

ARTICLES

CAN STATE HEALTH REFORM INITIATIVES ACHIEVE UNIVERSAL COVERAGE? CALIFORNIA'S RECENT FAILED EXPERIMENT

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I. INTRODUCTION: THE PROBLEM

Not very long ago, health care reform was near or at the top of the national political agenda. Alarmed at health care spending that topped out at \$2.1 trillion in 2006 while forty-five to fifty million Americans were completely uninsured, it seemed inevitable that the forty-fourth President of the United States would have to take some action to achieve universal or near-universal access to health care. At least, this was the thinking before the arrival of the current banking and liquidity crisis which may cost the federal government and of course the taxpayers as much as one trillion dollars.¹ This money, which the government will have to borrow by raising the national debt ceiling to almost eleven trillion dollars,² will be used to bail out institutions that offered cheap credit and created an unsustainable housing bubble as well as the institutions that securitized subprime mortgages and sold them globally.³ The problem now is not too much credit but too little, and many believe that the main goal of government bailout money is to create liquidity in the credit market, an experiment which is currently taking the form of recapitalizing major banks.⁴ This fiscal disaster managed to push almost everything else off the front page, including news

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¹ On Friday, October 3, 2008, President Bush signed into law the Emergency Economic Stabilization Act of 2008. Pub. L. 110-343 authorizes the United States Secretary of the Treasury to spend up to US \$700 billion to purchase distressed assets, especially mortgage-backed securities from the nation's banks.

² The federal debt is that amount of money that the United States owes its creditors, domestic and international. *United States Public Debt*, WIKIPEDIA, http://en.wikipedia.org/wiki/United_States_public_debt.

³ See generally Kevin Phillips, *BAD MONEY: RECKLESS FINANCE, FAILED POLITICS, AND THE GLOBAL CRISIS OF AMERICAN CAPITALISM* (Viking 2008). Mr. Phillips is a political and economic commentator and a regular contributor to the *Los Angeles Times* and National Public Radio. He is among a growing number of critics of the "financialization" of the economy, i.e. the increased dominance of the finance industry in the sum total of economic activity. *Id.* at 19-21. Mr. Phillips takes this argument further by alleging that the financial sector sets the economic and political agenda for the country. *Id.*

⁴ The irony of this highly unusual step is that this would be nationalizing the banks in any other country but the United States; here the public recapitalization is called "taking a public stake."

of the presidential election.⁵ All of this is not good news, however, for health care reform.

In California, another financial disaster was occurring: a budget impasse over how to close a \$15.2 billion state budget shortfall. Republicans opposed any new taxes to pay for state programs, while Democrats supported budget cuts with higher taxes on corporations and the wealthiest Californians. The impasse lasted an unprecedented three months and finally ended on September 16, 2008, when Governor Arnold Schwarzenegger signed a compromise budget of \$144.5 billion, agreed upon by the legislative bodies.⁶ The budget has \$7.1 billion in spending cuts which neither closes the \$15.2 billion shortfall nor provides assistance for the dislocation and losses of those who depend on state funding and were without it during the eighty-five day impasse.

Even before the current federal economic disaster, there was hope that the states, through innovation and experimentation in their multiple laboratories, would try out different approaches to universal health care access. And indeed, recently the Kaiser Family Foundation reported that three states—Massachusetts, Maine, and Vermont—have enacted universal coverage plans, while fourteen more have proposed such initiatives.⁷ This report includes states such as California and Illinois where reform initiatives have been attempted but have ultimately failed. While this may seem like little success, the fact that the states are working toward universal coverage is heartening. Unfortunately, with current economic conditions, there is a real question about whether the federal government will be able to address national health care reform efforts since, even if there might be bilateral political support, the financing may not be there.⁸

Governor Schwarzenegger, who will be termed out of the governor's seat in 2010, the end of his current term, had declared 2007 to be the Year of Health Care Reform. Making health care reform work in California, a state with a population of 36.5 million, at least 6.5 million uninsured, would have ensured his legacy as an innovative leader. And if he could

⁵ Sen. John McCain, the then-Republican candidate for the presidency and ostensible leader of the GOP, "suspended" his presidential campaign for a few days during the week of the first presidential debate in order to be in Washington to participate in negotiations between the administration and the legislature. He ended up participating in the debate against Sen. Barack Obama.

⁶ Gov. Schwarzenegger signed the budget without the usual fanfare stating that the budget that was three months late was nothing to celebrate. "It's three months late because both of the parties stayed in their ideological corners and refused to come out." Justin Ewers, *Schwarzenegger Signs California Budget, Ending 85-Day Standoff*, U.S. NEWS, Sept. 24, 2008, available at <http://www.usnews.com/articles/news/national/2008/09/24/schwarzenegger-signs-california-budget-ending-85-day-standoff.html>.

⁷ KAISER COMM'N ON MEDICAID & THE UNINSURED, STATES MOVING TOWARD COMPREHENSIVE HEALTH CARE REFORM (2008).

⁸ Not only is it highly unlikely that there will be federal financing to pay for health care reform, it is also unlikely that there will be agreement between the parties as to how to implement universality. While Sen. Barack Obama, the then-Democratic candidate, stated that he would use federal funding to create universal coverage where it does not currently exist, Sen. John McCain, the then-Republican candidate, favored consumer directed health care ("CDHC") funded by a \$5000-defined contribution to taxpayers to purchase health insurance in the open market.

have made inroads into solving the “health care mess”⁹ we are currently in, he would indeed have ensured himself some measure of immortality. Although the governor’s plan was not the only proposal on the table, it was certainly the most high profile. Not only was it supported by the governor but it was modeled after the recently enacted Massachusetts health reform plan.¹⁰

The gravamen of both the Massachusetts and California plans is nearly universal coverage achieved by means of individual and employer mandates and the shared responsibility of other key groups such as providers and governmental organizations, both state and federal. In California, because the size of the state and population made the task so much more daunting than in Massachusetts, the governor was counting on financing from other sources such as an increased tax on tobacco products. In early 2007, when the governor first introduced the health care reform bill, the Health Care Security and Cost Reduction Act, the state was financially flush, operating in a surplus environment. Since that time, the financial picture has radically changed. California faced a 2008–09 budget shortfall of \$14.5 billion offset by billions in budget cuts.¹¹ While initially the ten percent across-the-board cuts to all sectors included a budget reduction of \$1.1 billion to California’s thirty-four billion dollar Medicaid program, in the end the 2008–09 budget cuts affect only Medi-Cal physician reimbursement.¹²

Even in the face of a large projected budget shortfall for 2008–09, the governor continued to move forward with health care reform legislation, ABX1 1, and to that end submitted a proposed ballot measure, for the November 2008 statewide ballot, which would establish the funding mechanism for health care reform.¹³ However, despite the governor’s support, the support of California Assembly Speaker Nuñez and its passage in the State Assembly, the plan never came out of the Senate Health Committee chaired by Senator Sheila Kuehl (D-Santa Monica) who herself

⁹ This term comes from a relatively new book on health care reform by physician Julius Richmond and health economist Rashi Fein. JULIUS B. RICHMOND & RASHI FEIN, *THE HEALTH CARE MESS: HOW WE GOT INTO IT AND WHAT IT WILL TAKE TO GET OUT 1* (Harv. Univ. Press 2005).

¹⁰ Jesse McKinley & Kevin Sack, *California Senate Panel Rejects Health Coverage Proposal*, N.Y. TIMES, Jan. 29, 2008, available at http://www.nytimes.com/2008/01/29/us/29health.html?_r=1&oref=slogin/.

The Massachusetts health reform plan became effective on July 1, 2007, so it is too soon to evaluate its success or failure. The Massachusetts plan seeks almost universal health insurance through an individual mandate, i.e., a requirement that all residents obtain affordable health insurance. The plan was motivated in part by a threat from the federal government to eliminate \$385 million in federal Medicaid money unless the state reduced the number of uninsured people. Pam Belluck, *Massachusetts Sets Health Plan for Nearly All*, N.Y. TIMES, Apr. 5, 2006, available at http://www.nytimes.com/2006/04/05/us/05mass.html?pagewanted=1&_r=1&ci=5094&en=1efda02422b0267b&hp&ex=1144296000&partner=homepage.

¹¹ Tom Chorneau, *Governor’s Budget Aims to Curb Spending Mandates*, S.F. CHRON., Jan. 13, 2008, available at <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2008/01/13/MNNCUDQTG.DTL&hw=Governor+Budget+Aims+to+Curb&sn=001&sc=1000>. While just two years ago California was flush with billions of surplus tax dollars, tax revenue has since plummeted as a result of the home mortgage crisis and a lackluster economy. *Id.*

¹² Kevin Yamamura & Jim Sanders, *Court Rejects California’s Medi-Cal Reimbursement Cuts*, SACRAMENTO BEE, May 20, 2008, available at <http://www.scrippsnews.com/node/35502>.

¹³ Michael Rothfeld & Jordan Rau, *Nuñez Sweetens Deal for Unions*, L.A. TIMES, Dec. 20, 2007, available at <http://www.latimes.com/news/local/la-me-health20dec20,1,2651305.story>.

was the sponsor of competing legislation.¹⁴ One of the nails in the coffin of ABX1 1 was certainly the report of the independent legislative analyst, Elizabeth Hill, requested late in the day by Senate President Pro Tempore Don Perata (D-Oakland). Ms. Hill questioned the bill's proponents' assumption of the cost to the state of subsidized health insurance premiums, warning that higher subsidies than assumed could place great financial stresses on the state.¹⁵ Whether the legislation's defeat was due to political motivations,¹⁶ an unexpectedly large budget shortfall, bad policy, or excessively high costs is a question that surely will be discussed in future post-mortems of California's 2007 health care reform.

Health care is a mess in the United States. In 2006, the cost of health care was \$2.1 trillion or sixteen percent of a \$13.13 trillion GDP. This amounts to roughly \$7000 for each man, woman, and child. In 2004, California's health care costs of \$169 billion accounted for eleven percent of the state's economy, proportionally less than both federal spending for health care and most other states including other states like New York and Massachusetts with—until the recent fiscal crises—similarly strong economies.¹⁷ While private health insurance and consumer out-of-pocket costs combined account for the majority of health care spending, Medicare and Medicaid together pay thirty-six percent of health expenditures in California,¹⁸ yet as many as 6.5 million Californians remain uninsured. Most of the uninsured population are considered to be the working poor, i.e. working in a job that either does not offer health insurance or at a price that this population cannot afford. More than three in five earn less than 200% of the federal poverty level (“FPL”), which in 2006 was \$33,200 for a family of three.¹⁹

One of the more difficult problems presented by an uninsured population is how to reimburse physicians and hospitals that provide care to the uninsured. There are a number of ways in which this happens: for example, Medicaid disproportionate share hospital (“DSH”) payments, and charity care provided by not-for-profit hospitals in exchange for not-for-profit tax status. In addition, providers often shift the cost of care for the

¹⁴ *SB 840 (Kuehl): “Single Payer Health Care Coverage”*, CALHEALTHREFORM.ORG, Oct. 24, 2007, <http://www.calhealthreform.org/content/view/21/38/>. Senator Kuehl has been sponsoring SB 840, a competing health insurance reform bill. SB 840 would cover all Californians under a newly created single-payer California Health Insurance System (“CHIS”) which would be funded by a three to four percent individual income tax and an additional 8.17% employer payroll tax. *Id.* (link to a summary of the proposal's features: <http://www.calhealthreform.org/content/view/37/38/>).

¹⁵ *See Analyst Raises Possibility of Steep Costs for Health Care Reform*, CAL. HEALTHLINE, Jan. 23, 2008, <http://www.californiahealthline.org/articles/2008/1/23/Analyst-Raises-Possibility-of-Steep-Costs-for-Health-Care-Reform.aspx?topicID=37>. The report indicated that the estimated cost of the health insurance premium subsidy could be off by as much as fifty dollars, an underestimation that could cause a shortfall of \$1.5 billion in five years. *Id.*

¹⁶ Perata and Nuñez, by many accounts bitter enemies, are also termed out; victims of the failure of Proposition 93 which would have allowed them more years in the state legislature.

¹⁷ While the economies of New York and Massachusetts have been robust in the past few years, New York is experiencing the same kind of budget shortfall as California due to the sub-prime crisis, a declining housing market, the moving target stock market, and an impending recession.

¹⁸ CAL. HEALTHCARE FOUND., SNAPSHOT: CALIFORNIA ADDENDUM—HEALTH CARE COSTS 101 (2006).

¹⁹ Office of the Governor—State of California, Fact Sheet, Top 10 Indicators: California's Health Care System Is Broken, <http://gov.ca.gov/index.php?fact-sheet/5064> (citing Peter Harbage & Len M. Nichols, *A Premium Price: The Hidden Costs All Californians Pay in Our Fragmented Health Care System*, NEW AM. FOUND., Dec. 2006).

uninsured by charging insured Californians more for their health care. In California, this so-called “hidden tax” is estimated to cost \$455 per individual or \$1186 per family per year.²⁰ Other studies seem to indicate that the impact of uncompensated care for the uninsured is so minimal that fully paying hospital costs of indigent patients would reduce private payers’ costs by less than one percent.²¹ The purpose of the governor’s proposal would be to create a system where almost everyone, including seventy percent of those who are currently uninsured, are insured, thereby providing an access pathway so that almost all Californians can get health care that is reimbursed directly.

Since 1994, when President Clinton’s Health Security Act (“HSA”), which envisioned universal coverage through a market-based managed competition system, was defeated, there has been relatively little new health-care reform on the federal front.²² With the exception of the enactment of SCHIP, the addition of a prescription drug benefit to Medicare in 1997, and legislation authorizing medical or health security accounts for not only the private but the public markets, there has been relatively little momentum toward change to insure everyone through a single-payer or multiple payer approach. So it has been, to a large extent, up to the states to go beyond the reach of Medicaid and SCHIP and propose insurance or other coverage plans in order to create more universal coverage for their residents as well as improve the functioning of their health insurance markets.

Massachusetts and California, two very different states, but both with Republican governors (former Governor Romney (R-MA) and current Governor Schwarzenegger (R-CA)), are putting or have put all of their health care reform eggs in a individual mandate basket which is effectively universal but not single-payer coverage. Massachusetts’ plan became effective on July 1, 2007, while California’s health care reform bill, ABX1 1 was defeated in the California Senate’s Health Committee²³ on January

²⁰ *Id.*

²¹ Loren Kaye, *Loren Kaye: Finding the Right Health Care Solution*, SACRAMENTO BEE, Aug. 17, 2007 at B7, available at http://www.calchamber.com/Chamber_in_the_News/081707_LKoped_SacBee.htm (reporting on a recent study by the California Foundation for Commerce and Education).

²² See Philip Lee et al., *Politics, Health Policy, and the American Character*, 17 STAN. L. & POL’Y REV. 7, 29 (2006) (stating that there has been “little movement toward universal coverage”). While most health reform experts credit the defeat of the HSA to the complexity of the plan and a “behind closed doors” approach taken by its primary architects, then First-Lady Hillary Rodham Clinton and Chief Health Care Policy Advisor Ira Magaziner, its defeat was likely a harbinger of the fate of future federal health care reform. The HSA, like the individual mandate, was a compromise position between a free market approach and a single-payer approach. Its managed competition approach segmented the insurance market into community-rated pools offered as a choice to all Americans who were required to join. The plan was to be funded by a pay-or-play employer mandate. All plans were required to cover certain basic health care but richer plans were available for richer cost share. Although this plan seemed to use a relatively free market approach, the amount of government regulation of the insurance industry, the hardship of the employer mandate on small business, and its regulation of physician choice and compensation proved more than sufficient to defeat it. See generally Kerry Hughes, Note, *Federal Mandates in the Health Care Context*, 4 U. MIAMI BUS. L.J. 187, 190–92 (1994) (stating that under the HSA, the private sector would have control over health care, but would be “closely supervised” by the government).

²³ Anthony York, *Postmortem Analysis of Health Care Bill*, CAPITOL WEEKLY, Jan. 31, 2008, available at <http://www.capitolweekly.net/article.php?xid=vwax2pnrdc8z8>. The Senate Health Committee is chaired by Senator Kuehl (D-Santa Monica) who is sponsoring a single-payer bill, SB 840, which in 2006 was approved by the Legislature and vetoed by the governor. The bill was reintroduced in the

28, 2007, when it was unable to garner the six votes needed for it to be put to a vote of the entire Senate.²⁴ Before the vote in the Senate Health Committee, the governor and Assembly Speaker Nuñez had filed a ballot initiative with the state attorney general's office that created a \$14.4 billion financing package for the governor's universal individual mandate plan that would guarantee access to health care for the majority of Californians.²⁵ But with the defeat of ABX1 1 in the state Senate, there was no opportunity to resurrect health care reform in time to put another financing initiative in front of the voters in 2008.²⁶

The two plans—Massachusetts and California—were structured similarly, yet one has become law and the other has not. The purpose of this Article is to examine generally multi-payer individual mandates, explore the similarities between the Massachusetts and California plans, and analyze the differences that may have determined their respective fates. The Article will look as well to the effect of the demise of the individual mandate in California on state-led health reform. Everyone was looking to see if it could be done in California before conceding that large-scale health reform may be a job that can be accomplished realistically only at the federal level.

With respect to any expensive wholesale reform, the single biggest problem for states to overcome is the perpetual boom-bust fiscal cycle from surplus to deficit, and back again, that derails large scale funding on new programs such as health care reform.²⁷ Because states are required to balance their budgets and cannot deficit-spend in bust times, there is no escape route for expensive programs that may require additional revenue. Further exacerbating the problem is funding that is mandated by state or federal law.²⁸ For example, California spends eighty percent of its total general fund budget on education, health and social services, with

Senate where it passed and is currently languishing on the back burner in the Assembly. The single-payer bill is avidly supported by the California Nurses Association which lobbied hard in the Senate to defeat the governor's bill. George Lauer, *Will Health Care Reform Come Down to Dueling Ballot Measures?*, CAL. HEALTHLINE, Jan. 2, 2008, <http://www.californiahealthline.org/Features/2008/Will-Health-Care-Reform-Come-Down-to-Dueling-Ballot--Measures.aspx>.

²⁴ Tom Chorneau, *Troubled Health Care Bill Up for Vote Today*, S.F. CHRON., Jan. 28, 2008, available at <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2008/01/28/BAFOUMJ1U.DTL>. Even before the vote, four Republican senators and members of the committee and two Democrats, Kuehl and Leland Yee (D-San Francisco), had said they would not support the bill. Don Perata (D-Oakland), and president pro tem of the Senate, could have forced the bill out of committee and onto the full Senate floor where it probably would have failed anyway for lack of sufficient support. "I don't know of any member of our caucus that is wildly in support of this bill," said Yee. *Id.*

²⁵ *Id.* (stating that the health plan would provide health coverage for millions). Under the California ballot initiative system, the proponents of the initiative must first collect sufficient voter signatures to qualify the measure for a selected ballot. If the initiative qualifies, it then goes to the voters to decide on. See California Secretary of State—Elections & Voter Information, Initiative Guide, http://www.sos.ca.gov/elections/initiative_guide.htm.

²⁶ Timm Herdt, *Senators Reject Plan to Reform Healthcare*, VENTURA COUNTY STAR, Jan. 29, 2008, available at <http://www.venturacountystar.com/news/2008/jan/29/senators-reject-plan-to-reform-healthcare>.

²⁷ As we are all beginning to realize, if Congress approves a \$770 billion bailout to provide liquidity to the credit markets, there is unlikely to be federal money for health care reform and perhaps even federal programs like SCHIP and Medicaid may be at risk.

²⁸ Department of Finance, Budget FAQs, http://www.dof.ca.gov/HTML/BUD_DOCS/question.htm (stating that Proposition 98 provides funds for education around forty percent and varies based on the General Funds tax).

education's budget representing about fifty percent. Three-fourths of general fund state operations are earmarked for just four areas: The Department of Corrections and Rehabilitation,²⁹ debt service, the University of California, and the California State University System.³⁰ With such a major part of the budget already committed, it is understandably difficult to get an expensive and new, albeit essential, program off the ground.

Furthermore, California's revenue raising options are few; it cannot, like the federal government, either deficit spend or print money.³¹ Personal income taxes are the largest single revenue source, accounting for fifty-four percent of general fund revenues. In the 1960s, general fund revenues were funded in much larger part by sales and use taxes. The current reduced share for the sales tax reflects, in part, the increase in spending on services which generally are not taxed. The current increased share for personal income taxes reflects growth in real incomes, the state's progressive tax structure, and increased capital gains.³² While growth in real income is a good thing, it is subject to the vagaries of the economy and in "bad" economic times, personal income declines as does its tax revenue. The decline in the housing market, due in large part to the subprime mortgage crisis, has contributed to further losses in revenue.³³ Given such limited revenue-raising measures, the only options for California in a bust time is to raise taxes and/or trim expenses, the latter of which is what the governor's 2008–09 budget has proposed.³⁴ Unfortunately for Governor Schwarzenegger, the projected budget deficit for 2008 and 2009 must seem like back to the future 2003 when a budget deficit precipitated by the loss of revenue due to the dot-com industry failure and exacerbated by higher electricity costs³⁵ derailed the Gray Davis administration.³⁶

²⁹ Included in the Department of Corrections budget is health care for prisoners who are constitutionally entitled to state-provided health care while incarcerated. Currently, the California state prison health care system has been, by court order, taken over by a receiver who is administering the program, the costs of which are still undetermined.

³⁰ Legislative Analyst's Office, *Cal Facts 2006: California's Economy and Budget in Perspective*, State Budget, http://www.lao.ca.gov/2006/cal_facts/2006_calfacts_budget.htm.

³¹ Posting of Alan Katz to The Alan Katz Health Care Reform Blog, <http://alankatz.wordpress.com/2008/01/28/some-lessons-learned-from-californias-year-of-health-care-reform> (Jan. 28, 2008).

³² Legislative Analyst's Office, *Cal Facts 2000: California's Economy and Budget in Perspective*, State Budget, http://www.lao.ca.gov/2000/calfacts/2000_calfacts_state_budget.html.

³³ Abby Goodnough, *Housing Slump Pinches States in Pocketbook*, N.Y. TIMES, Apr. 8, 2007, available at http://www.nytimes.com/2007/04/08/us/08housing.html?pagewanted=1&n=Top/Classifieds/Real%20Estate/Locations/Florida&_r=1.

³⁴ *Governor Defends Health Care Plan in Face of Budget Shortfall*, CAL. HEALTHLINE, Nov. 12, 2007, <http://www.californiahealthline.org/articles/2007/11/12/Governor-Defends-Health-Care-Plan-in-Face-of-Budget-Shortfall.aspx?topicID=93>.

³⁵ *California Energy Crisis*, WIKIPEDIA, http://en.wikipedia.org/wiki/California_electricity_crisis (last visited May 1, 2009). The California electricity crisis stemmed from a combination of factors including an incomplete deregulation scheme, a passive FERC, and predatory schemes by electricity wholesalers such as Enron. *Id.*

³⁶ *Gray Davis*, WIKIPEDIA, http://en.wikipedia.org/wiki/Gray_Davis (last visited May 1, 2009). Governor Gray Davis (1999–2003) was the first governor in the history of California to be successfully recalled under California law that permits special recall elections. While other governors such as Pete Wilson, Ronald Reagan and Jerry Brown had all faced recall attempts, none had been successful. *Id.*

II. THE INDIVIDUAL MANDATE

Let us begin by analyzing insurance mandates. Individual mandates seek to compel people to obtain health insurance that they would not otherwise voluntarily purchase; employer mandates seek to compel employers to provide health insurance to their employees or pay into a state insurance pool that would provide individual health insurance policies to individuals who do not have access to group plans through employment or public programs. A good first question is, why compel participation? First, compelling universal participation in insurance guards against the effects of adverse selection. Adverse selection is the insurance phenomenon that occurs in voluntary programs when the older, sicker, and high demand population enroll in the insurance pool and younger, healthier and low demand individuals do not, thereby driving up the cost of health care and health insurance premiums and often resulting in making insurance unaffordable for the less well-off enrollees. There is evidence that people who are voluntarily uninsured make that decision in part to take advantage of more expensive safety-net health care services when they become ill again, unnecessarily driving up the cost of health care.³⁷ Second, for individuals who are eligible for public insurance programs but are not enrolled, individual mandates may force this group to finally enroll in the public program for which they are eligible. Third, mandates that require employers to “pay or play” force employers to participate in paying their fair share for health insurance instead of relying on public programs,³⁸ although it is arguable that perhaps health care costs ought not be borne by employers.³⁹ In addition, employer mandates are subject to the challenge that they violate ERISA which prohibits states from regulating health insurance plans.

To whom are individual mandates attractive? Without serious low-income products and subsidies, individual mandates are not particularly attractive to the uninsured.⁴⁰ For the low and even middle income uninsured with a demand for health insurance, the key issue is affordability.⁴¹ Unless health insurance is really affordable, there is little

³⁷ LeAnne DeFrancesco, *Safety Net “Crowding Out” Private Health Insurance for Childless Adults*, ACADEMYHEALTH, June 2004, at 1, <http://www.hcfo.net/pdf/findings0604.pdf>.

³⁸ Sherry A. Glied et al., *Consider It Done? The Likely Efficacy of Mandates for Health Insurance*, 26 HEALTH AFFAIRS 1612 (2007), available at <http://content.healthaffairs.org/cgi/content/abstract/26/6/1612>.

³⁹ See generally ROBERT B. REICH, *SUPERCAPITALISM: THE TRANSFORMATION OF BUSINESS, DEMOCRACY, AND EVERYDAY LIFE* (Alfred A. Knopf 2007).

⁴⁰ Katherine Swartz, Address at the Getting to Universal Health Insurance Coverage Conference: How Should We Balance Affordable and Comprehensive Coverage? (Jan. 31, 2008) (transcript available at http://www.kaisernetwork.org/health_cast/uploaded_files/013108_nasi_session3_transcript.pdf). Of the 45–50 million Americans who are uninsured, approximately 50–70% are low-income who cannot afford to buy insurance particularly in the individual market with some kind of a subsidy. *Id.*

⁴¹ See Posting of Rick Kronick to Health Affairs Blog, <http://healthaffairs.org/blog/2008/03/06/the-mandate-wars-in-california-and-beyond> (Mar. 6, 2008, 12:08 EST). A major issue of all health insurance is affordability and so all serious health access reform must include low-income subsidies that make insurance affordable for lower income folks. This is particularly true when the health reform includes a mandate for individuals to be covered. How the subsidy is structured matters as well. When the individual’s contribution is fixed as a proportion of income with the public subsidy bearing the remainder of cost, the risk of a rise in the cost of health insurance is allocated to the public entity paying

incentive for this population, who Professor Brad Herring calls “rational” free riders,⁴² to purchase health insurance as an alternative to the safety net that is already available in the form of hospital emergency departments that are required to provide charity care.⁴³ As for the cohort who simply chooses not to have health insurance, the group that health economist Mark Pauly calls “irrational buyers,” those are the people who will not sign up for insurance even if it were free, and certainly not if they have to pay for it.⁴⁴

So if mandated insurance is not attractive, for a variety of reasons, to the uninsured, why has this model become the health care reform *du jour*? I believe reformers have latched onto the individual mandate model because the status quo is untenable and unsustainable. Government-sponsored single-payer universal health insurance has had literally no traction,⁴⁵ and we therefore have to do something. As Pauly commented, whatever his own ultimate goal with respect to health care in the United States is, he is currently of the “for Pete’s sake, let’s do something” school of political science when it comes to seriously reducing the number of people without health insurance.⁴⁶ In defense of individual mandates, Professor Russell Korobkin explained that mandates are a “concession to constituencies that otherwise might favor the status quo against attempts to make insurance more affordable.”⁴⁷ Drawing an analogy to automobile insurance, Korobkin argued that mandates are good for people who might be hit by an uninsured motorist but are not welcomed by the uninsured who don’t have insurance because they feel they cannot afford it. Similarly, health insurance mandates are good for insured individuals, employers, and private insurers because the cost of subsidies for the unhealthy and poor uninsured is partially offset by health insurance premiums paid by the healthy uninsured who are required to purchase health insurance.⁴⁸

Not surprisingly, health insurance mandates are an important factor not only in state health care reform but also potentially at the federal level. In the Democratic presidential primaries, the individual mandate was almost the only difference between Hillary Clinton’s and Barack Obama’s plans to get to universal health insurance. While Senator Clinton proposed an individual mandate as her immediate path to universal coverage, Senator Obama said that he would take that path only if after other reforms and low-income subsidies, healthy “free riders” still do not buy coverage.⁴⁹

for the subsidy and not to the individual. While this design insures affordability by the individual, it puts the governmental entity at risk of having underfunded the insurance. *See id.*

⁴² Mark Pauly, Address at the Getting to Universal Health Insurance Coverage Conference: Can an Individual Mandate Promote Individual Responsibility? (Feb. 1, 2008) (transcript available at http://www.kaisernetwork.org/health_cast/uploaded_files/020108_nasi_part%20IV_transcript.pdf).

⁴³ See Len M. Nichols & Peter Harbage, *Estimating the “Hidden Tax” on Insured Californians Due to the Care Needed and Received by the Uninsured*, NEW AM. FOUND., May 21, 2007, http://www.newamerica.net/files/052107health_policy_memo.pdf [hereinafter *Hidden Tax*].

⁴⁴ Pauly, *supra* note 42, at 6.

⁴⁵ See generally Susan Adler Channick, *Come the Revolution: Are We Finally Ready For Universal Health Insurance?*, 39 CAL. W. L. REV. 303 (2003).

⁴⁶ See Pauly, *supra* note 42, at 3.

⁴⁷ Posting of Russell Korobkin to The Volokh Conspiracy, <http://volokh.com/posts/1204061613.shtml> (Feb. 26, 2008, 16:33 EST).

⁴⁸ *Id.*

⁴⁹ *Id.* Professor Russell Kobobkin, who was a supporter of Sen. Obama and the individual mandate, notes that compliance, a key component of a mandate, has been unsuccessful both in the automobile

Korobkin criticizes Clinton's universal mandate as destined for failure because it fails to specify its own enforcement mechanism without which the uninsured, particularly voluntary free riders, will have no incentive to enroll.⁵⁰

Another important issue of health insurance reform is deciding where the burden of its cost should fall. Since the mid-twentieth century, the cost of much health insurance has been paid for by employers who have been incentivized to offer it as an employment benefit because of generous federal income tax subsidies. The problem, acknowledged almost universally, with employment sponsored insurance ("ESI") is that its cost is almost certainly shifted to employees in the form of lower compensation. This phenomenon is particularly true in recent decades when the cost of health care and therefore health insurance has consistently outpaced growth in Gross Domestic Product ("GDP").⁵¹ In recent years, the cost of health insurance has become so onerous to corporate America that more of its costs have been directly shifted to employees. The argument in favor of individual mandates goes something like this: since the cost of ESI, including mandated employer insurance, is borne in the main by employees in the form of lost wages, the individual mandate only makes transparent what is actually happening.⁵² As health economist Pauly says, "I think it's important that citizens know who's paying for what, and it can be terribly confusing to think that the boss is paying for it."⁵³

In thinking about health care reform, we should be asking what is compelling enough about creating pathways to universal access to support an individual mandate approach. Surely basic health care is at the core of a decent life but so are many other necessities such as a decent income, decent housing, and decent education which we do not guarantee to every American.⁵⁴ What makes health care reform so much more compelling? I would posit that what is really compelling about health care is its cost, both absolute and relative to both the past and other budget sectors, as well as the historical insurance model that has third-parties paying for premiums⁵⁵ that are subsidized, in large part, by the federal government. While this system, an artifact of post-WWII wage freezes,⁵⁶ has worked well in the past, the continuing rise in health care costs makes it difficult to sustain. Because health care costs are outpacing GDP growth as well as the growth

insurance and the health insurance realms. In California, fully twenty-five percent of drivers are uninsured while in Massachusetts, twenty percent of state residents remain uninsured. *Id.*

⁵⁰ *Id.*

⁵¹ See generally CONG. BUDGET OFFICE, THE LONG-TERM OUTLOOK FOR HEALTH CARE SPENDING (Nov. 2007), available at <http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf> [hereinafter CBO].

⁵² Pauly, *supra* note 42, at 9.

⁵³ *Id.*

⁵⁴ Angus Deaton, *Policy Implications of the Gradient of Health and Wealth*, 21 HEALTH AFFAIRS 13 (2002), available at <http://content.healthaffairs.org/cgi/reprint/21/2/13.pdf>. There is increasing agreement and literature on what is known as the health/wealth gradient, i.e. the close inverse correlation between health and wealth. As explained by Angus Deaton, professor of economics and international affairs at Princeton University, "[t]he relationship between health and income is referred to as a gradient to emphasize the gradual relationship between the two; health improves with income throughout the income distribution and poverty has more than a threshold effect on health." *Id.*

⁵⁵ But see *supra* note 41 and accompanying text.

⁵⁶ RICHMOND & FEIN, *supra* note 9.

of the aging population, they will inevitably adversely affect the ability of Americans to make other consumption choices unless steps are taken to reduce them.⁵⁷

It is widely accepted that people without access to health care raise its costs both because they are sicker by the time they are able to access health care and because they receive their care in the most expensive and uncoordinated venues possible.⁵⁸ It is also widely accepted that people with multiple chronic diseases create the greatest financial burden on the health care system resulting in a highly skewed distribution of health care costs.⁵⁹ While this phenomenon may be less preventable in the aging population, it is certainly much more preventable in younger cohorts whose burden of disease is a result of lack of access to health care rather than aging. In addition to the economic issue and part of the health wealth gradient, the Institute of Medicine⁶⁰ and more recently Families USA⁶¹ have found an increased number of deaths among the uninsured that is directly linked to uninsurance. Families USA reported that in 2006, twice as many people died from lack of health insurance than from homicide.⁶² Among working Americans with access to health insurance, one of their greatest fears is the loss of their employer-sponsored health insurance, even though that benefit is neither guaranteed by law nor likely to be as generous as in the past. Working America is terrified of health problems and interventions that they would not be able to afford but for their ESI.⁶³ The irony of job lock that occurs when working Americans stay in jobs until they are eligible for Medicare has not been lost on many. That America's only true social health insurance⁶⁴ is the health access safety net for millions, while universal health insurance, which could take the form of an expanded Medicare,⁶⁵

⁵⁷ CBO, *supra* note 51. One of the newer movements in health care research is generating data on the comparative effectiveness of various treatment modalities to help providers make better, i.e. more economically efficient, treatment choices without giving up efficacy. *Id.*

⁵⁸ Peter Harbage & Len M. Nichols, *Coverage Without Gaps: Implementing Seamless Health Coverage in California*, NEW AM. FOUND., Sept. 2007, available at <http://www.newamerica.net/files/HPSeamCov.pdf>.

⁵⁹ Mark W. Stanton, *The High Concentration of U.S. Health Care Expenditures*, RES. IN ACTION, June 2006, available at <http://www.ahrq.gov/research/ria19/expndria.pdf>.

⁶⁰ INSTITUTE OF MEDICINE, *CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE* (Nat'l Acad. Press 2002). The IOM report estimates that 18,000 adults between the ages of twenty-five (the age young adults are no longer covered by their parents' health insurance) and sixty-four (the year before Medicare eligibility) died in the year 2000 because they did not have health insurance.

⁶¹ FAMILIES USA, *DYING FOR COVERAGE IN CALIFORNIA* (Apr. 2008), <http://www.familiesusa.org/assets/pdfs/dying-for-coverage/california.pdf>. Families USA reported that in California alone, 3100 working-age or eight daily Californians died from lack of health insurance in 2006.

⁶² *Id.*

⁶³ See Michelle M. Doty et al., *Seeing Red: Americans Driven into Debt by Medical Bills*, THE COMMONWEALTH FUND, August 2005, available at http://www.commonwealthfund.org/usr_doc/837_Doty_seeing_red_medical_debt.pdf. There is ample evidence available to demonstrate that health care expenses are the main cause of personal bankruptcies in the United States. See *id.*

⁶⁴ Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL'Y & L. 287 (1993). Social insurance is insurance where the insured's contribution such as a premium is delinked from her usage. Medicare, for example, provides beneficiaries with whatever health care usage is individually necessary within the coverage limits with no effect on cost. On the other hand, the cost of individual health insurance is usually determined actuarially, i.e. linked to usage; the higher the usage, the costlier the insurance. *Id.*

⁶⁵ Jacob Hacker, health policy and Medicare expert at Yale University, who has written prolifically on Medicare for twenty-five years, is proposing bringing virtually everyone under the umbrella of either

continues to be a complete non-starter, is a strange outcome indeed even in the United States.

III. CAN HEALTH CARE REFORM HAPPEN IN THE STATES ALONE? THE MASSACHUSETTS AND CALIFORNIA EXPERIENCES

The myriad problems of uninsurance notwithstanding, we have not yet resolved the issues—economic, cultural, political, policy—that are crucial to a solution acceptable to the majority necessary to pass such legislation. As stated earlier in this Article, the individual mandate is a compromise that does not represent the preferences of either political party but seems to be less offensive than other alternatives.⁶⁶ Although the individual mandate for health insurance is in effect in Massachusetts, it is too soon to know whether it is going to be viable on a longer-term or broader basis. Furthermore, even if Massachusetts succeeds, is its model replicable by other states? The experience in California seems to suggest that, while the defeat of the individual mandate has been attributed both to political divisiveness⁶⁷ and budgetary woes,⁶⁸ it was not a solution that either party in the legislature was really passionate about. The Republicans were opposed because there was too much government presence and the Democrats were opposed because there was not enough.⁶⁹ The only real passion for reform modeled on a personal responsibility philosophy came from the governor and, in the end, it was not enough.

There are, however, some real issues raised by California's and Massachusetts' experiences. One is whether, when it comes to wholesale health care reform, the states can go it alone. In Massachusetts, the number

qualified ESI or an expanded Medicare ("Health Care for America") for all those who do not have ESI. Employers would be required to pay or play. Individuals who are covered under HCA can essentially choose, as can Medicare beneficiaries, the fee-for-service option or a private managed care option. THE LEWIN GROUP, COST IMPACT ANALYSIS FOR THE "HEALTH CARE FOR AMERICA" PROPOSAL (2008), available at <http://www.sharedprosperity.org/hcfa/lewin.pdf>.

⁶⁶ See *id.* at 4. Republicans, who were represented by the last administration and the then-presidential nominee, Senator John McCain, favor using private market solutions such as the Health Savings Account ("HAS") and association purchasing pools. Democrats, on the other hand, are more likely to support universal single-payer insurance or a combination of ESI and expanded single-payer insurance for those not covered by ESI.

⁶⁷ Daniel Weintraub, *The Death of Health Care Reform: How Arnold Schwarzenegger's Overhaul Plan Was Doomed by the Legislature's Liberal-Conservative Partisan Crossfire*, SACRAMENTO BEE, Feb. 10, 2008, at E4 [hereinafter Weintraub, *Death of Health Care Reform*]. ABX1 1 was championed by both the governor and Fabian Nuñez, the democratic speaker of the California Assembly. It was opposed by most members of the democratic California Senate including the leader of the Senate, Don Perata, and the powerful chair of the Senate Health Committee, Sheila Kuehl, who has been championing a single-payer universal health insurance bill. *Id.*

⁶⁸ York, *supra* note 23 (stating that the Senate Health Committee defeated the plan because of the \$14.5 billion deficit). In the midst of the individual mandate campaign, the state, which had been experiencing a budget surplus under the Schwarzenegger administration, was caught short by various circumstances that resulted in a severe revenue shortfall. Marty D. Omoto, *Next Year's California Budget Deficit of \$10 Billion and the Most Vulnerable in Our State*, CAL. PROGRESS REP., Nov. 15, 2007, http://www.californiaprogessreport.com/2007/11/next_years_cal.html. In addition, the report of the Legislative Analyst's Office opining that a small premium assumption gap could result in a large budgetary shortfall was at least cover that senators voting against the bill could use to rationalize their opposition. York, *supra* note 23.

⁶⁹ Daniel Weintraub, *Autopsy: Who Killed California's Health Care Reform?*, FRESNO BEE, Feb. 22, 2008.

of people who were uninsured was small compared to California, and the ideological and financial infrastructure of health insurance reform was already in place. In contrast, California has a large pool of uninsured persons, somewhere between 4 and 6.5 million, and an unregulated individual insurance market. Since the individual mandate depends, in large part, on affordable individual policies with reasonable coverage and guaranteed access for people who do not have access to a group market,⁷⁰ reforming the individual market would have been much more onerous in California than in Massachusetts.⁷¹ In addition, Massachusetts was able to budget an additional \$500 to \$600 million from its already-existing state free-care pool which was set up to reimburse hospitals for providing care to the uninsured.⁷² California, on the other hand, does not have such a pool of money and much of the otherwise uncompensated hospital care is paid for through a so-called “hidden tax” on the insured.⁷³ Under ABX1 1, the additional revenue available to hospitals from the no-longer necessary tax would have been used by hospitals to satisfy their allocation to the individual mandate.⁷⁴

Even in Massachusetts, with its seemingly smaller pool of uninsured, its more highly regulated insurance market, its larger pools of federal and state funds already earmarked for health care purposes, and its culture of greater social solidarity, the going is tough. One reason is that the number of uninsured may have been badly underestimated—650,000, not 400,000. A second and related reason is that the cost of low-income premium subsidies is higher than first estimated. Massachusetts had budgeted \$472 million for the current fiscal year but will need an additional appropriation of \$150 million to meet its needs; this underfunding is estimated to continue into future years. Exacerbating the problem of insufficient funds is a loss of revenue from expected sources such as the state’s free-care pool which paid hospitals to treat the poor and insufficient funds from the less than adequate employers’ mandate.⁷⁵ The only way that health reform Massachusetts-style was sold to the legislature and the voters was to make the cost fit the budget,⁷⁶ something that could not be done in California for a number of reasons, many of which have already been discussed. California legislators were already skeptical and barely on board with the individual mandate when state coffers were flush; when the real numbers

⁷⁰ The individual mandate is meant to provide universal coverage by supplementing already existing group markets such as ESI, Medicare, Medicaid, and SCHIP.

⁷¹ Posting of Rick Curtis & Ed Neuschler to Health Affairs Blog, <http://healthaffairs.org/blog/2008/03/05/californias-shelved-health-care-reform> (Mar. 5, 2008, 15:04 EST). Massachusetts was able to bring the cost of individual policies down by merging its existing individual market with its less expensive small group market and then requiring everyone to purchase coverage in order to deal with adverse selection. In California, where individual policies are actuarially underwritten and there is no guaranteed issue, the task of creating an affordable individual market with decent coverage would have been much more difficult. *Id.*

⁷² Trudy Lieberman, *Cautionary Healthcare Tales from California and Massachusetts*, THE NATION, Mar. 25, 2008, available at <http://www.thenation.com/doc/20080407/lieberman>.

⁷³ See *supra* note 43 and accompanying text.

⁷⁴ Posting of Lucien Wulsin to Health Affairs Blog, <http://healthaffairs.org/blog/2008/03/06/california-negotiating-the-intersections-of-reform/> (Mar. 6, 2008, 12:27 EST).

⁷⁵ Lieberman, *supra* note 72.

⁷⁶ *Id.*

started to come in and the economy took a serious downturn, all except the hardest supporters quickly jumped ship.

Integral to the question of whether it is possible for the states to effectively reform health care on their own is the issue of cost. Cost is both an independent and a dependent variable of health care and it is always the Achilles heel of health care reform.⁷⁷ The more independent issue of cost is how much of the budget we are willing and can agree to allocate to health care. The United States currently spends \$2.1 trillion or in excess of sixteen percent of GDP on health care, and California spends \$146 billion or eleven percent of its available revenue, yet 46 million Americans and 6.5 million Californians are uninsured. These numbers are not accidental; they are the result of ideological beliefs that lead to policy decisions as to how we wish to provide access to health care in this country.

On the other hand, cost as a dependent variable relates to affordability, i.e. the cost of the current regime versus the cost of the regime that we aspire to. Universal coverage almost always includes explicit governmental subsidization for low-income populations that are not eligible for already existing public insurance in order to create affordable insurance with meaningful coverage. Revenue can come from already existing sources or new sources, usually taxes on personal income, and/or on revenue from the various players in the health care arena. For example, Massachusetts reallocated federal Medicaid money targeted for uncompensated hospital care and California's plan taxed hospitals and cigarettes to pay for health reform costs.⁷⁸

As the legislative effort played out in California, finding new sources of revenue was difficult, more difficult than reallocating already existing revenue.⁷⁹ When it became clear that physician providers would not be financial players in health reform, Schwarzenegger made a last ditch effort to secure financing by imposing an additional tax of \$1.75 per pack on cigarettes, a tax that would have been not only regressive but also inconsistent with the state's aggressive anti-smoking public health campaign. In addition to the state's real problem of finding additional revenue, it is impossible to underestimate the political influence of heavily funded special interests such as the tobacco and the insurance industries. One of the governor's health care experts, Daniel Zingale, has indicated that the bill's demise was due in large part to powerful groups whose economic interests were not in alignment. "There's nothing new about a panel of legislators voting down health care reform under intense lobbying

⁷⁷ Stephen L. Isaacs & Steven A. Schroeder, *California Dreamin'—State Health Care Reform and the Prospect for National Change*, 358 NEW ENG. J. MED. 1537 (2008).

⁷⁸ HEALTH ACCESS ANALYSIS, HEALTH REFORM IN CALIFORNIA & MASSACHUSETTS: DIFFERENT FROM START TO FINISH (Jan. 14, 2008), <http://www.health-access.org/advocating/docs/2008CA-MARreformComparison%2001%2014%2008.pdf>.

⁷⁹ See Weintraub, *Death of Health Care Reform*, *supra* note 67. At least some of the reason why Elizabeth Hill, the California independent Legislative Analyst, objected to the financing piece of ABX11 was a last-ditch attempt by its proponents to bridge the financing gap with an additional tobacco tax which Hill warned would likely wane in the future and leave the state with an additional budget item it could not cover. *Id.*

from special interests—tobacco, Blue Cross, whoever else was active over there,” Zingale said.⁸⁰

Notwithstanding the revenue raising difficulties, it is possible that the additional funding might have been offset by savings from the efficiencies of a more universal system. Assuming that the state could have found additional revenue to fund low-income subsidies,⁸¹ universal coverage could have provided some savings particularly with respect to uncompensated care, the so-called “hidden tax” on the insured by insurers to pay for the otherwise uncompensated care of the un- and underinsured.⁸² The amount of this tax on insured individuals has been estimated to be as high as ten percent. This cost savings does not include savings that would have been realized by the state which itself subsidizes uncompensated care in an unknown amount but within the range of \$1.7⁸³ to \$3.6 billion⁸⁴ in 2005. Whether such savings would have actually offset the cost of universal health coverage is, of course, still untested and unknown. What is known is that, no matter the potential for savings in dollars and lives, no matter the aspiration, the projected cost of ABX1 1 was simply too much for California to afford in a declining economy.⁸⁵

An equally perplexing question relating to cost as an independent variable is not so much what we must spend for a particular program, but the struggle for how to resolve the more philosophical questions upon which good, majoritarian policy depends. With regard to health care, it is a question of how much of our revenue, our gross domestic product, we are willing to allocate to health care in light of so many other societal and individual needs. The independent question of cost should be contrasted with the dependent question of how much we must spend to achieve almost universal coverage through, for example, an individual mandate in California. Clearly the answers to both questions of cost involve more than just a consideration of dollars. In the case of California’s recently failed health reform, the ideology of almost universal access must be distinguished from the predominantly private market solution which would have relied almost exclusively on the players—individuals, employers, insurers, providers, and the tobacco industry—to finance the reform. The state’s piece—heavy subsidization beyond its preexisting obligations—

⁸⁰ York, *supra* note 23.

⁸¹ *Id.* While in Massachusetts, some funding for health care reform was budgeted from the state’s general fund, California’s ABX1 1 was crafted to be budget-neutral, i.e. with no impact on the general fund without legislative approval. *See id.*

⁸² *Hidden Tax*, *supra* note 43.

⁸³ GERALD F. KOMINSKI ET AL., UCLA CTR. FOR HEALTH POL’Y RES., COST OF INSURING CALIFORNIA’S UNINSURED (2005), http://www.healthpolicy.ucla.edu/pubs/files/CostofInsuring_PB_052405.pdf.

⁸⁴ FAMILIES USA, PAYING A PREMIUM: THE ADDED COST OF CARE FOR THE UNINSURED (June 2005), http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf.

⁸⁵ *See* Daniel Weintraub, *Get California Off Its Financial Roller Coaster*, MERCURY NEWS, Mar. 12, 2008, available at http://www.mercurynews.com/opinion/ci_8542737. Both the governor and the independent Legislative analyst have proposals for getting California off of its financial roller coaster. The governor’s proposal looks more to limiting spending and making budget cuts automatic in bad times while the Legislative analyst’s proposal focuses on setting aside tax receipts that come in above projected levels for the year rather than use the surplus to push spending up automatically as required by mandates previously adopted by the voters. *Id.*

relied exclusively on the projected contributions of the players beyond which the state was neither willing nor able to contribute.⁸⁶

It has become apparent that the absolute cost of health care cannot be sustained at its current level. The growth in health care costs is well documented and is attributable to many factors, such as expensive new technology, third-party first-dollar health insurance that contributes to patient and provider demand, labor costs, and provider reimbursement schemes. In the United States, the \$2.1 trillion cost of health care means that we are spending \$7000 annually for each man, woman and child, substantially more than any of the other OECD⁸⁷ countries, and with, in many cases, much poorer outcomes. At this time, health care spending is the single biggest sector of the economy, larger even than the defense sector.⁸⁸ An early 2007 report from the Center on Budget and Policy Priorities demonstrates that if current fiscal policies—including Medicare and Medicaid spending and tax revenue losses from tax cuts and changes to the alternative minimum tax—continue, budget deficits will climb from a sustainable two percent of GDP to twenty percent of GDP in 2050.⁸⁹ At that rate, debt service on the national debt will consume more than half of federal revenues, making growth impossible.⁹⁰ The Congressional Budget Office's December 2007 projection of health care costs suggest that in the absence of changes in federal law, total spending on health care would rise from the current sixteen percent of GDP to twenty-five percent in 2025, thirty-seven percent in 2050, and forty-nine percent in 2082.⁹¹ If these projections sound alarming, that is because they are certainly meant to be.

Because of the continued rise of health care costs in the United States, there is now sustained pressure at many levels to implement changes that will contain costs as a necessary component of health care reform. Certainly an unaffordable projected cost of \$14 billion or more in the context of a steeply declining economy was central to the defeat of ABX1 1.⁹² A reasonable cost is therefore essential to the successful design of reform proposals which seek affordable sustainable health insurance with reasonable coverage. Even without reform, cost containment is essential to access for an increasing number of people who become uninsured because they or their employers cannot afford the cost of decent health insurance.⁹³

⁸⁶ National Coalition on Health Care, Health Insurance Costs, <http://www.nhc.org/facts/cost.shtml>.

⁸⁷ OECD, <http://www.oecd.org/home> (last visited May 1, 2009). The Organization for Economic Cooperation and Development compares all first-world countries on health care costs and outcomes. *Id.*

⁸⁸ RICHARD KOGAN, CTR. ON BUDGET & POL'Y PRIORITIES, FEDERAL SPENDING, 2001 THROUGH 2008: DEFENSE IS A RAPIDLY GROWING SHARE OF THE BUDGET WHILE DOMESTIC APPROPRIATIONS HAVE SHRUNK (Mar. 6, 2008), <http://www.cbpp.org/files/3-5-08bud.pdf>. As of the 2008 report, defense spending consumed 5.6% of GDP. *Id.*

⁸⁹ RICHARD KOGAN ET AL., CTR. ON BUDGET & POL'Y PRIORITIES, THE LONG-TERM FISCAL OUTLOOK IS BLEAK: RESTORING FISCAL SUSTAINABILITY WILL REQUIRE MAJOR CHANGES TO PROGRAMS, REVENUES, AND THE NATION'S HEALTH CARE SYSTEM (Jan. 29, 2007), <http://www.cbpp.org/1-29-07bud.pdf>.

⁹⁰ *Id.*

⁹¹ CBO, *supra* note 51.

⁹² Ed Mendel, *State Budget '\$20 billion out of whack': Schwarzenegger's Latest Estimate Covers Two Years*, UNION TRIBUNE, Apr. 29, 2008, available at <http://www.signonsandiego.com/news/state/20080429-9999-1n29budget.html>.

⁹³ *Controlling Costs*, ASCLEPIOS, Feb. 7, 2008, http://www.medicarerights.org/issues-actions/asclepios/2008_06.html.

Recent studies tell us that the primary drivers of personal health care spending growth are medical prices and utilization. The paradox of modern health care is that while the technology is available to enhance the quality and extend the duration of life, it is so costly that it will, if used without constraint, bankrupt the government, exactly the scenario described above.⁹⁴ The second driver of health care costs, utilization, looks to patients and providers, the consumers of health care, and our third-party payment system which makes the consumer indifferent to the cost of care, the moral hazard theory. One perspective of high usage posits that utilization is driven by demand of the well-insured “nervous well” who demand and receive high-cost diagnostic tests without regard to their effectiveness.⁹⁵ This perspective also includes overly-cautious providers practicing defensive medicine, and reimbursement schemes that incentivize high-cost behaviors.⁹⁶ A second perspective argues that health care expenditures are not spread evenly among the population but are highly skewed with a relatively small percentage of individuals consuming a disproportionately large share of health care resources and therefore is responsible for a disproportionate share of health care expenditures.⁹⁷

Health care usage data demonstrates that the skewed distribution perspective seems to be true and that the numbers are sustainable over long periods of time. There is much agreement that the distribution of health care costs is highly skewed, with one percent of the population accounting for twenty-eight percent of health care costs, five percent for more than half, and ten percent for a full two-thirds.⁹⁸ The corollary is fascinating as well: more than fifty percent of the population consumes only three percent of health care resources.⁹⁹ If these data are correct, it makes sense to focus cost containment research on these expensive populations where the possibility for improvement is substantially greater. A recent study by the Commonwealth Fund on options for achieving savings and improving value in U.S. health care spending suggests that aligning Medicare payment incentives to more coordinated care alone could save \$425 billion over ten years.¹⁰⁰

⁹⁴ HENRY J. AARON ET AL., *CAN WE SAY NO? THE CHALLENGE OF RATIONING HEALTH CARE* (Brookings Inst. Press 2005).

⁹⁵ Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures, Revisited*, 20 HEALTH AFFAIRS 9 (2001) available at <http://content.healthaffairs.org/cgi/reprint/20/2/9.pdf>.

⁹⁶ Recently, I heard stories from two unrelated friends whose elderly and well-insured parents were hospitalized by their physicians because of acute conditions. In one case, the parent, who had long been diagnosed with a slow-moving terminal illness, fell and was admitted to a hospital which did extensive and expensive testing revealing nothing more than what was already known. The testing stopped and he was released only when his daughter, a nurse, insisted. I am not suggesting that physicians who admit patients to hospitals are solely financially motivated but I do believe that current financial incentives may operate to skew professional judgment.

⁹⁷ Berk & Monheit, *supra* note 95.

⁹⁸ *Id.*

⁹⁹ *Id.* The data show that the bottom fifty percent incurred an average annual expenditure of \$122 while those in the top one percent spent \$56,459 per person per year. *Id.*

¹⁰⁰ Cathy Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, THE COMMONWEALTH FUND, Dec. 2007, available at http://www.commonwealthfund.org/usr_doc/EMBARGOED_FULL_REPORT_Bending_the_Curve_optimized.pdf?section=4059.

Finally, the last issue raised by the California and Massachusetts state health reform attempts is whether universal health coverage is best solved by greatly expanding the market in individual health insurance policies using a much more heavily regulated private insurance sector. In California, one of the biggest obstacles to the individual mandate was the objection by Blue Cross¹⁰¹ to proposed state regulation of the private insurance market in order to guarantee issue and keep the cost of individual policies affordable and coverage sufficiently comprehensive.¹⁰² Other options for getting to universal health coverage have been floated, including single-payer national health insurance and a system that would cover all Americans by expanding and building on the already-existing health insurance infrastructure of Medicare and employment-based insurance. Single-payer insurance has been raised repeatedly at both the federal¹⁰³ and state¹⁰⁴ levels but has never received much political traction.¹⁰⁵ Recently, Jacob S. Hacker¹⁰⁶ has proposed Health Care for America (“HCA”), a proposal for guaranteed affordable health care for all Americans building on Medicare and employment-based insurance.¹⁰⁷ Professor Hacker’s proposal is like the individual mandate in its structure that builds on already existing and successful programs. Its design demonstrates the drafters’ understanding that in order for health care reform to be politically successful, it must defer to the eighty-five percent of the population who are currently insured and want to retain their insurance coverage. Unlike the individual mandate, HCA would not achieve universal access through expanding the individual insurance market but would establish a new public insurance pool modeled after Medicare and financed through an employer pay-or-play regime.

The advantages of large insurance risk pools as opposed to fragmented risks have been explored by this author and many others.¹⁰⁸ As Professor

¹⁰¹ See York, *supra* note 23.

¹⁰² Pauly, *supra* note 42.

¹⁰³ See Physicians for a National Health Program, Single-Payer National Health Insurance, http://www.pnhp.org/facts/single_payer_resources.php. Physicians for a National Health Program have long been advocating for a single-payer national health insurance system where the federal government organizes the health financing but the delivery remains largely private. This group argues that changing health care financing to government as a single-payer compared with our current system of multiple private insurers could save as much as \$350 billion annually, enough to provide comprehensive coverage to all Americans. While this may be very good policy, it is so politically unfeasible that such a national proposal has never come out of a legislative committee. *Id.*

¹⁰⁴ Kevin Uhrich, *Universal Health Care: Is Senate Bill 840 Too Good to Be True?*, PASADENA WEEKLY, Feb. 23, 2006, <http://www.pasadenaweekly.com/cms/story/detail/?id=3031&IssueNum=8>. California State Senator Sheila Kuehl has a state single-payer bill, SB 840, which has passed the state Senate but has been languishing in the Assembly. After the recent defeat of the governor’s individual mandate universal health insurance bill, SB 840 may be revived. *See id.*

¹⁰⁵ Single-payer universal health insurance has never received traction in the United States because it is viewed not as social insurance but rather as socialism. Query whether the recent direct infusion of capital into major banks to ease the credit crisis which seems to be acceptable to even conservative Americans might grease the wheels of government-financed universal health insurance.

¹⁰⁶ Professor of political science and resident fellow of the Institution for Social and Policy Studies, Yale University, and a fellow at the New American Foundation.

<http://www.yale.edu/polisci/people/jhacker.html>.

¹⁰⁷ Jacob S. Hacker, Economic Policy Institute Briefing Paper #180: Health Care for America: A Proposal for Guaranteed, Affordable Health Care for All Americans Building on Medicare and Employment-Based Insurance (Jan. 11, 2007), *available at* <http://www.sharedprosperity.org/bp180/bp180.pdf>.

¹⁰⁸ Stone, *supra* note 64.

Hacker described, while HCA is not single-payer universal health insurance, it does embody many of its values, particularly “the time-tested idea of social insurance, the notion that major financial risks should be pooled as widely as possible across rich and poor, healthy and sick, young and old. Health Care for America would create a large publicly overseen insurance pool that would bargain for lower prices, capitalize on the vast administrative efficiencies of a single insurer, and use its reach and purchasing power to spearhead improvements in the quality and cost-effectiveness of medical care.”¹⁰⁹ Hacker’s proposal has the added advantage of building on a familiar, time-tested and well-accepted health insurance model, a factor that adds greatly to both its policy and political feasibility.

IV. CONCLUSION

To answer to the question posed by this Article’s title, I am skeptical that meaningful health reform can be accomplished at the state level, where vast differences in the states’ populations make replication difficult, and frequent boom-and-bust economic cycles make financing almost impossible. I am also philosophically skeptical of reform measures, such as the individual mandate, which rely on enlarging and regulating the individual insurance market rather than on widely pooling insurance risks. But I am also aware of the opposition that many Americans have to social insurance, i.e. the fact that the healthy and perhaps even the wealthier carry a disproportionate share of the cost of health care. The fact that single-payer government-financed health insurance has been and continues to be a non-starter is evidence of the general opposition to social insurance reform, particularly a reform proposal that dismantles and replaces a familiar existing system. I think that Medicare is a social insurance anomaly in America, acceptable because of the characteristics of the population—older Americans, many of whom are retired and living on fixed incomes. Whether a proposal to expand Medicare to the relatively small uninsured working population would be acceptable to a majority of legislators, voters, and vested interest groups is a policy effort worth pursuing. Its success requires the kind of political leadership, passion, and commitment that Governor Schwarzenegger demonstrated in California but that has been sorely lacking at the national level. To paraphrase Mark Pauly, we have to do something because the economic consequences of non-action are becoming too alarming. More importantly, however, we must do something because it’s the right thing to do.

¹⁰⁹ Hacker, *supra* note 107, at 2–3.

