seems to have health care overregulation in its DNA).

68. Health Insurance Coverage of the Total Population, States (2007-2008), U.S. (2008), http://www.statehealthfacts.org/comparebar.jsp ?typ=2&ind=125&cat=3&sub=39 (last visited Oct. 8, 2009).

69. *See* MICHAEL TANNER, INDIVIDUAL MANDATES FOR HEALTH INSURANCE: SLIPPERY SLOPE TO NATIONAL HEALTH CARE 1, 2 (2006), *available at* http://www.cato.org/pubs/pas/pa565.pdf.

70. Mitt Romney left the Massachusetts' governor's office and was a leading candidate for the Republican presidential nomination in the 2008 elections. His national health reform agenda does not speak to universal health insurance or individual mandates. *See id.* at 2.

71. Pam Belluck, *Massachusetts Sets Health Plan for Nearly All*, N.Y. TIMES, Apr. 5, 2006, at A1.

72. *Id.*

73. *See* KAISER FAMILY FOUND., MASSACHUSETTS HEALTH CARE REFORM: THREE YEARS LATER 1 (2009), *available at* http://www.kff.org/uninsured/upload/7777-02.pdf; U.S. Census Bureau—Population Finder, http://factfinder.census.gov/ servlet/SAFFPopulation?_submenuId=population_0&_sse=on (follow "alphabetic" hyperlink).

2008.[74] Fourth, Massachusetts' population is significantly less diverse than California's,[75] and social solidarity may perhaps be more directly correlated with demographic homogeneity than heterogeneity—the logic being that the greater the identification with others, the more likely one would be willing to help those not as fortunate. This homogeneity may well be one of the reasons why the social welfare state has arguably succeeded best in the societies of Western Europe and Japan.

The Massachusetts and California models count heavily on three basic, yet critical, elements: an individual mandate, an employer mandate, and health insurance policies that are affordable to those who neither qualify for public insurance—such as Medicare, Medicaid, or SCHIP—nor have coverage through private insurance.[76] Each of these elements has its own difficulties. The individual mandate theoretically ensures universal coverage, in that all state residents will have health insurance to enable them to seek care preventively so that disease can be treated less expensively in the early stages rather than when it has developed into an emergency condition. The employer mandate, which California has expanded to include providers, is a pay-or-play option that requires certain employers to either offer health insurance to their employees, or pay a percentage of their payroll toward the cost of employees' health coverage.[77] Both California and Massachusetts maintain a state purchasing pool through which residents without private or public coverage can obtain health insurance and receive sliding scale subsidies if eligibility requirements are met.[78]

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74. *See* U.S. Census Bureau—Health Insurance, http://www.census.gov/hhes/www/hlthins/hlthin08/hlthtables08.html (follow "Number and Percentage of People Without Health Insurance Coverage" hyperlink) (last visited Oct. 8, 2009).

75. *E.g.*, U.S. Census Bureau—Race and Hispanic Origin in 2005, http://www.census.gov/population/www/pop-profile/files/dynamic/RACEHO.pdf (last visited Oct. 8, 2009) (showing percentage distributions of various ethnic and racial groups in the United States).

76. *See* HYMAN, *supra* note 61, at 2; ANTHONY WRIGHT, MASSACHUSETTS' HEALTH CARE LAW: MODEL, MIRAGE, OR MOMENTUM? 1, 6 (2006), *available at* http://www.newamerica.net/files/MassCalHAFReportFinal.pdf.

77. In California, the employer mandate applies to employers with ten or more employees; in Massachusetts, it applies to employers who have eleven or more employees. In both cases, it applies to employers who choose not to offer insurance options to their employees and make a fair and reasonable contribution to the cost of such insurance. *See* WRIGHT, *supra* note 76, at 6 (stating that California would fine employers of ten or more employees who do not provide health care); HYMAN, *supra* note 61, at 2 (stating that Massachusetts requires employers with eleven or more employees to provide health care).

78. In California, the proposed minimum health insurance benefit that must be maintained was a $5000 deductible plan with maximum out-of-pocket limits of

Even though Massachusetts is the first state to achieve near-universal coverage, there are a number of criticisms of the health reform plan from both sides of the political aisle. One politically neutral observation is the risk of federal preemption of the pay-or-play provision in both plans. If courts interpret the Employee Retirement Income Security Act (ERISA) as they have in the past, it will bar states from regulating the health benefits of employers who self-fund their health plans.[79] To date, Hawaii is the only state with an employer-mandate that is protected from ERISA preemption by a Congressional exemption.[80] Attempts to amend ERISA to permit an employer mandate have been unsuccessful.

Criticisms of the Massachusetts reform from conservatives include inaccurate pricing resulting in an inadequate budget: Massachusetts budgeted $1.4 billion annually for three years and no amount for the fourth year.[81] Massachusetts believed that most of the money would come from diverting old funding such as federal Medicaid payments previously earmarked for safety net

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$7500 per person and $10,000 per family. *E.g.*, CA. GOVERNOR'S OFFICE, GOVERNOR'S HEALTH CARE PROPOSAL, 1, 6 (2007), *available at* http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf. In Massachusetts, uninsured residents purchase health insurance through the Commonwealth Health Insurance Connector, a panel of ten state residents drawn from business, labor, academia, and state government, which is charged with making difficult decisions such as what low-income families can afford for health care. Laura Meckler, *How 10 People Reshaped Massachusetts Health Care—The 'Connector' Board Makes Tough Choices for Sweeping New Law*, WALL ST. J., May 30, 2007, at A1.

79. Those employers who self-insure are protected from state regulation by ERISA's "deemer clause" and do not fall within any of the ERISA saving clauses (exceptions) that would subject them to state regulation. FMC Corp. v. Holliday, 498 U.S. 52, 61 (1990). The Supreme Court explained the relationship between the two clauses:

> [S]elf-funded ERISA plans are exempt from state regulation insofar as that regulation "relate[s] to" the plans. State laws directed toward the plans are pre-empted because they relate to an employee benefit plan but are not "saved" because they do not regulate insurance. State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws.

Id. However, on September 30, 2008, a three-member panel of judges of the Ninth Circuit Court of Appeals upheld the San Francisco Health Care Security Ordinance requiring certain covered employers to either make payments into their own retirement plans for their covered employees or, alternatively, to make payments to the city for the benefit of their covered employees. Golden Gate Rest. Ass'n v. City & County of S.F., 512 F.3d 1112, 1118 (9th Cir. 2008).

80. Employee Retirement Income Security Act, 29 U.S.C. § 1144(b)(5)(A) (2006). Notwithstanding the employer mandate, Hawaii continues to have a ten percent uninsurance rate. HYMAN, *supra* note 61, at 5.

81. *See* McDonough et al., *supra* note 66, at w427.

providers.[82] Governor Schwarzenegger, on the other hand, received a substantial commitment from the federal government for the increase in cost to California's Medicaid program, the expansion of which is a critical piece of the governor's plan to cover the uninsured.[83] In addition, there are the expected criticisms regarding governmental overregulation[84] and the slippery slope from individual mandates toward national health care.[85]

There are criticisms from the left side of the political spectrum as well. The most cogent criticism is that the insurance products available to uninsured populations are sub-par and exclude lower income individuals who simply cannot afford the comprehensive private plans that both Massachusetts and California promise.[86] "[T]hat's like promising chocolate chip cookies with no fat, sugar or calories. The only way to get cheaper plans is to strip down the coverage—boost copayments, deductibles, uncovered services etc."[87] A second criticism is that the individual mandate is administratively expensive as compared with single-payer systems.[88] Related to the issue of administrative costs is a third problem endemic to the world of private insurance, even mandated private insurance. For-profit insurers are incentivized—and in the case of publicly-held companies, are required—to be profitable for their shareholders. This natural profit motive creates a bias favoring relatively low medical loss ratio—defined as the percentage of the insurance premium dollar spent on member health care versus administration and profit.[89] A single-payer universal health care system would not be profit-oriented, and therefore would be biased in favor of high medical loss ratios so that the vast majority of the budget would be

82. *Id.* at w426.

83. *See* Judy Lin, *Health Plan Gets Federal Boost: Funds Spike Pledged in Bid to Help the State's Uninsured*, SACRAMENTO BEE, Mar. 15, 2007, at A3.

84. *See generally* HYMAN, *supra* note 61 (giving general criticisms of the reform, including overregulation).

85. *See generally* TANNER, *supra* note 69 (arguing that an individual mandate crosses an important line, leading the country down a destructive path towards government-run health care).

86. Steffie Woolhandler & David U. Himmelstein, *Massachusetts Health Reform Bill: A False Promise of Universal Coverage*, LIBERATION HEALTH GROUP, 1–2, http://liberationhealth.org/documents/HimmelsteinWoolhandlerHealthReformCommentary_.pdf (last visited Nov. 22, 2009).

87. *Id.* at 2.

88. *Id.*

89. *Medical Loss Ratio*, WASH. POST Apr. 30, 2006, http://www.washingtonpost.com/wpdyn/content/article/2006/04/29/AR2006042900256.html (defining medical loss ratio).

dedicated to health care costs instead of administrative costs.[90] Medicare, a single-payer system that pays for health care for the elderly, has administrative costs of about two percent, a fact that proponents of single-payer systems raise frequently in defense of that model.[91]

III. Federal Health Insurance Initiatives: Can We Get to Universal Coverage?

Notwithstanding credible evidence that a single-payer model could produce a more equitable and more efficient health care system, its absence is notable in the morass of health care plans currently being advanced by the states. The absence of the single-payer model in the health care platforms of the 2008 presidential candidates[92] clearly reflects the political barriers to such a wholesale change in health care policy.[93] Even a single-payer system that would be more universal, equitable, efficient, and

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90. In California, John Garamendi, former California insurance commissioner and current lieutenant governor, testified in favor of state regulations requiring higher medical loss ratios of private health insurers. While California law currently limits a plan's overhead costs to fifteen percent of premiums, it is not explicit about whether profits fall into that fifteen percent. *See* John Carroll, *Proposal Would Limit Profit of Some California Plans*, MANAGED CARE MAG., July 2006, *available at* http://www.managedcaremag.com/archives/0607/0607.regulation.html.

91. A recent study by the Council for Affordable Health Insurance found that the size of Medicare hides some of its administrative costs: taking those hidden costs into consideration raises the administrative costs of the program to approximately 5.2%. MERRILL MATTHEWS, MEDICARE'S HIDDEN ADMINISTRATIVE COSTS: A COMPARISON OF MEDICARE AND THE PRIVATE SECTOR 7 (2006), *available at* http://www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf.

92. *See* Hillary Clinton for President, The American Health Choices Plan: Ensuring Affordable, Quality, Health Care for All Americans, http://www.ahia.net/about/documents/0709americanhealthchoicesplan.pdf (last visited Oct. 8, 2009) [hereinafter Clinton's Plan]. In California, Democratic Senator Sheila Kuehl sponsored single-payer health care legislation, S.B. 840, which required both individuals and employers, à la Social Security and Medicare, to contribute toward funding of health care. The state insurance fund would cover a standard benefits package for all Californians; in addition, Californians would have access to a supplemental insurance private market. CalHealthReform.org, Coverage Expansion, SB 840 http://www.chcf.org/topics/healthinsurance/coverageexpansion/index.cfm?itemID=119939 (last visited Nov. 23, 2009). See *infra* notes 226–238 and accompanying text for a history of S.B. 840.

93. Having experienced the defeat of the HSA in 1994, of which she was one of the chief architects, then-senator Hillary Clinton understood the political resistance to wholesale change. Senator Clinton's universal health care proposal, like those of President Obama and former Senator John Edwards, built on the existing health care system by expanding it to provide health care coverage to the 47 million Americans who do not already have coverage. Clinton's Plan, *supra* note 92.

perhaps less expensive than any other model, is a political non-starter. As early as September 2007, such diverse groups as political candidates, congressional members, and the Bush administration were beginning to raise the specter of socialized medicine whenever there was talk of increasing the federal government's role in paying for health care.[94]

Agreement as to the need for universal coverage has not produced agreement regarding the means. There does, however, seem to be a consensus that the vehicle will not be universal health insurance provided by a single payer, the federal government. Republicans generally subscribe to the private market as the solution. There are many who would not dismantle the employer-subsidized private market but would instead ramp up the choice of health savings accounts and high deductible catastrophic coverage policies for employees and individuals.[95] Most of the proponents of private market solutions recognize the need for—and indeed the value of—premium assistance, either in the form of subsidies or tax credits, for the working poor who are not eligible for public assistance but can ill afford private insurance, particularly in the individual market.

For Democrats and moderate Republicans willing to concede that the private market has not provided all the answers, the prevailing reform model does not dismantle the current employer subsidy system or existing public programs. Instead, it attempts to close the gaps for the uninsured by expanding existing public coverage and making affordable insurance available to those who remain outside of the system through individual and employer mandates.[96] While acknowledging the drawbacks and problems with the current employer-based health insurance system, all 2008 presidential candidates chose not to dismantle it because of political expediency. As now-Secretary of State Hillary Clinton

94. Philip M. Boffey, *The Socialists Are Coming! The Socialists Are Coming!*, N.Y. TIMES, Sept. 28, 2007, at A28.

95. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which squeaked through Congress after much arm-twisting by the administration, would probably not have passed but for a provision that authorized health savings accounts in private plans as well as an option for Medicare beneficiaries. *See* Susan A. Channick, *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Will It Be Good Medicine for U.S. Health Policy?*, 14 ELDER L.J. 237, 245, 264 (2006). While health savings accounts may be an excellent option for the healthier, wealthier, and more informed health care consumer, such high-deductible insurance does not improve the situation for sicker, poorer populations who cannot afford a $5000 deductible any more than they can afford expensive premiums. *Id.* at 245.

96. *See* WRIGHT, *supra* note 76, at 6; HYMAN, *supra* note 61, at 2.

has said, one of the lessons she drew from the failure of the HSA "was that insured Americans get nervous if they think their coverage will have to change."[97] The trade-off for political buy-in to universal coverage may be keeping the current system intact so as to satisfy the approximately sixty percent of the population that has employer-based coverage.[98] As the cost of health care continues to outstrip the growth of the economy, thereby eroding the employer-based system,[99] satisfying the insured population will become less important politically, and other models may become more attractive. The challenge is understanding why resistance to a single-payer universal health care system is so great as to preclude it from consideration almost entirely until this shift occurs.

If the polls are correct and a majority of Americans believe that all Americans are entitled to access to health care,[100] then is not the obvious answer a single-payer universal health insurance system with the government as the single payer? Why retain the current system with employment as the primary pathway to health insurance in light of its diminishing success? The number of Americans insured by their employers has historically decreased, both because fewer employers are offering group health insurance as an employment benefit for cost reasons, and because increases in the employee share of cost has made employer-based health insurance unaffordable to many employees.[101] Will there ever come a point where the majority of Americans will prefer government-funded health insurance?

A. Hillarycare Redux

The popular wisdom has been that unless and until the middle-class population feels the pain of expensive and difficult-to-obtain health insurance, the status quo of employer-sponsored health insurance will be hard, if not impossible, to change. Whether or not that time has arrived, the conflict that insured Americans are wrestling with, at least when they are made aware of it, is between their desire to retain their vested insured status

97. Meckler, *supra* note 62, at A12.

98. *Id.*

99. *Id.*

100. Lydia Saad, *Americans Rate National and Personal Healthcare Differently*, GALLUP, Dec. 4, 2008, http://www.gallup.com/poll/112813/Americans-Rate-National-Personal-Healthcare-Differently.aspx.

101. U.S. GEN. ACCOUNTING OFFICE, EMPLOYMENT-BASED HEALTH INSURANCE: COSTS INCREASE AND FAMILY COVERAGE DECREASES 2–3 (1997), *available at* http://www.gao.gov/archive/1997/he97035.pdf.

and their belief, like the residents of Massachusetts, that broader coverage is the right thing to do.[102] In her quest to become the Democratic candidate in the 2008 presidential election, Secretary Clinton's health insurance proposal demonstrated her perfect understanding of this dilemma.[103] She knew, no doubt from past experience with health care reform, that insured Americans would resist changes that infringed on their insured status, even changes that reduced the costs of coverage. She thus attempted to provide universal coverage without disturbing the status quo. To a large extent, that is what both the Massachusetts and California individual mandates sought to do as well.[104]

Secretary Clinton's last experience with health reform, the HSA, which dissipated in 1994 under the heavy weight of disapproval from a myriad of sources, also sought to provide universal coverage using "managed competition."[105] This managed competition system would have supplanted, not supplemented, existing employer-based health insurance, requiring employers to contribute and virtually all Americans to be insured.[106] Employers with 5000 or more employees could opt out of the scheme and become their own insurers.[107] The HSA envisioned the use of health alliances run by the states as regional purchasing groups

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102. *See* Harvard Sch. of Pub. Health, *supra* note 63.

103. *See generally* Clinton's Plan, *supra* note 92 (describing Clinton's health insurance proposal).

104. Neither the Massachusetts nor the California individual mandates disturb employer-based insurance; instead both states have created pay-or-play employer mandates that require employers of more than ten employees to either provide health insurance to their employees or pay a percentage of payroll to a fund through which health insurance could be purchased. *See* WRIGHT, *supra* note 76, at 6; HYMAN, *supra* note 61, at 2.

105. Managed competition is a market-based strategy for restructuring the health care industry. BARRY R. FURROW ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 150–53 (5th ed. 2004). It attempts to organize the market for health care finance to make health insurers, managed care plans, and health plans compete with each other for beneficiary enrollment. *Id.* Managed competition usually requires health plans to sell a uniform product or a manageable number of standardized products to permit price and quality comparisons. *Id.* Because of the likelihood that health plans will select enrollees who are better risks, explicit risk selection is expressly forbidden and open enrollment and community rating are required. *Id.* Medicare Part C, also known as Medicare Advantage, is an unsuccessful attempt to apply a market-based approach to Medicare, the United States' best and last example of social insurance in health care. *See* Marsha Gold, *Medicare's Private Plans: A Report Card on Medicare Advantage*, 28 HEALTH AFF. w41, w41, Nov. 24, 2008, http://content.healthaffairs.org/cgi/reprint/28/1/w41.

106. ROBERT E. MOFFIT, TALKING POINTS: A GUIDE TO THE CLINTON HEALTH PLAN 2 (1993), *available at* http://www.heritage.org/research/healthcare/upload/tp_00.pdf.

107. *Id.* at 8.

that would collect and distribute premiums, certify health plans and offer them to consumers,[108] assure that average premiums grew no faster than federally set limits, and negotiate with doctors and hospitals to set fees for services provided outside of HMOs.[109]

The failure of the HSA is attributable to a multitude of factors: its undue complexity, its increase in both bureaucracy and government incursion into health care, the perception of a secret process led by then-First Lady Clinton, and resistance by multiple vested interests such as the health insurance industry (America's Health Insurance Plans) and the association for independent businesses (National Federation of Independent Business).[110] Additionally, key legislators were prodded by a strategy document circulated by leading conservative operative William Kristol, seeking to kill, not amend, the plan.[111] Less overt, but equally important, was the resistance of the majority of Americans who were happy enough with the insurance that they had through their employment and who feared that the change would somehow diminish their insured status.

While it seems clear that the Bush administration made serious efforts to privatize government-financed health care,[112] the fear of large government incursions into health care generally cannot be overestimated. When Senator Clinton announced her health plan as a presidential candidate, former New York City Mayor Giuliani, otherwise the most moderate of the Republicans who bid for the 2008 Republican presidential nomination, said

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108. The available plans, each priced differently depending primarily on the amount of choice given to subscribers, included (1) the Basic plan, which would provide health care through an HMO; (2) the Midlevel PPO-type plan; and (3) the Premium plan, which was basically a fee-for-service or indemnity insurance plan. Rob White, *The Great Healthcare Debate—President Clinton's Health Security Act Proposal from a Small-Business Perspective*, HOME OFF. COMPUTING, Jan. 1994, http://findarticles.com/p/articles/mi_m1563/is_n1_v12/ai_15035372/.

109. *See* MOFFIT, *supra* note 106, at 11.

110. PBS, A Detailed Timeline of the Healthcare Debate Portrayed in "The System," http://www.pbs.org/newshour/forum/may96/background/health_debate_page2.html (last visited Nov. 7, 2008).

111. *Id.*

112. The Medicare Advantage program was added to Medicare in an attempt to shift beneficiaries from fee-for-service Medicare to market-based managed competition. Channick, *supra* note 95, at 246–49. Medicare Part D, which added a prescription drug benefit to Medicare beginning in 2006, requires Medicare beneficiaries to participate in a managed competition stand-alone prescription drug plan or alternatively to get prescription drug coverage through a Medicare Advantage health plan. *Id.* An example of the Bush administration's determination to play a diminished role in the provision and financing of health care is President Bush's vetoes of expanded SCHIP legislation. *See* Krugman, *supra* note 47, at A17.

that her plan was "essentially the Michael Moore-Hillary Clinton approach which is let's see if we can build socialized medicine."[113] Former Massachusetts Governor Mitt Romney, who was also a Republican presidential candidate and the primary architect of the individual mandate plan now in effect in Massachusetts, criticized Senator Clinton's plan as "government insurance, not private insurance. It's European style socialized medicine."[114] These comments, it appears, were calculated to appeal not only to a Republican voter constituency, but also to moderate Democrats fearful of socialized medicine. In this context, the adjective "socialized" in connection with "medicine" is intended to be an unattractive descriptor of health care reform that is meant to make health care affordable and available to all Americans.

B. SCHIP: The Canary in the Coal Mine

Secretary Clinton's proposed health care reform plan did not make the federal government the single-payer for her Health Choices Plan; nonetheless, it was still criticized as "socialized medicine." This begs the question of what exactly the label "socialized medicine" means to Americans. Although Medicare, the United States' clearest example of social insurance, has a single public payer—the federal government—it is a partnership between the government and private providers.[115] Notwithstanding the fact that Medicare is not socialized medicine but rather a single-payer system that relies on the private sector for the provision of health care, the majority of Americans believe Medicare is socialized medicine,[116] but that the Veterans Health Administration (VHA), which is most similar to European

113. Posting of Anonymous to ABC News, The Radar, http://blogs.abcnews.com/politicalradar/2007/09/giuliani-clin-1.html (Sept. 17, 2008, 17:51 EST).

114. Julie Rovner, *Clinton Unveils New Health Plan*, NPR, Sept. 17, 2007, http://www.npr.org/templates/story/story.php?storyId=14478117.

115. *See* Maria Bizzle et al., *The Specter of Socialized Medicine*, CTR. FOR AM. PROGRESS, May 14, 2008, http://www.americanprogress.org/issues/2008/05/socialized_medicine.html.

116. According to a recent poll conducted by the Harvard Opinion Research Program at the Harvard School of Public Health and Harris Interactive, although the phrase "socialized medicine" has been used to attack health reform proposals in the United States, Americans are now split on whether a socialized medical system would be better or worse than the current system. Press Release, Harvard Sch. of Pub. Health, Poll Finds Americans Split by Political Party Over Whether Socialized Medicine Better or Worse Than Current System (Feb. 14, 2008), *available at* http://www.hsph.harvard.edu/news/press-releases/2008-releases/poll-americans-split-by-political-party-over-socialized-medicine.html. About sixty percent of those surveyed believe that Medicare is socialized medicine. *Id.*

socialized medicine, is not.[117] Legislators have used the threat of socialized medicine to block numerous health reform efforts by playing on Americans' fears of communist or socialist states such as China, Cuba, and the former U.S.S.R.[118] As one example demonstrates, SCHIP—the joint state/federal legislation that insures low-income children who are not eligible for Medicaid—was embroiled in a messy conflict between Congress and President Bush; the epithet "socialized medicine" was frequently used.[119] To a large extent, the SCHIP expansion debate put the question of who is entitled to health care in stark relief.[120]

The Balanced Budget Act of 1997 (BBA)[121] originally budgeted $24 billion in federal funds over ten years to subsidize SCHIP, but actual costs have reached $40 billion.[122] While there was no explicit eligibility limit in the original legislation, the HHS's understanding was that SCHIP would target children at no greater than 200% of the poverty level.[123] SCHIP's original authorization expired on September 30, 2007, and debate over its reauthorization raged.[124] Both houses of Congress passed versions of SCHIP reauthorization legislation that differed in many ways but similarly expanded the reach of the program to greater than 200% of the poverty level.[125] President Bush consistently said that

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117. VHA qualifies as a socialized system of medicine under the strictest definition. The VHA provides medical services to retired, disabled, or recently discharged military personnel who are eligible to receive benefits. *See* Bizzle et al., *supra* note 115. VHA medical benefits are only redeemable at VHA hospitals and medical centers, which are owned and operated by the government; health care providers working within the VHA are government employees. *Id.*

118. *Id.*

119. *See Both Parties Have Strengths in "SCHIP" Debate*, GALLUP, Oct. 17, 2007, http://www.gallup.com/poll/102004/both-parties-strengths-schip-debate.aspx [hereinafter *SCHIP Debate*] (describing the tension between Congress and President Bush, who wanted to stay away from a plan that he thought to be a step towards socialized medicine).

120. Len M. Nichols, *The Moral Case for Covering Children (and Everyone Else)*, 26 HEALTH AFF. 405, 405 (2007), *available at* http://content.healthaffairs.org/cgi/content/full/26/2/405?ijkey=6Dc65w1oECZrs&keytype=ref&siteid=healthaff.

121. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 314(a), 111 Stat. 251, 251 (1997) (setting the fiscal expenditures for SCHIP for each of the following ten years).

122. *See* CONG. BUDGET OFFICE, THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM 4 (2007), *available at* http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf (describing the disparity between the proposed expenditures of SCHIP and the actual expenditures).

123. David Hogberg, *SCHIP Expansion: Socialized Medicine on the Installment Plan*, NAT'L POL'Y ANALYSIS, Sept. 2007, http://www.nationalcenter.org/NPA560.html.

124. *SCHIP Debate*, *supra* note 119.

125. Compare S. 1893, 110th Cong. § 110 (2007), with H.R. 3162, 110th Cong. §

he would veto the bicameral legislation.[126] Both bills funded SCHIP expansion by an additional federal excise tax on cigarettes. Like all so-called sin taxes, opposition emerged calling these taxes regressive and therefore unfair.[127] The bigger issue, however, was the expanded reach of SCHIP, which opponents of the legislation claimed would cost the federal government substantially more than the BBA estimated[128] and exacerbate the "crowd out" phenomenon that was already occurring under the original legislation. Crowd out occurs when people who have private insurance coverage drop that coverage in favor of getting coverage from a less costly government-run insurance program.[129]

A recent study on crowd out in SCHIP by Professors Jonathan Gruber and Kosali Simon found the rate to be sixty percent;[130] that is for every ten new children in SCHIP, private coverage of children declines by six.[131] Predictions by the Congressional Budget Office on crowd out for the reauthorized SCHIP is forty-two percent; of three million children who are predicted to enroll in the SCHIP, 1.4 million will previously have had private insurance that their parents discontinued in favor of

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115 (2007) to evaluate their proposed breadth and expansion of the program.

126. The Senate version of the reauthorization passed on August 2, 2007, by a vote of 68 to 31, making it veto-immune. S. 1893. On August 1, 2007, the House of Representatives passed its version of SCHIP reauthorization by a margin of 225 to 204. H.R. 3162.

127. *See* THE CTR. FOR TOBACCO POLICY & ORG., FEDERAL LEGISLATIVE UPDATE, (2007), *available at* http://www.center4tobaccopolicy.org/_files/_files/Federal_Update_August_2007.pdf. The SCHIP reauthorization legislation would raise the federal excise tax to as much as one dollar per pack under the Senate version. *Id.* An increase in the federal excise tax could have a negative effect on state revenues that come from state sin taxes. *Id.*

128. *See* 42 U.S.C. § 1397dd (2006) (mapping SCHIP funding and finding that if it were to remain at its current level, it would cost about $25 billion over five years and $50 billion over ten years); Children's Health Insurance Program Reauthorization Act, Pub. L. 111- 3, § 101, 123 Stat. 8, 5 (2009). The total funding provided by the Senate bill for the fiscal years 2008–2012 is $61.4 billion. Letter from Peter R. Orszag, Dir., Cong. Budget Office, to Charles B. Rangel, Chairman, Comm. on Ways and Means (July 30, 2007), *available at* cbo.gov/ftpdocs/85xx/doc8501/hr3162Rangel.pdf. According to the Congressional Budget Office, the House bill would cost $47.4 billion over five years and $128.7 billion over ten. *Id.*

129. David Cutler & Jonathan Gruber, *Does Public Health Insurance Crowd Out Private Insurance?*, 111 Q. J. ECON. 391, 391 (1996). Cutler and Gruber coined "crowd out" to describe the effect of those people who drop their private coverage and switch to the public coverage when states expand their public medical coverage through programs like Medicaid. *Id.*

130. Jonathan Gruber & Kosali Simon, *Crowd-Out Ten Years Later: Have Recent Public Expansions Crowded Out Private Health Insurance?* 2–3 (Nat'l Bureau of Econ. Research, Working Paper No. 12858, 2007), *available at* http://www.nber.org/papers/w12858.pdf?new_window=1.

131. *Id.*

public insurance paid for by taxpayers.[132] It is to this "free lunch" phenomenon that President Bush objected.

Perhaps even more philosophically fundamental was President Bush's slippery slope argument: increased crowd out will move more children from private insurance to public insurance, fueling a strategy President Bush called "the federalization of health care."[133] That argument seems improbable given the design of SCHIP as an insurance program that generally does not create new—or expand existing—federal entitlements.[134] In fact, in the large majority of cases, states have chosen to use SCHIP dollars to subsidize premiums for insurance products privately purchased for SCHIP beneficiaries.[135]

Nonetheless, the ideological debate about the expansion of SCHIP and universal health care rages on. An editorial in the Wall Street Journal called Congressional plans to expand SCHIP a Democratic effort to "expand government control of health care and undermine private insurance . . . ."[136] It went on, "Democrats think they have a political winner in the guise of helping 'children,' but the House bill shows that their higher priority is expanding government."[137] As political columnist Paul Krugman noted, wanting the public to believe that the government is always the problem, never the solution, was at the core of President Bush's philosophy. "It's not because he thinks the plans wouldn't work. It's because he's afraid that they would. That is, he fears that voters, having seen how the government can help children, would ask why it can't do the same for adults."[138]

C. What We Know About the High Cost of Health Care

The problem of providing universal health care is confounded by many factors, including policy, politics, economics, and

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132. Hogberg, *supra* note 123 (applying statistical analysis tools to the Gruber-Simon study and acknowledging that their figures may be conservative).

133. Krugman, *supra* note 47, at A17.

134. *See* Sara Rosenbaum, *SCHIP Reconsidered*, 26 HEALTH AFF. 608, 610–12 (2007), *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.26.5.

135. William Novelli & Edward Langston, Letter to the Editor, *SCHIP-Shape Health Care*, WALL ST. J., Aug. 22, 2007, at A9, *available at* http://online.wsj.com/article/SB118757533020402581.html?mod=googlenews_wsj; Posting of Sara Rosenbaum to Health Affairs Blog, http://healthaffairs.org/blog/2007/08/16/schip-a-falsely-politicized-debate/ (Aug. 16, 2007, 15:24 EST).

136. Editorial, *The SCHIP Revelation,* WALL ST. J., Aug. 9, 2007, at A12, *available at* http://online.wsj.com/article/SB118662306308792513.html?mod=opinion_main_review_and_outlooks.

137. *Id.*

138. Krugman, *supra* note 47, at A17.

philosophy. There seems to be little doubt that individuals and populations are healthier when they have affordable access to regular health care focusing on preventing disease, promoting wellness, and detecting and treating disease in the earliest possible stages.[139] If this premise is correct, the cost of health care in the United States, currently at $2.3 trillion, with annual growth well in excess of the growth of the economy, should start to flatten out.[140] The distribution of health care costs is also highly skewed; as of 2004, five percent of the population accounted for forty-nine percent of the total health care expenditures.[141] On the flip side, the fifty percent of the population with the lowest health care expenditures accounted for only three percent of total health care spending.[142] The high-cost users spend seventeen times more than low-cost users.[143]

1. High-Cost Users

Who are these high-cost users? They are primarily people with multiple chronic conditions who are elderly and may have had little or no access to health care prior to their eligibility at age sixty-five for Medicare.[144] Whether the focus of health care cost-reduction research should be spent on identifying both high-cost populations and interventions that mitigate expenditures, rather than on techniques to reduce expenditures in the general population, is in debate. The latter are the mitigating techniques that have been identified as those that tend to discourage health care use in the general populations, such as high deductibles and co-payments, and systems of managed care.[145]

Assuming high-cost populations could accurately be identified,[146] what kinds of strategies could be successful in

139. *See* INST. OF MED., COVERAGE MATTERS: INSURANCE AND HEALTH CARE 19–28 (2001) [hereinafter COVERAGE MATTERS].

140. Ceci Connolly & Lori Montgomery, *Senate Panel Advances Health-Care Overhaul; But Battle Lines Sharpen Over Industry Fees, Medical Cost Controls*, WASH. POST., July 16, 2009, at A4, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2009/07/15/AR2009071500229.html.

141. MARK W. STANTON, THE HIGH CONCENTRATION OF U.S. HEALTH CARE EXPENDITURES 2 (2006), *available at* http://www.ahrq.gov/research/ria19/expendria.pdf.

142. *Id.*

143. *Id.*

144. *See* CONG. BUDGET OFFICE, HIGH COST MEDICARE BENEFICIARIES 5–6 (2005).

145. *See* Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures, Revisited*, 20 HEALTH AFF. 9, 13–15 (2001), *available at* http://content.healthaffairs.org/cgi/reprint/20/2/9.pdf.

146. *See* CONG. BUDGET OFFICE, *supra* note 144, at 8–12.

reducing the cost of their care? One possibility that has had extremely limited success is the Oregon Medicaid initiative, which prioritized the expenditures the state would reimburse under the state Medicaid program.[147] Oregon's approach did not reimburse certain high-cost procedures such as heart, liver, pancreas, or bone marrow transplants.[148] Notably, no other jurisdictions have adopted Oregon's explicit approach to the allocation of Medicaid resources, thus it seems very unlikely that Medicare would take this approach, at least explicitly.[149]

A second possibility for cost-reduction is disease management programs that attempt to identify beneficiaries with specific chronic conditions, then provide effective and cost-efficient care.[150] These programs may vary widely in the techniques used, but they share certain goals to achieve higher quality, lower cost care: patient buy-in through education. This education includes how to use medication properly, regular monitoring of clinical symptoms and treatment plans using evidence-based standards, and coordination of care among providers including physicians, hospitals, laboratories, and pharmacies.[151]

A third possible way to reduce costs would be to assign workers direct responsibility for managing the care of patients, particularly patients with multiple chronic diseases or elderly, frail patients. For example, a primary care physician could provide a so-called "medical home" that would include case and disease management.[152] The United Kingdom employs such a system, and primary care physicians are able to earn bonuses for

147. *See* Marsha Gold, *Markets and Public Programs: Insights from Oregon and Tennessee*, 22 J. HEALTH POL. POL'Y & L. 633, 636–37 (1997) (discussing Oregon's approach to expanding health coverage, cutting costs, attaining minimum standards of health care for all, and critically evaluating the effectiveness of care).

148. *See* James F. Blumstein, *The Oregon Experiment: The Role of Cost-Benefit Analysis in the Allocation of Medicaid Funds*, 45 SOC. SCI. & MED. 545, 545–48 (1997).

149. *See* STANTON, *supra* note 141, at 7–8 (finding that a "small number of conditions accounted for most of the growth in total health care spending between 1987 and 2000—with the top five medical conditions (heart disease, pulmonary disorders, mental disorders, cancer, and trauma) accounting for 31 percent," and that this concentration affected Medicaid and Medicare negatively).

150. *See* Gerald F. Riley, *Long-Term Trends in the Concentration of Medicare Spending*, 26 HEALTH AFF. 808, 814–15 (2007), *available at* http://content.healthaffairs.org/cgi/content/abstract/26/3/808.

151. *See generally* STANTON, *supra* note 141 (describing the high cost of treating chronic conditions).

152. Alice Dembner, *A More Welcoming Model for Care*, BOSTON GLOBE, May 19, 2008, at A11, *available at* http://www.boston.com/news/health/articles/2008/05/19/a_more_welcoming_model_for_care.

keeping their patients healthy.[153] In the United States, the medical home model has been endorsed by the major primary care specialists to support more effectively the core functions of primary care and the management of chronic diseases.[154]

2. Reimbursement Incentives: Treatment Versus Prevention

Related to the impact of reducing the cost burden of chronic disease is the equally compelling issue of disease prevention and the role of lifestyle choices. A recent study researching sources of the U.S.-European health spending gap found significant differences in disease prevalence and rates of medication treatment in the older adult populations of the United States and Europe.[155] The prevalence of certain chronic diseases in the older adult U.S. population was twice the rate in similar European populations.[156] According to Kenneth Thorpe, Chair of the Health Policy and Management Department at Emory University's Rollins School of Public Health and author of the study, "[w]e expected to see differences between disease prevalence in the United States and Europe, but the extent of the differences is surprising. It is possible that we spend more on health care because we are, indeed, less healthy."[157] The study demonstrated that the prevalence of both obesity and tobacco use was significantly higher among older adults in the United States than in Europe, although it did not establish the connection between these lifestyle choices and the prevalence of chronic disease.[158]

The study recommended making the reduction of chronic disease a key policy goal in the United States. In an interview with the Los Angeles Times, Professor Thorpe noted that the U.S. health care system is neither preventive nor proactive. "We wait for people to get sick. They show up. We treat them. And doctors and hospitals get paid. That's not a very good way for managing

153. *Frontline: Sick Around the World* (PBS television broadcast Apr. 15, 2008) (transcript *available at* http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/etc/script.html).

154. Elliott S. Fisher, *Building a Medical Neighborhood for the Medical Home*, 359 NEW ENG. J. MED. 1202, 1202–03 (2008).

155. Kenneth E. Thorpe et al., *Differences in Disease Prevalence as a Source of the U.S.-European Health Care Spending Gap*, 26 HEALTH AFF. 678, 679 (2007), *available at* http://content.healthaffairs.org/cgi/content/abstract/26/6/w678.

156. *Id.* at 680.

157. *Study Shows U.S. Outweighs Europe*, WASH. TIMES, Oct. 2, 2007, at C8.

158. *Study: Chronic Diseases Twice as Likely in U.S. as Europe*, CAL. HEALTHLINE, Oct. 2, 2007, http://stage.californiahealthline.org/articles/2007/10/2/Study-Chronic-Diseases-Twice-as-Likely-in-US-as-Europe.aspx?topicID=37.

disease."[159] A second report stated that much chronic disease is preventable, and that a reorientation toward prevention could avert forty million cases in seven categories of chronic diseases by the year 2023, thereby "reduc[ing] anticipated treatment expenses associated with the seven diseases and improv[ing] productivity by $1.1 trillion that year."[160] Both studies pointed to reimbursement practices of both Medicare and private plans that incentivize treatment rather than prevention. Professor Thorpe said he hoped his comparative study would "help to shift the focus of the debate over healthcare reform away from arguing about who pays for what to a focus on preventing diseases that affect the quality of life and run up costs."[161]

3. What We Know Matters: Comparative Effectiveness Research

If we believe, and can to some extent prove, that universal affordable access, prevention, early diagnosis, and disease management all lead to more effective, less-costly health care, why are we so resistant? First, the United States has not spent the money necessary to have precise empirical data about what does and does not work. Robert Reischauer, President of the Urban Institute, believes that until we have compelling research on what works most effectively and efficiently, we are condemned to a cycle of failure. In order to follow Robert Reischauer's lead, we need to

> develop[] and disseminat[e] information on the comparative performance of alternative health delivery systems in a way that we can convince the American people that integrated health care systems that use resources parsimoniously have as good or better outcomes than the ala carte uncoordinated systems we have so that health reform to them does not mean that we are taking something away . . .[162]

Paul Farmer, the physician/anthropologist who embodies the credo that the best can sometimes be the enemy of the good,

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159. Lisa Girion, *Europe Healthier than U.S.*, L.A. TIMES, Oct. 2, 2007, at C3, *available at* http://articles.latimes.com/2007/oct/02/business/fi-healthspend2.

160. Lisa Girion, *Study: Prevention Saves Lives, Money; The Milken Institute Says Chronic Disease is Hurting the Economy*, L.A. TIMES, Oct. 3, 2007, at C1, *available at* http://www.careoregon.org/carenews/2007/fall/documents/071003_L.A. Times_HealthyLiving.pdf. The Milken Institute is a private economic think tank based in Santa Monica, California. The Milken Institute, www.milkeninstitute.org/ (last visited Nov. 23, 2009).

161. Girion, *supra* note 159, at C3.

162. Video: Health Care Reconsidered: Options for Change: Health Care Reform Opportunities and Challenges (Hamilton Project Forum 2007) (transcript *available at* http://www.kaisernetwork.org/health_cast/uploaded_files/041007%20hamilton_panel2_transcript.pdf) [hereinafter Hamilton Project].

provides extremely effective but quite inexpensive health care to very poor, very sick populations in Haiti.[163] Reischauer echoes this message, that very expensive health care modalities are often not more effective than less expensive ones; however, without empirical evidence of that fact, it is impossible to make such an assertion.[164]

Until discussion about comparative effectiveness began,[165] the research had been focused on determining whether technologies are effective. But as the many constituencies who support comparative effectiveness point out, a central government research center would go a long way toward improving health care, as well as containing costs in a rational way. As economist Gail Wilensky, who recently wrote a comparative effectiveness piece,[166] notes regarding the future of health care, "[w]e need to find ways to spend smarter."[167]

D. Health Care Cost Containment

Dr. Wilensky's words echo universally. Whatever process for universal health care coverage the United States adopts, keeping health care costs in check must be part of the plan. According to Henry Aaron and Joseph Newhouse, two prominent health economists,

> [t]he stakes in achieving such control are enormous. If health care spending outpaces income growth by 2½ percentage points a year—a bit less than the historical average of the past four decades—and if economic growth proceeds at the rate projected by the CBO, per capita income available for purposes other than health care will still grow strongly for the next

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163. *See generally* TRACY KIDDER, MOUNTAINS BEYOND MOUNTAINS: THE QUEST OF DR. PAUL FARMER, A MAN WHO WOULD CURE THE WORLD (2003). Dr. Paul Farmer traveled to Haiti in order to cure infectious disease and deliver medical care to those areas that need it most. *Id.*

164. Hamilton Project, *supra* note 162.

165. *See* Medicare Modernization Act of 2003, Pub. L. No. 108-173, § 1013, 117 Stat. 2438 (2003). The Medicare Modernization Act of 2003 (MMA) which, among other things, legislated a Part D prescription drug coverage for Medicare beneficiaries, authorized $50 million to the Agency for Healthcare Research and Quality for comparative effectiveness research. *Id.*

166. Gail R. Wilensky, *Developing a Center for Comparative Effectiveness Information*, 25 HEALTH AFF. 572, 572 (2006), *available at* http://content.healthaffairs.org/cgi/content/abstract/25/6/w572. Wilensky is a senior fellow at Project Hope and a former administrator of the Health Care Financing Administration, the precursor of Centers for Medicare and Medicaid Services. *Id.*

167. Kathryn Foxhall, *Push Is On for Research on Comparative Effectiveness: What Works Best in Drugs, Devices, Biologicals, and Procedures*, DRUG TOPICS, May 7, 2007, *available at* http://www.drugtopics.com/drugtopics/content/printContentPopup.jsp?id=423919.

> decade, but then will stagnate and eventually fall. Simply put, the United States faces a *health care financing challenge—public and private*—that it cannot ignore.[168]

Aaron and Newhouse make it clear that the problem is not simply that the United States is drowning in general entitlement costs—Medicare, Medicaid, and Social Security—but that the more pressing problem is out-of-control health care costs, caused by financing and delivery issues that exist in both the public and private sectors.[169]

Health care reform faces a number of challenges, at least two of which this Article addresses. One is universality—every American should be able to afford access to meaningful health care. As of 2007, at least forty-five million Americans were uninsured.[170] The other challenge is cost containment: ever-increasing health care costs must be addressed. Currently, the United States spends in excess of $2 trillion annually, more than $7000 for each man, woman, and child.[171] Annual health expenditures continue to swell, and health care costs are soon expected to swallow up twenty percent of the nation's economy.[172] While the clarion call is usually universal coverage, it is now cost containment. The irony is that cost containment will not be achieved without universal access. In both the public and the private sectors, the following drive costs: overuse of hospital emergency departments, too much uncompensated care, unnecessary or non-efficacious treatments, continuous improvements in expensive technology, uncoordinated care, coverage and reimbursement of administrative costs, the heavy

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168. Henry J. Aaron & Joseph P. Newhouse, *Meeting the Dilemma of Health Care Access: Extend Insurance Coverage While Controlling Costs*, BROOKINGS, Feb. 28, 2007, http://www.brookings.edu/papers/2007/0228useconomics_aaron02_Opp08.aspx (emphasis added).

169. *Id.;* Henry J. Aaron, *Budget Crisis, Entitlement Crisis, Health Care Financing Problem–Which Is It?*, 26 HEALTH AFF. 1622, 1624–26 (2007), *available at* http://content.healthaffairs.org/cgi/content/abstract/26/6/1622. Henry Aaron, a health economist at the Brookings Institute, argues that the real problem is health care spending in both the private and public sectors, not the sheer cost of public entitlements. *Id.* He argues that if the United States can get control over health care spending, we will solve the entitlement crisis. *Id.*

170. Hamilton Project, *supra* note 162.

171. Press Release, Ctr. for Medicare & Medicaid Servs., CMS Reports U.S. Health Care Spending Growth Accelerated Only Slightly in 2006 (Jan. 8, 2008), *available at* http://www.cms.hhs.gov/apps/media/press_releases.asp (follow the "January 8, 2008" hyperlink).

172. *Id.*; Posting of Jim Cooper to Health Affairs Blog, http://healthaffairs.org/blog/2008/02/26/health-spending-a-growing-economic-crisis/ (Feb. 26, 2008, 6:45 EST) (discussing how the health sector is growing faster than other sectors of the economy).

presence of the for-profit sector, grossly disproportionate compensation arrangements in both the for-profit and non-profit sectors, and insufficient preventive care.[173]

IV. The Universal Single-Payer Option: The Barriers of Inertia, Free Market, and Culture

There are many other reasons why health care reform does not and will not include a shift from a multiple-payer private market model to a public single-payer model. The order of the reasons presented is not intended to be one of descending importance to the outcome. Some of these reasons have already been articulated and others not; some reasons are apparent and others more hidden. Taken together, they represent the overwhelming odds against the adoption of tax-financed national health insurance.

First, approximately eighty-four percent of Americans currently have health insurance,[174] and eighty-eight percent of them rate their coverage as "good" or "excellent."[175] That coverage includes both private and public employer-sponsored insurance, insurance stemming from public programs like Medicare, Medicaid, and SCHIP, and individual insurance policies.[176] The majority of the insured perversely wait to get old enough to be eligible for Medicare, an almost incomprehensible perspective in an otherwise youth-oriented society.[177] Just as changes to Social Security and Medicare are considered the third-rail of politics, so too is the current system by which a large percentage of Americans have access to health insurance. However fragmented, inequitable, unfair, impermanent, and regressive the current

173. *See* COVERAGE MATTERS, *supra* note 139, at 35–56 (discussing the unstable, inconsistent manner of health insurance coverage in the United States); INST. OF MED., INSURING AMERICA'S HEALTH: PRINCIPLES AND RECOMMENDATIONS 66–85 (2004) (discussing inefficient, incomplete, and uncoordinated care, and recommending policy initiatives to broaden coverage). *See generally* INST. OF MED, HIDDEN COSTS, VALUE LOST: UNINSURANCE IN AMERICA (2003) (discussing the unequal cost distribution in the health care and insurance industries, and the societal costs of the uninsured and underinsured).

174. Press Release, U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2008 (Sept. 10, 2009), *available at* http://www.census.gov/Press-Release/www/releases/archives/income_wealth/014227.html.

175. *Health Care Reform: A Pill Too Bitter for U.S. to Swallow,* USA TODAY, Oct. 17, 2006, at A17.

176. *Id.*

177. Barry R. Furrow, *Access to Health Care and Political Ideology: Wouldn't You Really Rather Have a Pony?*, 29 W. NEW ENG. L. REV. 405, 406 (2007).

system is,[178] having health insurance calms people's fears of the potentially catastrophic financial consequences of noninsurance.[179] The current entrenched system survives in spite of altruistic instincts to the contrary, namely, that the system is unfair to the uninsured outsiders.[180] This entrenchment is part of the inertia barrier.

Another part of the inertia barrier is what social scientists call "path dependence," a term that posits that the evolution of institutions is based on past experience.[181] "[W]hat comes first (even if it was in some sense 'accidental') conditions what comes later."[182] The U.S. health care system is a prime example of path dependence: an acknowledged flawed system that we might indeed redesign into something more effective if we could go back some sixty years and start again. Our system, with its multiple payers from both the private and public sectors, is the result of a historical accident—a combination of World War II wage freezes[183] and the persuasiveness of President Lyndon Johnson in convincing Congress to enact Medicare.[184] Because of the current system's sunk costs and entrenched players, it would be enormously difficult to adopt a universal single-payer system. Thus, the momentum for change is heavily weighted in the direction of existing institutions rather than in the direction of an entirely new system. This phenomenon of accident as opposed to planning is not unique to the United States. The health care paths taken in both the United Kingdom and France were extensions of systems that already existed rather than the products of analysis and

178. Insurance premium costs are usually distributed equally across all of the insured in the pool, making them regressive with respect to their effect on low and high earners. Jonathan Oberlander, *The Political Economy of Unfairness in U.S. Health Policy*, 68 LAW & CONTEMP. PROBS. 245, 250–51 (2006). Clark Havighurst and Barak Richman call attention to other examples of distributional unfairness such as the so-called "head tax" that insurers pass on to insurees to cover the cross-subsidization costs imposed by monopolistic providers. Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 68 LAW & CONTEMP. PROBS. 7, 28–30 (2006).

179. Oberlander, *supra* note 178, at 248.

180. *See* Harvard Sch. of Pub. Health, *supra* note 63 (discussing the poll of Massachusetts residents conducted by the Kaiser Family Foundation, Harvard School of Public Health, and Blue Cross Blue Shield of Massachusetts that demonstrates residents' satisfaction with health reform).

181. Atul Gawande, *Getting There From Here*, NEW YORKER, Jan. 26, 2009, at 26.

182. ROBERT D. PUTNAM, MAKING DEMOCRACY WORK 8 (1993).

183. *The Line Against Inflation*, N.Y. TIMES, Sept. 12, 1944, at 18.

184. RICK MAYES, UNIVERSAL COVERAGE: THE ELUSIVE QUEST FOR NATIONAL HEALTH INSURANCE 67–68 (2004).

planning,[185] and both seem to work well for the citizens of their respective countries.[186]

How our health care system—mostly its access and financing—became linked to employment rather than to Social Security is a story well and completely told by many others. After World War II, with much of the workforce returning from war and seeking employment, President Roosevelt was concerned about wage inflation due to the competition among employers to attract employees.[187] The result was a freeze on wages so that employers, who were foreclosed from offering higher salaries, began to use employment benefits such as health insurance to attract employees.[188] Companies, who might not have been trying to attract better employees but instead were trying to resist unionization, facilitated the linking of employment and health insurance.[189] The relationship between employment and health insurance was solidified by its favorable tax treatment—a deduction to the employer and non-inclusion of the health insurance benefit in the employee's income—that was intended to incentivize employers to provide health insurance.[190] Today, the favorable tax treatment of ESI has been estimated to equal foregone revenue of $225 billion annually which, if eliminated, would be a good down payment on the adoption of a universal single-payer system.[191]

The adoption of Medicare in 1965 was intended to be the first step toward embracing a universal single-payer system.[192] As Robert Ball, Social Security's commissioner from 1962 to 1973, later admitted, incrementalism was the covert strategy for achieving universal health insurance coverage.[193] "We all saw insurance for the elderly as a fallback position, which we advocated solely because it seemed to have the best chance politically. . . . [W]e expected Medicare to be a first step toward universal national health insurance, perhaps with 'Kiddicare' as

185. Gawande, *supra* note 181, at 27–28.

186. For example, in 2000, the World Health Organization ranked the French system the best health care system in the world and ranked the U.S. system thirty-seventh. *Id.*

187. *The Line Against Inflation*, *supra* note 183, at 18.

188. *Id.*

189. MAYES, *supra* note 184, at 47–48.

190. Jonathan Gruber, Statement at Health Reform Summit 2008 (June 16, 2008) (transcript *available at* http://finance.senate.gov/healthsummit2008/Statements/Jon%20Gruber%20Statement.pdf).

191. *Id.*

192. MAYES, *supra* note 184, at 81.

193. *Id.*

another step."[194] This strategy has failed, in part, because of the high costs of Medicare, which emerged early on as problematic.[195] That Medicare Part A—hospital insurance funded by the same type of payroll tax as Social Security—is perpetually on the verge of insolvency[196] makes a universal social insurance system predictably frightening to legislators and voters alike. It is not the high costs of public entitlements that we should fear, however; it is the high and uncontrolled costs of health care, whether in the public or private sector.[197]

Part of the reason for Medicare's profligacy was Congress' fear of alienating providers, what others have called the "politics of accommodation."[198] Both physicians and hospitals were initially given a license to spend in an effort to cement the attractiveness of the program. This complete lack of fiscal restraint resulted in an astonishing growth, in not only Medicare expenditures, but also health care expenditures in general, which totaled $38.9 billion, or 5.9% of GNP, in 1965, and $247.2 billion, or 9% of GNP, by 1980.[199] On the one hand, this spike in health care costs has soured Medicare's reputation and diminished the political viability of Medicare as a model for national health insurance.[200] On the other hand, the enormous stakes in the fragmented system that we do have—private multi-payer employer-based insurance as the centerpiece with public programs such as Medicare, Medicaid, SCHIP, and the VHA for select populations—make it seemingly impossible to move in another direction. We will, in all likelihood, continue to build on what we have toward the goal of universality.

The second barrier to the adoption of a single-payer system, the free market barrier—the belief that the private sector can better solve problems, even social problems, than government—is

194. Robert M. Ball, *Perspectives on Medicare: What Medicare's Architects Had in Mind*, 14 HEALTH AFF. 62, 62–63 (1995), *available at* http://content.healthaffairs.org/cgi/reprint/14/4/62. Ironically, although a universal single-payer system has never been adopted, the next population to achieve near universal coverage was children through the expansion of SCHIP. *See supra* Part III.B.

195. Ball, *supra* note 194, at 65.

196. T. W. Farnum, *Social Security, Medicare Face Insolvency Soon*, WALL ST. J., May, 13, 2009, at A6, *available at* http://online.wsj.com/article/SB124212734686110365.html.

197. Aaron, *supra* note 169, at 1624.

198. MAYES, *supra* note 184, at 84–85 (citing Medicare experts Theodore Marmor and Paul Starr).

199. *Id.* at 87.

200. *Id.* (citing Jonathan Oberlander, Medicare and the American State (1995) (unpublished Ph.D. dissertation, Yale University)).

entrenched and difficult to dislodge.[201] This belief is true in spite of over forty successful years of Medicare, a federal social insurance program that not only provides fee-for-service insurance for seniors using a prospective payment system, but also acts as the policy-making body.[202] Notwithstanding its limited beneficiary pool—approximately forty-four million individuals sixty-five and older or disabled—and its cost of $374 billion in 2006,[203] a Republican administration and Republican controlled legislature added an expensive benefit to the Medicare program to provide outpatient prescription drug coverage for Medicare beneficiaries.[204] Medicare Part D is estimated to cost the federal government and taxpayers at least an additional $500 billion over the next eight years.[205] While its passage was, in the vernacular, "a squeaker," a Republican administration and legislature added appreciably to a high-cost, albeit popular, entitlement program. The story of the Medicare Modernization Act (MMA) explains this otherwise apparent conflict.[206]

How historically small-government Republicans could be pressured into agreeing to add an expensive prescription drug benefit to an already expensive entitlement program is, to a large extent, due to the program's design. Unlike Parts A and B of Medicare, where the federal government is the insurer, Part D coverage can only be purchased through so-called private drug plans that compete with each other to provide prescription drug benefits at competitive prices.[207] The MMA, while touted as the first meaningful expansion of the Medicare benefit structure in

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201. Greg Anrig, *The Problem with Conservatism is Conservatism*, AMERICAN PROSPECT, June 2, 2008, http://www.prospect.org/cs/articles?article=the_problem_with_conservatism_is_conservatism.

202. PAUL KRUGMAN, THE CONSCIENCE OF A LIBERAL 174 (2007). Centers for Medicare and Medicaid Services is the federal government agency charged with not only administering the Medicare program but also with making policy such as the scope of covered services, reimbursement to providers, and regulation of Medicare supplemental insurance. *Id.*

203. Part D of Medicare, which provides an outpatient prescription drug benefit, was first available to Medicare beneficiaries in 2006. In 2006, nine percent of the $374 billion Medicare price tag was attributable to outpatient prescription drugs. KAISER FAMILY FOUND., MEDICARE SPENDING AND FINANCING FACT SHEET 1 (2007), *available at* http://www.kff.org/medicare/upload/7305-02.pdf.

204. *See* Channick, *supra* note 95, at 262–67 (arguing that the high cost of Medicare Part D will outweigh the benefits of the program and that its focus on privatization will hinder progress towards universal health care).

205. *Id.* at 272.

206. *See id.*

207. *See id.* at 247–49. This experiment with managed competition in the prescription drug arena is one that failed in the managed care part of Medicare Part C. *See* Gold, *supra* note 105, at 41.

almost forty years, became law because the Bush administration was able to convince reluctant legislators that it represented the beginning of the privatization of Medicare.[208] For President Bush, who promoted the notion of an "ownership society" from the beginning of his first term by putting the privatization of Social Security at the top of his domestic agenda,[209] privatizing health care was not a surprising or unexpected move. "The administration believes we are millions and millions of individuals not bound together into a society . . . . [M]edical care is just another good or service that we purchase as we will in the marketplace subject to normal market forces."[210] This sentiment is the antithesis of the belief that we are a society of individuals who assist each other through an instrument called government.[211]

The view that the private sector is better positioned to solve our social problems than the government is not unique to the Bush administration; it has been, however, far more pervasive. When the leadership of the country so publicly dismisses the ability of government to solve important social problems, like public education and health care, while instead promoting self-reliance represented by the privatization of Social Security, it cannot be surprising that a significant portion of the population shares that view.[212] Retaining the social safety net is expensive and will no doubt require an increase in direct taxation as well as indirect cross-subsidization of the poorer by the wealthier. This scenario seems very unlikely in a time when spending has exceeded taxing. Beginning with 2001, federal government expenses, largely due to the war in Iraq, have increased, while revenues have decreased.[213]

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208. Christine C. Ferguson et al., *The Long Road to Health Reform Requires Bipartisan Leadership*, 27 HEALTH AFF. 711, 713 (2008), *available at* http://content.healthaffairs.org/cgi/reprint/26/6/1622.

209. Richard W. Stevenson, *Social Security Panel Faces Challenges*, N.Y. TIMES, May 3, 2001, at A14.

210. Rashi Fein, *'Sharing' Is Not What This Administration Is About*, NEIMAN WATCHDOG, Feb. 26, 2007, http://niemanwatchdog.org/index.cfm?fuseaction=ask_this,view&askthisis=00265. Professor Fein is a Professor Emeritus of Medical Economics at Harvard Medical School. *Id.*

211. *Id.*

212. *See* KRUGMAN, *supra* note 202, at 12–13.

213. The cost of the war in Iraq as of 2008 was $694 billion, while taxes on earned income, capital gains, and transfers have decreased. Julian E. Barns, *Iraq War Costs: New Spending Likely To Drive Cost of Iraq War Past That for Vietnam*, CHICAGO TRIB., Apr. 11, 2009, *available at* http://archives.chicagotribune.com/2009/apr/11/nation/chi-iraq-cost_11apr11. These tax cuts, which took effect during the Bush administration, were structured to disproportionately benefit the wealthiest Americans. Carl Hulse, *Senate Backs Freeze on Tax Without Cost Offsets*, N.Y. TIMES, Dec. 7, 2006, at A18. The Bush White House and Congress, often under threat of a presidential veto, continued to pass such tax cuts. *Id.* For

President Bush's vetoes of an expanded SCHIP program, citing the specter of government-sponsored health insurance, were disguised as an attempt to balance the budget.[214] The Bush administration will be remembered for systematically trying to disassemble the social safety net erected by earlier administrations and respected by Presidents from both parties.[215]

Yet, in 2008, the United States experienced a historic presidential election where the same electorate that gave Republican George W. Bush two terms as President elected a young, energetic, progressive Democrat.[216] It is clear that if Senator John McCain had been elected on November 4, 2008, his administration would have continued the Bush administration's pursuit of a relatively unregulated free market and private market solutions to large social issues such as the financing of health care.[217] Because Barack Obama was elected instead, and particularly with a Democratic Congress, there is likely to be significantly less antipathy towards government solutions to social problems.[218] Although the goal of President Obama's plan is universal or near-universal coverage, he certainly has not proposed a single-payer solution to replace the current multi-payer system. Instead, he proposes, as did Secretary Clinton in her recent run for the Democratic presidential nomination, to build on existing ESI.[219] President Obama seeks to increase ESI through a

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example, on December 6, 2007, Congress, in attempting to control the reach of the alternative minimum tax to middle-income Americans, froze the Alternative Minimum Tax without finding a $50 billion replacement for it. *Id.*

214. Ferguson et al., *supra* note 208, at 715–16.

215. *See* Fein, *supra* note 210.

216. *See* Nagourney, *supra* note 1, at A1.

217. LEWIN GROUP, *supra* note 29, at 2. Notwithstanding the current hostility toward regulation, the current fiscal tsunami may persuade even a conservative administration of its value, at least at the margins where greed seems to have overcome good sense. Former Federal Reserve Chairman Alan Greenspan recently testified in front of the House Committee on Government Oversight and Reform that his failure to push for tighter banking regulations was due to his mistaken belief that the financial sector would self-regulate. *See* Posting of topeditor to Wall Street Journal, Real Time Economics, http://blogs.wsj.com/economics/2008/10/23/greenspan-testimony-on-sources-of-financial-crisis/ (Oct. 23, 2008, 8:27 EST).

218. The deep recession of 2008, the result of the free market gone wild with little or no regulation, has brought about an unprecedented federal bailout of a number of traditionally private sectors, such as the banking and auto industries. Hearing former Federal Reserve Chairman Alan Greenspan and other free market proponents talking about the wisdom of nationalizing the banks is so anomalous it barely can be believed. Greg Brown, *Greenspan Suggests Bank Nationalization*, MONEYNEWS.COM, Feb. 18, 2009, http://moneynews.newsmax.com/streettalk/greenspan_nationalization/2009/02/18/182900.html.

219. Joseph R. Antos, *Symptomatic Relief, but No Cure—The Obama Health Care Reform*, 359 NEW ENG. J. MED. 1648, 1648 (2008).

national pay-or-play employer mandate,[220] which would require employers to make meaningful contributions to the cost of their employees' health plans or pay a tax that would help pay for a new public health insurance plan.[221]

While many consider it fair for employers to contribute to the health care of their employees, this contribution has generally taken the form of a voluntary rather than mandatory subsidy.[222] When employers are mandated to subsidize their employees' health insurance, they often shift the burden of health insurance to their employees in the form of decreased wages or other benefits.[223] Employers are particularly induced to shift costs for employee health insurance when the supply of the unemployed increases, making it more difficult for employees to demand increased benefits and easier for employers to pare their benefits packages without jeopardizing their attractiveness to new employees. The prediction of the national unemployment rate increasing in 2010 to as high as ten percent,[224] in conjunction with an employer mandate for health care, is likely to result in fewer hires as well as lower compensation packages. If this outcome is predictable, it does not enhance the economic position of the employed except to guarantee them access to hopefully affordable health insurance in the same way that mandated employer

220. *Id.* Massachusetts' health reform has relied on various sources of financing including an employer mandate which requires employers to set up cafeteria plans to allow employees to purchase health insurance with pre-tax dollars and make a meaningful employer contribution to their employees' coverage or, alternatively, pay a tax of up to $295 per worker per year into a state uncompensated care fund. *See* DEBRA A. DRAPER ET AL., MASSACHUSETTS HEALTH REFORM: HIGH COSTS AND EXPANDING EXPECTATIONS MAY WEAKEN EMPLOYER SUPPORT 2 (2008), *available at* http://hschange.org/CONTENT/1021/1021.pdf. While employers initially favored the plan, increased costs as well as state pressures to increase their responsibilities are causing increased employer frustration. *Id.* at 3.

221. Antos, *supra* note 219, at 1648.

222. *Id.* During decades when the cost of health insurance to employers was relatively low and it was in the self-interest of employers to attract employees with decent employment benefits, employer contributions were accomplished through the free market rather than regulation. *See supra* notes 187–189 and accompanying text.

223. *Id.* The same phenomenon is true of the mandatory Social Security contribution made by employers on behalf of employees; the effect of the mandatory employer tax is a shift to the employee in the form of decreased compensation. *See generally* Anna Rappaport, *Variation of Employee Benefit Costs by Age*, SOC. SEC. BULLETIN 47 (2000) *available at* http://www.ssa.gov/policy/docs/ssb/v63n4/v63n4p47.pdf (discussing variations in employers' costs for employee benefits).

224. Briana Bierschbach, *Fed: Unemployment Rate Will Top 10% in 2009*, TWIN CITIES BUS. J., July 15, 2009, http://twincities.bizjournals.com/twincities/stories/2009/07/13/daily39.html.

contributions to Social Security guarantees workers an income-replacement floor.

The third barrier to a universal single-payer program is the fear of a bigger government with a mandate to tax and spend. Although the fear of increased spending and taxing has generally been more closely associated with Democratic administrations, the Bush administration managed to hold up its end of the spending phenomenon as well as, and even better than, previous Democratic administrations.[225] At the state level, the spending barrier is even greater since states have much more limited revenue options, mandatory spending requirements, and generally a requirement to balance their budgets.

In California, for example, Democrats fearful of the fiscal impact of health care reform opposed Republican Governor Schwarzenegger's individual mandate universal health insurance proposal.[226] State of California Senator Don Perata[227] slowed the momentum of the Governor's $14 billion proposed plan by asking the state's legislative analyst to determine how the overhaul plan could affect California's projected budget shortfall of $10 billion to $14 billion dollars over the next two years.[228] State of Californa Senator Denise Ducheny[229] also withheld her approval of the legislation pending more examination.[230] In defense of these tactics, state governments, unlike the federal government, are constitutionally required to balance their budgets.[231] The Governor's plan would have required substantially all California residents, including some six million uninsured, to obtain health insurance, which was to be funded through employer

225. *See generally* RICHARD A. VIGUERIE, CONSERVATIVES BETRAYED: HOW GEORGE W. BUSH AND OTHER BIG GOVERNMENT REPUBLICANS HIJACKED THE CONSERVATIVE CAUSE (2006) (arguing that President Bush abandoned the conservative platform that he had espoused and implemented expansive government programs that ran counter to conservative ideals).

226. Susan A. Channick, *Can State Health Reform Initiatives Achieve Universal Coverage: Lessons from California's Recent Failed Experiment*, 18 S. CAL. INTERDISC. L.J. 485, 496 (2009).

227. Senator Don Perata was the President Pro Tempore of the California Senate from 2004 to 2008. Don Perata, Join California, http://joincalifornia.com/candidate/5388 (last visited Dec. 3, 2009).

228. *Fate of Health Reform Rests with Senate, California Voters*, CAL. HEALTHLINE, Dec. 19, 2007, http://www.californiahealthline.org/articles/2007/12/19/Fate-of-Health-Reform-Rests-With-Senate-California-Voters.aspx?topicId=93.

229. Senator Denise Ducheny is a Democratic Senator from San Diego. Join California, http://joincalifornia.com/candidate/5388 (last visited Dec. 3, 2009).

230. Keith Darcé, *Governor Promotes Health Reform*, SAN DIEGO UNION-TRIB., Dec. 2, 2007, *available at* http://legacy.signonsandiego.com/uniontrib/20071220/news_1b20health.html.

231. Channick, *supra* note 226, at 490.

contributions, a hospital tax, a tobacco tax increase, and an expansion of federal funds.[232] In the end, the money was simply not there.[233]

Although the Governor's health reform bill passed the State Assembly, it did not pass the Senate.[234] In addition to the fiscal opposition of then-President Pro Tempore Don Perata and Senator Denise Ducheny, Senator Sheila Kuehl, the chairperson of the Senate Health Committee and sponsor of SB 840—a bill introduced in February 2007 that would have created universal single-payer health insurance in California—was able to prevent the Governor's health reform bill from even getting out of the Senate health committee and on to the Senate floor for a full vote.[235] SB 840 would have achieved overall savings of more than $29 billion, most of which would be used toward covering the uninsured and providing financial savings to employers and families.[236] According to one economic impact analysis, SB 840 would have achieved universal coverage with broad benefits while actually reducing total health spending for California by about $8 billion in the first year alone.[237] Unlike either the Massachusetts or California health reforms, or the health reform as proposed by President Obama, Kuehl's universal single-payer proposal did not rely on an employer mandate.[238]

Since the November 2008 election, the likely shape that health reform will take has become more predictable. As noted

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232. ANTHONY WRIGHT & HANH KIM QUACH, HEALTH REFORM IN CALIFORNIA & MASSACHUSETTS: DIFFERENT FROM START TO FINISH 2 (2008), *available at* http://www.health-access.org/files/advocating/2008CA-MAReformComparison%2001%2014%2008.pdf.

233. Given the events that actually transpired, leaving California with a $42 billion dollar budget gap and no budget, the decision not to take on health care reform was probably wise. On February 19, 2009, the California legislature passed a budget that closed the deficit with a combination of increased taxes, cuts in programming, and assistance from the federal government economic stimulus package. *California Senate Approves Budget, Tax Hikes*, CNBC, Feb. 19, 2009, http://www.cnbc.com/id/29279663?__source=RSS*tag*&par=RSS.

234. Jesse McKinley & Kevin Sack, *California Senate Panel Rejects Health Coverage Proposal*, N.Y. TIMES, Jan. 29, 2009, at A14.

235. *Id.*; Steve Hahn, *Does California Have the Cure?*, METROACTIVE, Apr. 18–24, 2007, *available at* http://www.metroactive.com/metro/04.18.07/senate-bill-840-0716.html.

236. Hahn, *supra* note 235.

237. JOHN F. SHIELDS & RANDALL A. HAUGHT, THE HEALTH CARE FOR ALL CALIFORNIANS ACT: COST AND ECONOMIC IMPACTS ANALYSIS 40 (2005), *available at* http://www.healthcareforall.org/lewin.pdf.

238. Hahn, *supra* note 235. SB 840, the California Health Insurance Reliability Act, which at one point had passed both the California Assembly and Senate but was vetoed by Governor Schwarzenegger, would have been funded by employer and employee contributions. *Id.*

above, President Obama supports universal coverage incrementally with immediate universal coverage of children, a population remarkably inexpensive to insure.[239] While popularity of universal health care for children has not always been the norm, recent bipartisan Congressional support for expanding SCHIP seems to prove its current cachet.[240] President Obama's plan would also include expanding Medicaid to include more low-income Americans.[241] The retention of employer-sponsored health insurance as part of the President's health reform model demonstrates a pragmatic policy orientation. President Obama is both an idealist and a pragmatist: he knows that retaining ESI will be much more palatable to Americans than converting to a single-payer model with the federal government as the payer. The President's plan also includes a national health plan for employees of small employers and those without ESI.[242] It would offer a choice of plans ostensibly on the order of the Federal Employees Health Benefits Program (FEHBP), which offers a range of health insurance products from expensive plans with excellent benefits to plans with either decreased benefits or higher out-of-pocket costs for lower premiums.[243]

It seems clear that the Obama administration, while committed to health care reform, is also practically and perhaps philosophically committed to incrementalism as opposed to a systematic overhaul of the current health care system, no doubt dictated by a perceived political resistance to health reform. For example, in a recent survey of employers by the International Foundation of Employee Benefit Plans, a majority of those polled believe the employer-based system should continue to be the primary mechanism for benefits delivery.[244] A second survey

239. LEWIN GROUP, *supra* note 29, at 6. The goal of universal coverage for children could be accomplished by reactivating the SCHIP expansion legislation that President Bush vetoed twice in 2007. Krugman, *supra* note 47 at A17. Since SCHIP relies on both federal and state funds, the burden of covering children would be shared. CONG. BUDGET OFFICE, *supra* note 17, at VII.

240. *See* Ferguson et al., *supra* note 208, at 715–16.

241. LEWIN GROUP, *supra* note 29, at 2.

242. *Id.* at 6.

243. *See* Antos, *supra* note 219, at 1649.

244. These beliefs is notwithstanding the fact that thirty-seven percent of those polled said the U.S. health care system needs a complete overhaul, while an additional thirty-seven percent said the system needed significant changes. *Voters: Health Care System Needs Complete Overhaul or Significant Change*, RESEARCH!AMERICA, July 19, 2007, http://www.researchamerica.org/release_07july19_yourcongress.

conducted by the Washington Post and ABC News[245] also showed strong support for health system reforms but with concerns that sweeping reforms would replicate the HSA fiasco at the beginning of the first Clinton administration.[246] Even former Senate Majority Leader Tom Daschle was not proposing a single-payer system.[247] Senator Daschle made it clear that he would indeed learn from history and steer clear of the missteps made by the Clinton administration, such as excluding key players—health insurers, providers, and even congressional leaders.[248]

Even before the appointment of replacements for Senator Daschle as Secretary of HHS and health reform czar,[249] President Obama forged ahead with plans for health care reform, announcing that he has budgeted $630 billion over ten years as a down payment.[250] As part of a $3.6 trillion 2010 budget, this is a big commitment over and above the $700 billion Troubled Assets Relief Program (TARP) legislation and $787 billion economic stimulus package, which itself contained a large fiscal commitment to health care.[251] To support the health reform plan,

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245. Gary Langer, *Health Care: The Politics of Reform,* ABC NEWS, June 24, 2009, http://abcnews.go.com/PollingUnit/story?id=7910801.

246. The HSA, the Clintons' health reform legislation that would have supplanted an ESI system with a managed competition system, was defeated in 1994 before even getting to the floor of Congress. Jason Ross Penzer, *Grading the Report Card: Lessons from Cognitive Psychology, Marketing, and the Law of Information Disclosure for Quality Assessment in Health Care Reform*, 12 YALE J. ON REG. 207, 210 (1995). Although then-Majority Leader George Mitchell introduced a compromise bill on the floor of the Senate, the compromise bill was defeated in August 1994, a defeat that weakened the Clinton administration. *Id.* at 215–16.

247. The President named Senator Daschle Secretary of HHS and head of a new health reform task force prior to Daschle's withdrawal from consideration. Noam N. Levey, *Daschle's Got His Own Health Plan*, L.A. TIMES, Dec. 15, 2008, at A8, *available at* http://www.latimes.com/news/nationworld/nation/la-na-daschle15-2008dec15,0,6827362.story. Senator Daschle signaled his intention to make more systemic changes to health reform, including the creation of a new federal agency called the Federal Health Board, with authority to set guidelines for what treatments and procedures are most cost-effective. *Id.*

248. *Id.*

249. On March 2, 2009, President Obama named Nancy-Ann DeParle, a former administrator of Health Care Financing Administration (the predecessor to the Centers for Medicare and Medicaid Services) during the Clinton administration, as his choice for director of the White House Office for Health Reform. Robert Pear & Jeff Zeleny, *On Health, President Takes Team Approach*, N.Y. TIMES, Mar. 3, 2009, at A14, *available at* http://www.nytimes.com/2009/03/03/us/politics/03health.html. He also announced his choice for Secretary of HHS, Kansas Governor Kathleen Sebelius, whose credentials in health care reform include a six-year stint as the Kansas insurance commissioner. *Id.*

250. John K. Iglehart, *Budgeting for Change—Obama's Down Payment on Health Care Reform*, 360 NEW ENG. J. MED. 1381, 1381 (2009).

251. American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123

the government would reduce Medicare and Medicaid spending over ten years and increase taxes for those in the highest income tax brackets.[252] In addition, President Obama's plan includes reductions in spending on Medicare payments to private health plans that exceed the amount paid by Medicare for its fee-for-service beneficiaries by about fourteen percent.[253] As previously noted, President Obama has expressed his intention of retaining ESI with an employer pay-or-play mandate as the centerpiece of health reform, and choices of FEHBP-type private plans or a Medicare-like public plan for those who either have no insurance through employment or are dissatisfied with such insurance.[254] The President is working closely with Congress in the design of health reform, however, and it is obvious that compromises will be made.[255] One of the key debates centers on whether he will have to concede a "public option"—a government-run insurance plan—in order to get any reform implemented.[256]

Even without single-payer government-run health care, there are still major objections to budgeting an unprecedented amount for government interventions into the private sector. At a gathering of the Conservative Political Action Committee, House Minority Leader John Boehner[257] referred to President Obama's

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Stat. 115 (2009). The budget deficit for 2009 alone is predicted to be a staggering $1.75 trillion dollars. Posting of Foon Rhee to Political Intelligence, http://www.boston.com/news/politics/politicalintelligence/2009/02/obama_outlines.html (Feb. 26, 2009, 15:02 EST).

252. The initial plan for revenue from tax increases includes not renewing the former administration's tax cuts for high earners as well as cutting tax deductions for home mortgage interest and charitable deductions for those earning in excess of $250,000. Jackie Calmes & Robert Pear, *Obama to Call for Higher Tax on Top Earners*, N.Y. TIMES, Feb. 26, 2009, at A1, *available at* http://www.nytimes.com/2009/02/26/us/politics/26budget.html.

253. In response to the cut in payments to Medicare Advantage private plans, the stock of Medicare contractors like Aetna, Humana, and United Health Group tumbled by double digits on Friday, February 27, 2009, one day after the budget was announced. *Wall Street: Stocks Slide as Obama Outlines Budget*, INT'L BUS. TIMES, Feb. 27, 2009, http://www.ibtimes.com.hk/articles/20090227/wall-street-stocks-slide-obama-outlines-budget_all.htm.

254. *See* Ferguson et al., *supra* note 208, at 715–16.

255. President Obama is exquisitely aware that one of the factors that defeated the HSA was the exclusion of Congress from the design and drafting of the plan until it had been completed by the White House. Chris McGreal, *Obama Launches Campaign Urging Congress to Pass Healthcare Reform*, GUARDIAN, July 21, 2009, *available at* http://www.guardian.co.uk/world/2009/jul/21/obama-healthcare-reform-republicans.

256. By the time of publication, President Obama had conceded this point. *See* Deidre Walsh et. al., *Health Care Proposal Mandates Coverage, Drops Public Option*, CNN, Sept. 16, 2009, http://www.cnn.com/2009/POLITICS/09/16/health.care/index.html#cnnSTCOther1.

257. Senator John Boehner has represented Ohio in the United States of

budget proposal and the economic stimulus plan as "one big down payment on a new American socialist experiment."[258] While the view that a shift from a private market model to a public government model is seismic and precarious is held by the most conservative of politicians, it appears that many Americans feel the shift is dangerous as well.[259] This fear of government interference in the traditional private market is notwithstanding the fact that there seemed to be relatively little resistance to the infusion of TARP money into the capital markets, a move that has euphemistically been called the "recapitalization of banks via injection of public capital."[260] TARP legislation does not explicitly allow for recapitalization, and both the U.S. Treasury and the banking industry were opposed to the idea of the government taking equity positions in financial institutions.[261] Yet, despite the absence of explicit authorization, the U.S. Treasury has been infusing large amounts of public capital into financial institutions in hopes of attracting private capital back into the financial sector. This infusion has been called a pipe dream for institutions with tens of billions of dollars of risky assets.[262]

If the federal government is willing to spend literally billions and perhaps trillions of dollars bailing out banks by means of capital infusions of public money—partial nationalization—what remains of public and governmental objections to nationalizing health care? The problem of a frozen credit market was impossible for the private sector to solve; rather than risk greater financial disaster, the private sector looked to the only feasible solution. In spite of Congress' refusal to use TARP funds for an automakers'

Representatives since 1991. Boehner, John Andrew, Biographical Directory of the United States Congress, http://bioguide.congress.gov/scripts/biodisplay.pl?index=B000589 (last visited Dec. 3, 2009).

258. Susan Cornwall & Thomas Ferraro, *Republicans Set Course in Congress Budget Battle*, REUTERS, Feb. 27, 2009, http://www.reuters.com/article/latestCrisis/idUSN27364194.

259. As evidence of this, the stock market fell by twenty-five percent in just the first two months of 2009. Jack Healy, *U.S. Stocks Surge on Hopes for Banks*, N.Y. TIMES, Mar. 10, 2009, http://www.nytimes.com/2009/03/10/business/worldbusiness/10iht-11stocks.20730087.html.

260. Nouriel Roubini, *How Authorization to Recapitalize Banks via Public Capital Injections ("Partial Nationalization") Was Introduced—Indirectly Through the Back Door—into the TARP Legislation*, RGE MONITOR, Oct. 9, 2008, http://www.rgemonitor.com/roubini-monitor/253956/how_authorization_to_recapitalize_banks_via_public_capital_injections_partial_nationalization_was_introduced_-_indirectly_through_the_back_door_-_into_the_tarp_legislation.

261. *Id.*

262. Colin Barr, *Why the Banks Need Stronger Medicine*, FORTUNE, Nov. 25, 2008, http://money.cnn.com/2008/11/25/news/banks_medicine.fortune/index.htm.

bailout, the White House agreed to a $17.4 billion infusion of public money to bail out Chrysler and General Motors rather than allow the companies to reorganize under bankruptcy protection.[263] Why not save health care through a federal government single-payer system? President Obama successfully endorsed a large economic stimulus package, the American Recovery and Reinvestment Act,[264] which included a significant subsidy for health care.[265] Health care information technology would presumably get a bump if providers—physicians and hospitals—were required to use technology, such as electronic health records, as a condition for participation in Medicare.[266] In addition, the plan allocates federal money to the states for Medicaid assistance, and includes a proposal to allow U.S. residents between the ages of sixty-two and sixty-four to pay to enroll in Medicare.[267]

While a good deal of "reform" to health care has already been proposed, all of it involves incremental changes to an existing system that are aimed at decreasing the number of the uninsured, and controlling the currently out-of-control costs of health care in both the public and private sectors.[268] There are few experts who are advocating a single-payer system to replace the complex, expensive, multi-payer system that the United States currently

263. In order to receive the loans, General Motors and Chrysler were required to demonstrate their continued viability by March 31, 2009 or pay back the loans. *White House Green Lights Automaker Bailout*, CBS NEWS, Dec. 19, 2008, http://www.cbsnews.com/stories/2008/12/19/business/main4676962.shtml. Notwithstanding a previous infusion of $13.4 billion from the Treasury, General Motors filed for Chapter 11 bankruptcy protection. Neil King, Jr. & Sharon Terlep, *GM Collapses into Government's Arms*, WALL ST. J., June 2, 2009, at A1, *available at* http://online.wsj.com/article/SB124385428627671889.html.

264. American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115 (2009).

265. One hundred fifty billion dollars of the $787 billion economic stimulus package is directed to health care. Robert Steinbrook, *Health Care and the American Recovery and Reinvestment Act*, 360 NEW ENG. J. MED. 1057, 1057 (2009). *See also* Kaiser Daily Health Policy Report, CBO Reports Analyze Major Health Insurance Proposals' Potential Effects on Federal Budget, the Uninsured, Costs (Dec. 19, 2008), http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=2&DR_ID=56186.

266. Robert Pear, *Budget Office Sees Hurdles in Financing Health Plans*, N.Y. TIMES, Dec. 19, 2008, at A29, *available at* http://www.nytimes.com/2008/12/19/us/politics/19health.html?_r=1.

267. Kaiser Daily Health Policy Report, *supra* note 265.

268. Cost savings proposals that have been floated include requiring physicians and hospitals to adopt electronic records, requiring pharmaceutical companies to give the federal government a discount or rebate on prescription drugs used in Medicare Part D, and various pay-for-performance reimbursement schemes. *Id.* In addition, President Obama's health reform plan includes an employer mandate that the Congressional Budget Office says would raise $47 billion in additional revenue over ten years. *Id.*

has. As some advocates of a single-payer system opine, the United States should say yes to a Medicare-for-All option, not "yes but." The "yes but" contingent, which includes such health economics luminaries as Henry Aaron, Rashi Fein, and Paul Krugman, believes that a single-payer system modeled on Medicare would not have political legs.[269] On the other side of the policy debate are Merton Bernstein and Ted Marmor, two experts in welfare state policy, who argue for answering "yes," not "yes but," to Medicare-for-All because it is simpler, cheaper, more efficient, and more practical than other more complex, more incremental, and less well-tested paradigms.[270] One scholar, Jacob Hacker, has suggested a compromise between single-payer Medicare-for-All and the incremental approach favored by the Obama administration: universal health coverage that combines ESI with an employer mandate and an expansion of Medicare for Americans without ESI.[271] The Lewin Group has estimated that this "Health Care for America" would cost the federal government an additional $50 billion per year, a relatively modest sum, by capitalizing on Medicare's simplicity and lower pricing.[272]

Hacker envisions his plan, while initially incremental—it builds on an already existing employer-sponsored system where the employer can elect to play or pay—will inevitably achieve universal single-payer insurance.[273] Although most employers who currently provide health insurance coverage will initially continue to do so, many may elect the pay option of the pay-or-play mandate, particularly if the federal government is able to control more successfully the costs of providing care than the private sector.[274] A plan that would incrementally get the United States to universal single-payer health care might satisfy the need to reform the system without unnecessarily disturbing the status

269. Henry J. Aaron, *The Costs of Health Care Administration in the United States and Canada—Questionable Answers to a Questionable Question*, 349 NEW ENG. J. MED. 801, 801–03 (2003); Posting of Paul Krugman to The Conscience of a Liberal, http://krugman.blogs.nytimes.com/2007/10/07/why-not-single-payer/ (Oct. 7, 2007, 17:31 EST); Rashi Fein, *Lesson: Know Your History and Learn From It*, COMMONHEALTH, Jan. 19, 2009, http://commonhealth.wbur.org/guest-contributors/2009/01/lesson-know-your-history-and-learn-from-it-by-rashi-fein/.

270. Posting of Merton Bernstein & Theodore Marmor to Health Affairs Blog, http://healthaffairs.org/blog/2008/08/28/medicare-for-all-why-we-should-say-yes-not-yes-but/ (Aug. 26, 2008, 23:22 EST).

271. Jacob S. Hacker, *Putting Politics First*, 27 HEALTH AFF. 718, 721 (2008), *available at* http://content.healthaffairs.org/cgi/reprint/27/3/718.

272. *Id.*

273. JACOB S. HACKER, HEALTH CARE FOR AMERICA 8–9 (2007), http://www.sharedprosperity.org/bp180/bp180.pdf.

274. *Id.* at 4–5.

quo. Why, one may ask, is this stealth approach to universal single-payer health coverage necessary? Why can Americans not accept express single-payer government health insurance without obfuscation? Is there something about the model that is deficient, or is there something about Americans that makes a government solution to a huge and ongoing societal problem impossible? Ingrained cultural beliefs are a fourth reason why single-payer universal government health insurance will not work in the United States.

Since every other democracy except the United States views sickness as a relatively random risk to everyone and health care as a human right to which none should be excluded for lack of ability to pay, it would be reasonable to suppose that there is something unique about the United States that makes a social solidarity model for health care impossible, even as the United States moves from a conservative, antigovernment, market-oriented regime to a one that seems to believe in the power of government to solve social problems. Until now, health care has been inextricably tied to individual success. Those who succeeded in obtaining employment that included health care as a benefit were safe from the economic vagaries of illness, but those who were unsuccessful were unprotected and consigned to bad default positions. Only the elderly, certain populations of the very poor, and now children—none of whom could get coverage through employment—were exempted from this model. Politicians and policy makers have generally believed Americans would not politically or financially support a system delinked from employment, delinked from wealth status, and founded instead only on membership in society and the random need for health care.

Conclusion

The United States is facing an economic crisis that is predicted to result, not only in much higher unemployment, but also in a significant decrease in personal wealth.[275] Large corporations as well as small businesses are shedding employees in order to survive.[276] As we well know from the sorry sight of the CEOs of the big three automobile companies coming hat-in-hand to plead with Congress for a bailout, the cost of health care as well

275. Growing Poverty and Despair in America, http://sjlendman.blogspot.com/2009/08/growing-poverty-and-despair-in-america.html (Aug. 26, 2009, 3:07 EST).

276. Ken Sweet, *Jobless Rate Hits 7.6%; 598,000 Positions Lost in January*, FOX BUS., Feb. 6, 2009, http://www.foxbusiness.com/story/markets/economy/employers-shed--jobs-january-unemployment-rate-hits/.

as other employment benefits is part of the reason that U.S. companies are not only unprofitable and uncompetitive, but perhaps also unsustainable.[277] As the saying goes, we are all feeling the pain. Is the pain sufficiently universal to create empathy for the less fortunate by the more fortunate; the kind of empathy that might support a redistribution of wealth? With the health care system an acknowledged mess, the economic system shaky enough to scare even those who currently have affordable health insurance, a terrible economy, and a new administration that believes in the power of government to solve problems, is the time right for systemic health care reform? In other words, has the policy window for health reform opened?[278]

Currently there are many reasons to believe that federal health care reform is an idea whose time has come. The President is a Democrat, and Democrats control both houses of Congress, but this does not guarantee a policy outcome. A recent Gallup poll on Americans' perception of the health care system versus their own health care demonstrates what seems to be an inexplicable attitude: while seventy-three percent of respondents believe that the health care system is in crisis or has major problems, eighty-three percent rank the quality of their own health care as excellent or good and sixty-seven percent rank their own health care coverage as excellent or good.[279] Is there a coherent take-away message about what the electorate wants from this administration in the way of health care reform?

Certainly one interpretation is that whatever is done to reform health care, the majority of Americans are not only happy enough with the coverage they have, but more importantly, fear any change that might jeopardize or undermine their own personal coverage. This dichotomy may be even more compelling today because of the real fear of unemployment. It may be that hard

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277. Guy T. Saperstein, *Medicare for All: The Only Sound Solution to Our Healthcare Crisis*, ALTERNET, Jan. 16, 2007, http://www.alternet.org/story/46550/.

278. JOHN W. KINGDON, AGENDAS, ALTERNATIVES AND PUBLIC POLICIES 165–72 (2d ed. 1984). John W. Kingdon, a political scientist at the University of Michigan, explores the important question of why legislators pay attention to some ideas and not to others. *Id.* In other words, what makes an idea's "time come" so that it appears to catapult to the top of the political agenda? *Id.* at 1. Even when an idea is on the agenda, there is no guarantee that it will result in legislation. *Id.* Professor Kingdon studies health care reform using national health insurance proposals to exemplify how what seems like a good idea can perennially fail. *Id.* at 6–9.

279. Lydia Saad, *Americans Rate National and Personal Healthcare Differently*, GALLUP, Dec. 4, 2008, http://www.gallup.com/poll/112813/Americans-Rate-National-Personal-Healthcare-Differently.aspx.

times—rather than increasing empathy for those without employment and therefore without health insurance—increase fear and engender protectionism for what one has, however imperfect. In a culture that prizes individualism over community, and believes only in equality of opportunity, those who do not or cannot take advantage of opportunity are considered redundant and undeserving of support by the productive sector of society.[280] Rather, Americans need to believe in solidarity: that all members of society, regardless of their success or failure, deserve social aid in order to insure that everyone's health care needs are met.[281] Social solidarity and human decency mean that health care be available to those who most need it, not just those who can afford it.[282] Those who most need it are always the sick, and more often than not, those who can least afford it.

Although single-payer universal health care is a political, economic, and cultural non-starter, apparently health reform under the Obama administration is not. While many remember the systematic dismantling of the HSA by the various entrenched players in the health care arena,[283] there seems to be general agreement that it will not happen this time around. At the Wharton Entrepreneur Conference, there seemed to be general agreement among all the participants on the panel that health reform is nigh.[284] As Len Nichols, a health economist and director of the Health Policy Program at the New American Foundation, a non-profit public policy think tank, put it, the current economic slump has "helped to make the case [that] we are indeed in one boat."[285] Perhaps something positive will emerge from this economic disaster: the social solidarity necessary to make decent, affordable, health care available to all Americans. This solidarity would help to mitigate the pain we are all feeling, not only for ourselves and our families, but for all the strangers who make up this great nation.

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280. *See generally* ZYGMUNT BAUMAN, WASTED LIVES: MODERNITY AND ITS OUTCASTS (2004) (theorizing that economic progress has created a growing number of poverty stricken human outcasts and that understanding how contemporary culture and politics deal with this problem can give us valuable insight into our shared social conscious).

281. Deborah Stone, *Protect the Sick: Health Insurance Reform in One Easy Lesson*, 36 J.L. MED. & ETHICS 652, 653 (2008).

282. *Id.*

283. HAYNES JOHNSON & DAVID S. BRODER, THE SYSTEM: THE AMERICAN WAY OF POLITICS AT THE BREAKING POINT 628–631 (1996).

284. *Health Reform Is Nigh*, FORBES, Mar. 5, 2009, http://www.forbes.com/2009/03/05/health-care-wharton-entrepreneurs-human-resources_wharton.html.

285. *Id.*