2000

Markets, Myths, and A Man On The Moon: Aiding and Abetting America's Flight From Health Insurance

Andre Hampton
MARKETS, MYTHS, AND A MAN ON THE MOON: AIDING AND ABETTING AMERICA’S FLIGHT FROM HEALTH INSURANCE

André Hampton*

“Giving money and power to the government is like giving whiskey and car keys to teenage boys.”

—P.J. O'Rourke1

Television Announcer: “Things are changing, and not all for the better. The government may force us to pick from a few health care plans designed by government bureaucrats.”

Louise: “Having choices we don’t like is no choice at all.”

Harry: “They choose.”

Louise: “We lose.”

—Harry and Louise2

* Professor of Law, St. Mary’s University School of Law, San Antonio, Texas; B.A., 1979, J.D. & M.P.A., 1983, University of Texas at Austin. I am grateful to Colette Singh, Markes Kirkwood and Ellette Harold for their research assistance on this Article, and to Hortense Cannon for her secretarial assistance. I would also like to thank Professor Emily Hartigan and Professor Will Rice of St. Mary’s who provided me with valuable input on previous drafts of this Article. I also want to thank my wife, Santa Hampton, for her support and patience while I was completing this Article.


“They can put a man on the moon, [but they] can’t make a coffee without caffeine [that tastes good?]”


I. INTRODUCTION

The presumption that the government is wasteful and inefficient is central to the American credo. Adherence to this belief yields a distinctly American mythology—the Mythology of the Market (“the Mythology”). According to the Mythology, markets are better for allocating resources than the government. We cannot trust the government with too much power to allocate resources because the government—being inherently inefficient—will squander resources. The Mythology is partly responsible for the lack of universal health coverage in the United States.

with alarm. See Duncan, supra, at 28. Harry and Louise are given credit for creating opposition to the Clinton health care reform plan and its ultimate demise. See id.; see also Johnson & Broder, supra.

3. Kyle Larson, In "Fence," Bigotry Invades Boys' World, THE ARIZONA REPUBLIC, Jan. 18, 1998, at G6 (discussing a playwright's recollection of a 1970s coffee commercial which ran after Neil Armstrong's moon walk); see also Like Man on Moon, Stadium is Great Rhetoric, Letter to the Editor, THE CINCINNATI POST, Feb. 27, 1998, at 22A. Following the National Aeronautic & Space Administration's (NASA) successful mission of placing a man on the moon in 1970, the expression “[t]hey can put a man on the moon” has entered into the popular lexicon as an expression of frustration over mankind's inability to overcome seemingly easy problems. For example, “[t]hey can put a man on the moon but they can't make an army boot that keeps your toes warm in the wintertime.” Id. For our purposes, it is important to note that NASA is a government agency.


One explanation for the apparently deep-seated public distrust of government is found in the widespread impression that government is, by and large, ineffective in solving the nation's problems, inefficient in carrying out its assigned functions, wasteful of the taxpayers' dollars, and highly subject to fraudulent practices by those who work for the government and those who benefit from its programs.

Id.

5. See infra note 6 and accompanying text for discussion of Americans' distrust of government.

6. See John K. Iglehart, Health Policy Report: The American Health Care System, 326 NEW ENG. J. MED. 962, 963 (1992) (noting failed attempts to enact universal health coverage dating as far back as the presidency of Theodore Roosevelt due to "Americans' distrust of government, the heterogeneity of their values, and the absence of a sense of noblese oblige") (citing Victor Fuchs, National Health Insurance Revisited, 10 HEALTH AFF. 7-17 (1991)); see also Robert J. Blendon et al., The American Public and the Critical Choices for Health System Reform, 271 JAMA 1539, 1543 (1994) (noting forty-year low in percentage (19%) of individuals expressing trust in the federal government). In addition, 51% of the respondents believed the private insurance
The American health care scene is nothing less than a nightmare. During 1998, 44.3 million U.S. citizens, over sixteen percent of the population, were not protected by any form of health coverage. Persons who currently have health coverage are constantly in fear of losing their coverage, being denied coverage for services they and their physician believe are medically necessary, or being toyed with by some profit-maximizing HMO. This health care nightmare demonstrates that the provision of health coverage through the market is "Bad Business." Bad Business is the term I use to describe the inappropriate assignment to the market of an activity which should be reserved to the government. No matter how fervently Americans desire to cling to the Mythology, the reality can not sustain the Mythology's alluring promise as it relates to health coverage.

When a society leaves health coverage to the market, that society inevitably comes up short. This is because the market does not account for the existence of externalities in the allocation of health coverage. An externality is a benefit or a cost that a private actor does not need to take into account when consuming or producing a good or industry would better manage the health care system, versus 32% who believed government would better manage the system. Id.


8. See Congressional Roundup: Clinton Calls for Patients’ Rights Bill: Public Anxiety About Health Care Grows, 7 BNA HEALTH L. REP. 1499 (Sept. 24, 1998) (describing results of survey released by The Henry J. Kaiser Foundation and Harvard University which indicated that 36% of persons believed that "managed care plans do a bad job serving consumers while 30% said they do a good job"). In the Kaiser Foundation survey, 57% of those surveyed indicated they had trouble with their health plan. Id; see also Blendon et al., supra note 6, at 1540 (noting that "[t]wo-thirds of Americans still worry that their future health costs will not be adequately covered by insurance" and that 43% "worry a lot about not having enough health insurance to pay for good medical care"). HMOs' penchants for profit maximization have become part of the public perception, as reflected in the following exchange between Carol the Waitress (played by Helen Hunt) and a physician in the 1997 movie "As Good As It Gets."

Dr. Battes: "It's OK. Actually, I think that's their technical name."

Dr. Battes: "It's OK. Actually, I think that's their technical name."

George Skelton, California and the West: Who Remembers What the "M" in HMO Means?, L.A. TIMES, Sept. 2, 1999, at 3. This exchange was cheered by movie audiences all over the country. See id.
a service.9 Externalities are social costs which are imposed on or social benefits enjoyed by others. The failure to address externalities results in a sub-optimal production or consumption of a good or service.10 In the United States, adherence to the Mythology has resulted in an inadequate approach to the problems of externalities in health coverage. This has led to the current sub-optimal level of health coverage.

The problem with externalities in health coverage is two-fold. First, the status of being protected against out of pocket health expenditures has social benefits.11 These benefits are not taken into account when individuals make decisions about obtaining health coverage. Without governmental intervention, the result is a sub-optimal consumption of health coverage.12 Second, negative externalities arise from the actions of private insurers who are attempting to respond to problems inherent in the insurance model of health coverage. Private insurers operate pursuant to rational insurance principles.13 Unfortunately, when applied to insuring against expenditures for health care, these rational insurance principles invite and even require exclusionary practices and fragmentation of risk pools.14 Such exclusionary practices and fragmentation of risk pools produce negative externalities in the form of higher costs for health coverage and shortages in, or even the absence of, health coverage.15

Without comprehensive governmental intervention, the market exacerbates the problem of externalities.16 This is the essence of Bad Business. The appropriate governmental response to the existence of externalities would be to provide subsidies to induce consumption or production of goods with positive externalities and to prohibit or penalize activity which produces negative externalities. The United States has undertaken a rather tepid approach to the problems of externalities in the health care coverage system. Instead of providing sufficient direct subsidies we have relied on indirect subsidies. We

---

10. Id.
11. See infra notes 53-55 and accompanying text for a discussion of social benefits resulting from adequate health coverage.
12. See infra notes 56-70 and accompanying text for a discussion of effect of externalities on optimal level of health coverage.
13. See infra notes 77-91 and accompanying text for a discussion of insurance principles.
14. See infra notes 92-98 and accompanying text for a discussion of impact of insurance principles on health coverage market.
15. See infra notes 63-69 and accompanying text for a discussion of externalities resulting from operation of insurance market.
16. See discussion infra notes 92-98 and accompanying text for a discussion of the results of combining insurance principles in the market as a means to provide health coverage.
have also not systematically intervened in the health care coverage market to prevent the exploitation of externalities arising from insurance practices. Limited and indirect governmental intervention in the health coverage market is consonant with the Mythology. The Mythology's credo is clear: "The best is government which governs least."\(^{17}\)

Such limited and indirect governmental attempts to intervene in the health coverage market have further aggravated the problem of externalities by aiding and abetting a flight from health insurance risk by the private health insurance industry. This flight is reflected in the movement towards self-funded health benefit programs by employers and risk sharing arrangements with health care providers. Under self-funded benefit programs, employers assume the first dollar risk of their employees' health expenditure.\(^{18}\) Risk sharing is an arrangement by which insurers contract with health care providers for the health care providers to assume some of the financial risk for the health care expenses resulting from their treatment of patients.\(^{19}\) Each of these phenomena allow the private insurance industry to export some of its risks to other actors in the health care system.

Self-funding arrangements and risk-sharing arrangements are symptomatic of the underlying problems associated with relying on the market to allocate health coverage in light of the fragility of the insurance model. Efforts to curtail exploitation of externalities invite resistance, which may be reflected in decreases in or elimination of health coverage. Given its limited role in health coverage, the government is forced to find substitutes for direct subsidies and regulation. Allowing self-funding arrangements and risk sharing provides a substitute (albeit, an arguably poor one) for explicit governmental subsidization of health coverage and strict regulation of the health coverage market. Not surprisingly then, these phenomena are absent in countries which have adopted universal health coverage.\(^{20}\) These governments can resort to more explicit means to produce adequate health coverage and to control costs.\(^{21}\)

17. OXFORD DICTIONARY OF QUOTATIONS 502 (5th ed. 1999) (quoting John L. O'Sullivan); see also Robert W. McGee, Some Tax Advice for Latvia and Other Similar Emerging Economies, 13 INT'L TAX & BUS. L. 223, 226 (1996) ("This author begins with the premise that the best government is one that governs least, a position consistent with the view that the private sector can do just about anything more efficiently than the government.").

18. See infra notes 102-08 and accompanying text for a discussion of self insurance by employers.

19. See infra notes 117-51 and accompanying text for a discussion of risk sharing arrangements.

20. See infra notes 199-200 and accompanying text for a discussion of absence of risk sharing and self insurance in OECD countries.

21. See infra notes 202-06 and accompanying text for a discussion of cost contain-
Adherence to Bad Business leaves the United States as the only developed country without universal health coverage. All Organization for Economic Cooperation (OECD) countries (and even most developing countries) have established systems to ensure that nearly one hundred percent of their population is covered for at least a basic minimum level of health benefits. These countries achieve universal coverage through a variety of financing mechanisms. However, all such governments have abandoned either: (1) reliance on the market to allocate health coverage; (2) reliance on the insurance model for the provision of health coverage or (3) both. In essence they have eschewed Bad Business.

The managed care industry has created the temporary illusion that we can have access to adequate and affordable health coverage through operation of the insurance model in the free market. However, the rising public dissatisfaction with managed care indicates that this illusion is being sorely tested. We are beginning to witness an increase in legislative proposals and citizen referenda designed to rein in managed care. For the most part such proposals are aimed at patient approaches in OECD countries.

22. See infra notes 170-81 and accompanying text for a description of universal health coverage in OECD countries. The OECD was formed to study economic relationships among Atlantic Powers. See Rebecca A. Kirby, Note, The Basel Convention and the Need for United States Implementation, GA. J. INT'L & COMP. L. 281, 287 n.25 (1994). The OECD's objective is "to achieve the highest sustainable economic growth and employment and a rising standard of living in Member countries, while maintaining financial stability." Id. In 1996, the OECD included "Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Portugal, South Korea, Spain, Sweden, Switzerland, Turkey, the United Kingdom, the United States, and Yugoslavia." Sofia Wu, Taiwan Faces Stronger Competition After S. Korea OECD Entry, CENT. NEWS AGENCY (Taiwan), Dec. 23, 1996.


24. See, e.g., Peter T. Kilborn, Trend Toward Managed Care Is Unpopular, Surveys Find, N.Y. TIMES, Sept. 28, 1997, at 25 (describing the Harris survey which reported that 54% of respondents believed "the trend toward managed care is harmful for them"); see also Andy Miller, Survey: Dissatisfaction Rising with Managed Care in Atlanta, ATLANTA J. & CONST., May 19, 1999, at 2D (noting a survey of 150,000 U.S. consumers by Hewitt Associates that showed an increase of national dissatisfaction with managed care from 17% in 1997 to 22% in 1998).

25. See infra notes 164-67 and accompanying text for discussion of Patients' Bill of Rights proposals and debate.
at creating a "Patients' Bill of Rights," which guarantees patients with procedural protections against financially motivated decisions by managed care entities. However, the debate about a "Patient's Bill of Rights" is a side show which detracts from discussion about the more central issue of health care in the United States: Can we continue to allow our distrust of government to cheat us out of decent health coverage?

Part II of this article will examine the Mythology and why it is inappropriate to health care. Inevitably, the market will only produce inadequate health coverage. This result is explained by market theory and by problems which are indicative of a market failure in health care. Part III will discuss problems inherent in utilizing an insurance model to provide health coverage. These inherent problems are only exacerbated by the market. Part IV will further demonstrate the idea that providing health coverage through an insurance model operating in the market is Bad Business by describing the inevitable flight from insurance risk that the private insurance industry has undertaken during the past several years. Part V will discuss the financing and payment mechanisms in countries that provide universal health care. Such countries have abandoned either the market, the insurance model or both as a means of achieving universal health coverage while controlling health care expenditures. Countries with universal health coverage recognize the "public goods" quality of adequate health coverage and respect the socialized risk sharing aspects of insurance. These societal features of health coverage appear to be all but forgotten by critics of additional direct governmental intervention in health care financing in the United States. Part VI will discuss the inevitable failure of cost containment policies in a system of health coverage that relies on an insurance/market model.

II. OF MARKETS AND MADNESS — THE PROBLEM OF UNTAMED EXTERNALITIES IN THE PRIVATE HEALTH INSURANCE MARKET

One scholar states the Mythology as follows: "Government inefficiency is so pervasive it has become an axiom." Such belief seems to underlie Americans' notable distrust of government. Economists have bolstered this conventional wisdom with elaborate economic

26. See id.
27. Matthew W. McGann, Note, Federal Preemption: CSX Transportation Inc. v. Easterwood: Give the Plaintiff a Brake; Derailed Preemption, 47 OKLA. L. REV. 571, 584 n.133 (1994); see also RANDALL G. HOLCOMBE, AN ECONOMIC ANALYSIS OF DEMOCRACY 190-92 (1985) (describing the sources of governmental inefficiency as (1) "the excess burden of taxation"; (2) government bureaucrats' incentive to maximize their budgets; (3) lack of an incentive to produce efficiently due to lack of individual entitlement to profits; (4) "rent seeking" behavior; and (5) "special interest politics").
28. Roth, supra note 4, at 961.
models designed to prove that government allocation of resources is inherently and unavoidably inefficient. However, even if the Mythology is generally true, it implodes when applied to health care.

---

29. Prescott, supra note 1, at 2019 ("During the past fifteen years, a growing cadre of social scientists has used the tools of economic analysis to argue that when governments act, they do so inefficiently."); id. n.1 (citing DONALD P. GREEN & IAN SHAPIRO, PATHOLOGIES OF RATIONAL CHOICE THEORY 3-4 (1994) (noting economic models have "raised the possibility that democratic institutions might be profoundly dysfunctional"); HOLCOMBE, supra note 27, at 188-92 (discussing the sources of governmental inefficiency); Herbert Hovenkamp, Rationality in Law & Economics, 60 GEO. WASH. L. REV. 293, 296 (1992) (arguing that economists choose economic models according to their outlook and ideology); Barry R. Weingast et al., The Political Economy of Benefits and Costs: A Neoclassical Approach to Distributive Politics, 89 J. POL. ECON. 642, 643 (1981) (developing a theory that politics biases public decision making "toward larger than efficient projects").

According to Hovenkamp:

The defense of the free market is inspired by the Coase Theorem and urges that markets and private bargaining are generally better at achieving efficient results than state intervention is. The attack on the welfare state is inspired by the pioneering work of Mancur Olson, James Buchanan, Gordon Tullock, and others who have analyzed the functioning of public decision-making bodies, as well as by Arrow's Impossibility Theorem. The general thrust of this attack has been to show that voting, where each individual participant in a decisionmaking process receives one vote, cannot yield outcomes that are either stable or socially optimal. In other words, political markets cannot be shown to produce efficient outcomes the way that private economic markets can.

Hovenkamp, supra, at 296 (footnotes omitted).

30. See DONALD WITTMAN, THE MYTH OF DEMOCRATIC FAILURE 187 (1995). Wittman notes: "A number of studies have compared the technological efficiency of private and public firms. Most, but by no means all, have shown private firms to be technologically more efficient than public firms." Id. Wittman questions the appropriateness of such comparisons by raising the question: "[M]aybe the enterprise is public because it is less technologically efficient rather than it is technologically inefficient because it is public." Id. He points to evidence in Eastern Europe that efficient enterprises are privatized first. See id. Hovenkamp is also critical of the public choice theorists' characterization of actors in political markets. As Hovenkamp states:

One reason that legislative markets fare so poorly in public choice theory while Coasian markets fare so well is that voters and consumers seem to be so different from each other . . . . The actors in public choice theory are not the same people as the actors in neoclassical private markets. Perhaps they are similar in some general sense—for example, both wish to maximize their own utility. But beyond that they are quite different. Consumers are savvy, cautious, and have a well-defined conception of their own best interest. Voters, by contrast, are easily manipulated by the most trivial things and pay little attention to what is in their best interest. In neoclassical market theory, competition weeds out or disciplines inefficient actors, and even in Coasian bilateral monopolies the bargainers obtain efficient results. In political markets, by contrast, competition appears to have no effect: ineffective lobbying organizations simply stay around and represent their constituents inefficiently, thus ensuring that legislative favors go to someone else.

Hovenkamp, supra note 29, at 316-17.
Ironically, market theory itself explains the inherently and unavoidably inadequate provision of health care that will result from reliance on the market alone. In the United States, limited expansion of governmental involvement in health care thus far acknowledges the existence of market failure, at least with respect to the most vulnerable members of society—the poor, the elderly and the disabled—by funding for Medicare and Medicaid Programs. However, we cannot correct the market failure evident in the health care financing system until the government brings the entire system under its comprehensive control. Provision of health coverage based on the insurance model in the market is subject to externalities which inhibit development and maintenance of systems of adequate health coverage.

Health care is a peculiar commodity that differs from other goods and services that are distributed in the market. The market for health care is not a free market. In this regard, some policy analysts have advocated measures that would remove the barriers to free market operation of the health care sector. In their view, the fact that the health care market does not act in accordance with the free market is not due to anything special about health care. Instead they attach blame for this "non-market" behavior to the fact that third

31. Jason B. Saunders, Note, International Health Care: Will the United States Ever Adopt Health Care for All?—A Comparison Between Proposed United States Approaches to Health Care and the Single-Source Financing Systems of Denmark and The Netherlands, 18 SUFFOLK TRANSNAT'L L. REV. 711, 735 n.86 (1995) (citing Lawrence D. Weiss, It's Time to Replace Private Health Insurance with a National Health Care System, 10 PRENTICE HALL HEALTHSPAN 13, 14 (1993)). "The public sector is more efficient than the private sector in providing health insurance. One third or more of each dollar paid for commercial health insurance goes for non-medical expenses, which is almost ten times what it would cost the public sector to deliver the same health insurance." Saunders, supra, at 735 n.89 (citations omitted).

32. William M. Sage, Funding Fairness: Public Investment, Proprietary Rights and Access to Health Care Technology, 82 VA. L. REV. 1737, 1746 (1996) ("Government currently pays approximately forty percent of the health care dollar, primarily through the federal Medicare program for the elderly and through federally supported but state-administered Medicaid programs for poor families and the disabled.").

33. See Kenneth J. Arrow, Uncertainty and the Welfare Economics of Medical Care, 53 AM. ECON. REV. 941, 945 (1963) (discussing why markets for health risk coverage are "poorly developed or nonexistent"). Part of the problem is attributable to the fact that health care has special characteristics that distinguish it from other commodities. Arrow lists the following as significant: (1) "An individual's demand for medical services is ... not steady in origin as, for example, for food or clothing, but irregular and unpredictable." Id. at 948. (2) "The behavior expected of sellers of medical care is different from that of business men in general" in that the medical seller's behavior is "supposed to be governed by a concern for the customer's welfare" and not the seller's own self interest. Id. at 949. (3) There is more "uncertainty as to the quality of the product ... than in any other important commodity." Id. at 951. (4) There is an acknowledged inequality of knowledge between the patient and the physician. Id. (5) Restrictions on entry into the market by suppliers and (6) "unusual pricing practices and attitudes." Id. at 953.
party payers assume responsibility for paying for health services. Third party payment removes individual incentive for the patient and the physician to act as prudent consumers of health services. These analysts argue that this lack of personal responsibility causes high health care costs and inflation. They also argue that we should return to a more market oriented health system by introducing more personal responsibility for paying medical bills. Sadly, this approach plays into the Mythology by blaming third party payment for the health system’s failure to cooperate with the dictates of the market. This blind devotion to the market fails to recognize that the problem with health care costs may be indicative of market failure. Market failure would justify less reliance on the market approach to health care financing and more governmental intervention.

According to classical economic theory, one legitimate basis for governmental intervention in the market is the existence of market failure. Market failure exists when the market is unable to produce an optimal allocation of goods. This may result from the lack of

34. See Saunders, supra note 31, at 731 n.81 (citing Edmund F. Haislmaier, Why Global Budgets and Price Controls Will Not Curb Health Costs, HERITAGE FOUNDATION: BACKGROUNDER NO. 929, March 8, 1993, at 2) (arguing that the health-care system is overregulated and thus, not a free market system). “Medical costs are rising because consumers are mostly insulated from such cost by the illusion that employers pay for their health insurance coverage, and no free market in health care exists because such markets have been disrupted by governmental policies.” Id.; see also Evan M. Melhado, Economists, Public Provision, and the Market: Changing Values in Policy Debate, 23 J. HEALTH POL. POL’Y & L. 215, 236-37 (1998) (noting certain economists’ concern that “insurance affords a price subsidy at the point of service, thereby inducing the insured person to purchase more health services than optional”).

35. See id; see also T.R. Marmor et al., Medical Care and Procompetitive Reform, 34 VAND. L. REV. 1003, 1012 (1981) (describing consumer sovereignty advocates’ belief that restructuring of health markets requires increased cost sharing by consumers in the form of increased deductibles, copayments or coinsurance). The rationale of this view is that “making the consumer responsible for significant proportions of the cost of care at the time of use would generate economizing alertness in both patients and doctors . . . .” Id. Abolition of the tax breaks for health care spending is another pro-market reform. Id.

36. See, e.g., Wallace Wen-Yeu Wang & James Ting-Yeh Yang, Financial Institutions in Taiwan: An Analysis of the Regulatory Scheme, 4 J. CHINESE L. 3, 33 (1990) (“Under the efficiency criterion, government intervention in the free market is justified only to the extent that such intervention is necessary to correct classical market failures.”); see also Hovenkamp, supra note 29, at 334 (noting classical political economists “believed the state should stay entirely out of the business of transferring wealth, and should provide only those things that the market fails to provide in the proper amount, such as lighthouses, public streets or national defense”); Mark Sievers, An Economic Analysis of Utility - Coal Company Relationships, 8 J. ENERGY L. & POLY 27, 58 (1987) (“Under traditional welfare economics, regulation in the form of government intervention is justified only when there is a ‘market failure.’”) (citations omitted).

37. Wang & Yang, supra note 36, at 33.
competition, lack of information or high transaction costs. The existence of externalities will also cause market failure. Externalities are the effects of an individual’s actions that the individual either does not or cannot take into account when deciding to produce or consume a good or a service. Externalities may be positive or negative and their existence results in allocations of resources that are less than optimal for a society. The provision of health coverage through an insurance model in the market is hampered by positive and negative externalities which result in sub-optimal allocation of health care coverage.

A positive externality exists when two conditions are present: (1) an individual’s consumption or production of a good or service produces benefits for third parties and (2) the individual cannot obtain payment or other compensation from such third parties. Goods which generate such positive externalities are known as “public goods.” Because an individual cannot recoup the benefit accruing to the third parties the rationally calculating individual will consume or produce less of the good involved than might be socially optimal. For example, suppose a wealthy resident of Los Angeles (“Ms. Market”) could purchase a device for $500,000,000 which could protect the city from

38. See id. at 41-42.
39. Id. at 33.
40. See, e.g., Paul Stephen Dempsey, Market Failure and Regulatory Failure as Catalysts for Political Change: The Choice Between Imperfect Regulation and Imperfect Competition, 46 WASH. & LEE L. REV. 1, 17 (1989) (“An external effect of a transaction is a positive or negative impact upon a person not a party to it.”).
41. See, e.g., Melhado, supra note 34, at 221 (“Externalities result in a less than optimal supply of ... goods, and governmental action is mandated as a remedy.”).
42. Id. (describing the public goods aspects of national defense). As noted by Melhado:

As suggested by the archetypical case of national defense, a public good is equally available to all citizens, all of whom benefit from it, whether or not they contribute to paying its costs. External benefits flow to the nonpayers, who cannot be excluded from consumption; nonexcludability in consumption (or equal availability of the good) is the traditional criterion of a public good. . . .

Id. Melhado points out that national defense would be an example of a public good which is characterized by nonexcludability in production in that the supply or production units are equally available to all citizens. See id. He notes that other economists have pointed to “another category of public goods for which externalities are generated in consumption, that is, where the external benefit enjoyed by citizens lies in the consumption of a good (e.g., education) by others.” Id. at 225 (noting the analysis of James Buchanan, in his book THE DEMAND AND SUPPLY OF PUBLIC GOODS (1968)) (emphasis omitted); see also HOLCOMBE, supra note 27, at 25 (“Many goods have public goods characteristics because they produce significant spillover benefits, or because it is excessively costly to exclude consumers.”).
43. See HOLCOMBE, supra note 27, at 25 (“[Public] goods will be underproduced in the private sector, generating an efficiency argument for public sector production.”).
earthquakes. If the benefit that she would receive from purchasing the device was only $250,000,000, Ms. Market wouldn't buy the device. However, if the total benefit that would accrue to all the residents was $500,000,001, it would make economic sense for someone to purchase the device. However, absent some type of governmental intervention, there would be no way to ensure that this purchase would occur. If third parties could enjoy the benefit of the device without having to pay for it (otherwise known as “free riding”), such parties wouldn’t contribute to its purchase." Therefore, if the decision to purchase the earthquake prevention system is left to the market, Ms. Market would not privately purchase the system, because she would have no mechanism to require others to share the costs of purchasing the device. Society in general would be worse off.

In a situation like the one facing Ms. Market, the government could intervene to cause the purchase. It might do this by assessing each resident some portion of the costs in order to prevent free riding or it might subsidize Ms. Market’s purchase. Ms. Market’s earthquake prevention device would be a public good. The existence of public goods features have justified government intervention in the provision of national defense, highway construction, and public education.

A negative externality results when an individual is not required to bear all of the costs of their decision to produce or consume a good or service. For example, a handgun manufacturer who is not re-

44. See id. at 27-28 (noting that if public provision is called for “it would also call for compulsory payment” to prevent free riding); see also Mark A. Hall & John D. Colombo, The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption, 66 WASH. L. REV. 307, 392 (1991) (“Classical economics tells us that providing public goods is the quintessential role of government, since the government is able to correct the free-rider defect through its power to tax—in essence coercing the public’s purchase of public goods.”).

45. Cf. Melhado, supra note 34, at 221 (citing defense as an example of a public good).

46. See Hall & Colombo, supra note 44, at 391 (citing border defense as an example of a pure public good).

47. See, e.g., Daphna Lewinsohn-Zamir, Consumer Preferences, Citizen Preferences, and the Provision of Public Goods, 108 YALE L.J. 377, 377 (1998) (noting that due to the market failure problem known as “public goods” which would result in a sub-optimal supply of national defense, roads, national parks, health, and education systems, the government assumes a major role in the provisions of such goods).


49. See Kenneth J. Vandevelde, Investment Liberalization and Economic Development: The Role of Bilateral Investment Treaties, 36 COLUM. J. TRANSNAT’L L. 501, 505 n.16 (1998) (“A negative externality is a detriment suffered by a person other than the one who produced it. Markets will oversupply goods or services that produce negative externalities because the producer does not have to pay for all the adverse conse-
quired to take into account the costs associated with the use of a
“Saturday night special” sold by the manufacturer will produce more
of those guns than is optimal for society.\footnote{50} The existence of negative
externalities is another legitimate basis for government intervention
in the market.\footnote{51} The social recognition of negative externalities has
led to environmental laws to curb pollution, for example.\footnote{52}

Adequate health care coverage has attributes of a public good.
An individual’s status of being covered against health risks generates
positive externalities. An individual’s status as a person covered by
some health plan benefits third parties. For example, health coverage
may prevent the spread of communicable disease either by preven-
tion or treatment.\footnote{53} In addition, individuals appear to be more con-
cerned about the health status of others, than other life conditions.\footnote{54}

\begin{thebibliography}{99}
\item 50. \textit{See} Dempsey, \textit{supra} note 40, at 20 (giving examples of alcohol, tobacco, and
firearms as goods for which the producers have not had to account for the cost to
health and life resulting from their use). Thinking about the social consequences of
handgun manufacturing in terms of the negative externalities created by such manu-
ufacturing gives new insight into the lawsuits filed by cities against such manufactur-
ers. Such suits may properly be viewed as an attempt to internalize the externalities of
production. \textit{See}, e.g., Mark Schlinkmann, \textit{St. Louis Files Lawsuit Against 22 De-
defendants in Gun Industry}, \textit{St. Louis POST-DISPATCH}, May 1, 1999, at 8 (describing law-
suits by St. Louis, New Orleans, Chicago, Bridgeport, Miami/Dade County, Atlanta,
and Cleveland to recoup damages resulting from use of handguns in such cities). In
addition, the lawsuits filed by various state attorney generals against the tobacco in-
dustry may be viewed along similar lines.

\item 51. \textit{See} Vandevelde, \textit{supra} note 49, at 516-17.

\item 52. \textit{See} id. (giving the example of pollution); \textit{see also} Stephen Breyer, \textit{Analyzing
Regulatory Failure: Mismatches, Less Restrictive Alternatives, and Reform}, 92 HARV.
L. REV. 549, 555 (1979) (giving the example of production of steel and the air pollution
that it causes).

\item 53. \textit{See} Arrow, \textit{supra} note 33, at 944. In discussing the concept of private and social
costs and benefits, Arrow points to the example of the spread of communicable dis-
ease: “\textit{a}n individual who fails to be immunized not only risks his own health, a dis-
utility which presumably he has weighed against the utility of avoiding the procedure,
but also that of others.” \textit{Id.}

\item 54. \textit{Id.} at 954; \textit{see also} Einer Elhauge, \textit{Allocating Health Care Morally}, 82 CAL. L.
REV. 1449, 1483 (1994) (describing the moral discomfort we feel when others must do
without health care as an “intangible externality”). Elhauge explores various externality
arguments for the enactment of public provisions of health coverage for the poor.
\textit{Id.} at 1480-86. He describes the externality associated with the failure to obtain im-
munizations. \textit{Id.} at 1481. However, he believes that the existence of such an externali-
ity provides a rationale for public provision of immunization rather than health cover-
age. \textit{See} id. (stating that most health conditions which might result from inadequate
health coverage are not contagious and therefore, generate no such externalities). El-
haug also explores the externality supposedly associated with the fact that people
without health coverage are forced to seek free medical care, the costs of which are
passed on to society in general. \textit{Id.} at 1481-83. He criticizes this particular externality
argument because “[t]he amount and quality of health care provided free of charge is

\end{thebibliography}
The amount of charitable giving with regard to health care and the level and extent of volunteerism associated with health care provides empirical evidence for the existence of interdependent utilities in health care. This indicates that a person's status as covered by health care generates a positive benefit to third parties. However, it is not possible for the individual who has health coverage to charge third parties for such positive benefits. Therefore, like Ms. Market, the individual will purchase health coverage at a level that is less than optimal for society. Note that this public good analysis also applies to an employer who is making a decision about whether to provide health benefits for its employees. The employer cannot charge third parties for the benefits such third parties enjoy as a result of the employer providing adequate health coverage for its employees. Therefore, the employer will provide coverage in amounts that are less than optimal for society.

far from generous." Id. at 1482. Elhauge's view is that the moral discomfort externality argument is the most defensible although he remains ultimately dissatisfied with this justification. See id. at 1483-84. He offers his own justification for public provision of health care by indicating the following:

what distinguishes health care [as a special case calling for public subsidy for the poor] is not that there are better reasons for distributing it without regard to ability to pay, but that there are fewer reasons to oppose such an egalitarian distribution because providing health care reliably identifies and meets a variable need with less harm to productive incentives than providing other goods.

Id. at 1486; see also Roberta J. Labelle & Jeremiah E. Hurley, Implications of Basing Health Care Resource Allocations on Cost-Utility Analysis in the Presence of Externalities, in Restructuring Canada's Health Services System 245, 247-50 (Raisa B. Deber & Gail G. Thompson eds., 1990) (describing external benefits of health care). Among the external benefits described in this article are benefits derived from interdependent utility; i.e., when "one person's consumption of health care affects another person's utility." Id. at 248. The authors identify three types of interdependent utility: selfish, paternalistic, and altruistic. Id. As explained by the authors:

Selfish interdependence exists when individual A cares about individual B's consumption of health services because B's consumption directly affects A's health status. An example is treatment for a communicable disease: when B is treated for hepatitis, thereby decreasing the probability that A will get the disease, for purely selfish reasons A's utility increases. Paternalistic interdependence exists when B's consumption of health care, B's level of health status, or both, directly enter A's utility function. That is, A cares about B's consumption of health care not because of its effects on A's health but because of its effects on B's health. Finally, altruistic interdependence exists when B's level of utility (as opposed to health status) enters A's utility function. How B obtains this utility does not matter to A; the only thing that matters to A is B's level of utility, which is determined only in part by B's health status.

Id. at 248-49.

55. Labelle & Hurley, supra, note 54, at 249; see also Arrow, supra note 33, at 954 (describing a more general interdependence as the individual's concern for others' health).
Individuals' and employers' decisions to purchase health coverage, however, only expose one part of the externality problem inherent in providing health coverage through the market. The insurance industry engages in activities that also produce negative externalities. Insurance companies who decide to provide coverage at a set premium are required to maximize profits. Insurance businesses generate profits when premium income exceeds health care expenditures paid by the insuring entity. Without government intervention, insurance companies will attempt to maximize profits by insuring only persons who are good health risks or persons who are poor health risks at premiums that are cost prohibitive. They will engage in mechanisms to weed out poor health risks, such as small groups and individual underwriting, excluding, or charging substantially higher premiums to "those with pre-existing conditions," exclusions of pre-existing conditions, exclusion of costly treatments, and po-

---

56. See William A. Glaser, Health Insurance in Practice: International Variations in Financing, Benefits, and Problems 16 (1991) ("The insurance carrier and its investors also have a self interest: if they maximize premiums and minimize losses, they earn profits and pay their staffs and sales agents generously.").

57. See id.

58. See Katherine Pratt, Funding Health Care with an Employer Mandate: Efficiency and Equity Concerns, 39 St. Louis U. L.J. 155, 207 (1994) (noting criticism of the insurance industry's practices of "underwriting health insurance policies for small groups and individuals" where such practices include "cherry-pick[ing]" the least risky insureds, . . . charg[ing] high-risk insureds very high premiums, or . . . completely deny[ing] coverage to high-risk groups or individuals and those with pre-existing conditions"). Pratt's article describes a panoply of insurance practices including insurance "redlining"—"the practice employed by companies [to] systematically refuse to insure certain high risk firms." Id. n.230 (citing Wendy Zellers, et al., Small Business Health Insurance: Only the Healthy Need Apply, 11 Health Aff. 164, 178 (1992)). "A firm can be considered high-risk for a variety of reasons, including its industry type." Id. at 207 n.230. Pratt lists redlined industries as including:

- hair salons, bars and taverns, entertainment businesses, mining, transportation services (including bus, limousine and taxi services), fishing industries,
- logging and sawmills, detectives, security guards, collection agencies, manufacturing and distribution of explosives, hospitals, liquor stores, government agencies and municipalities, junkyards and salvage firms, law firms, nursing homes, trucking firms, restaurants and physician groups.

Id. at 208 n.230 (citing Zellers at 177) (noting that insurance is either not available to such redlined industries or only available at a substantial additional premium); see also Lewis D. Solomon & Tricia Assaro, Community-Based Health Care: A Legal and Policy Analysis, 24 Fordham Urb. L.J. 235, 238 (1997) (noting commercial insurers, as opposed to Blue Cross plans, adopted underwriting policies pursuant to which "[a]pplicants [who were] perceived to be high risk might be charged higher premiums, or be denied coverage for . . . pre-existing conditions").

59. See Pratt, supra note 58, at 207.

60. Id.

tentially, genetic testing. Just as in the manufacture of "Saturday night specials," these exclusionary activities produce costs to society, in general, that the insuring entity does not have to take into account.

The history of Blue Cross health plans illustrates the impact of negative externalities in the health coverage market. Blue Cross plans originally endeavored to insure all applicants in a designated geographic region. They established their premiums by using community rating. Under community rating, the plans based an individual's health insurance premium on the health experience of the community in which the individual resided, not on the individual's particular health status. Community rating socialized health risks and enabled individuals who might not otherwise be able to obtain insurance to obtain such insurance. The advent of commercial insurers made it impossible for Blue Cross to continue this practice.

Commercial insurers recognized that in a community rating system, where everyone paid the same premium, there would be winners and losers. Winners were the individuals who were getting insurance at a cheaper premium than they would actually be willing to pay because of their higher health risk. Losers were individuals whose health status meant that they were probably paying more for insurance than the individual benefit that they would derive from the coverage. Recognizing this disparity, commercial insurers developed systems of individual health underwriting in which the insurance company would screen each applicant and base the applicant's premium on their individual health status. By utilizing individual

(1991) (noting that insurers may use "poorly defined experimental treatment exclusions" to exclude coverage for treatments that are new and expensive, though arguably not actually experimental).


It is predicted that, as a result of the Human Genome Project ("HGP"), by the year 2002, 99% of the human genome sequence will be mapped at an accuracy of 99.9%. Consequently, the HGP has the potential to have a major impact on the ways insurers evaluate each applicant's health risks.

Id.

63. Jacobi, supra note 23, at 316 (describing the Blue Cross as the "first large scale health insurance program in the United States"). Blue Cross Plans were nonprofit and covered hospital costs. Id.

64. Id.

65. Id. (noting that Blue Cross's use of community rating made coverage available "to all members of the community at the same rate, rather than higher rates to high risk groups" (quoting SYLVIA LAW, BLUE CROSS: WHAT WENT WRONG? 11 (2d ed. 1976))).

66. See id.

67. See id.
risk underwriting, the commercial insurers could offer low health risk insureds lower premiums and exclude high-risk insureds. This would help maximize profits for the commercial insurers. As the low-risk insureds abandoned the Blue Cross plans for the cheaper commercial plans, this threatened to leave the Blue Cross plans with only the higher risk individuals. This forced Blue Cross plans to move to experience rating, which would increase the cost of insurance for higher risk individuals. This decision would make health coverage less available for high-risk individuals.

The commercial insurers did not have to take into account the negative impact on the viability of Blue Cross plans and the availability of insurance for high-risk individuals. Hence, their actions, which are perfectly defensible in the market, created negative externalities. This example underscores the inherent problem involved in attempting to provide adequate health coverage pursuant to an insurance model in the private market. Cherry picking, as the practice of weeding out poor insurance risk is called, produces a negative externality. Without governmental intervention, the end result of cherry picking would be that the only people with insurance would be the ones least likely to need it. In the market, the tactics that lead to this result are predictable, if not axiomatic.

The government has intervened to alleviate some of the impact of externalities in the market for health care coverage. In order to induce individuals and employers to purchase more insurance, the government provides an indirect subsidy by allowing a tax deduction for health care expenses (including insurance premium payments).

68. See GLASER, supra note 56, at 21 (noting that after Blue Cross plans faced competition by commercial insurers who offered cheaper rates to younger and healthier individuals, "[i]n order to keep market share, the Blues throughout the country . . . reluctantly moved toward age-graded rate structure for individuals, experience rates with rebates of surplus to groups and exclusion clauses for poor health risks").

69. See id.

70. See Erica Worth Harris, The Regulation of Managed Care: Conquering Individualism and Cynicism in America, 6 VA. J. SOC. POLY & L. 315, 353 n.199 (1999) (describing cherry-picking as "setting up services and benefits to attract only the healthiest individuals"); see also M. Cathleen Kaveny, Managed Care, Assisted Suicide and Vulnerable Populations, 73 NOTRE DAME L. REV. 1275, 1289 (1998) (noting that even when managed care companies are prohibited from risk underwriting, they may engage in subtle practices to "attract a desirable population and discourage an undesirable one" and indicating that this practice is referred to as "cherry picking"); Ursula Weide, A Comparison of American and German Cost Containment in Health Care: Tort Liability of U.S. Managed Care Organizations vs. German Health Care Reform Legislation, 13 TUL. EUR. & CIV. L.F. 47, 55 (1998) (describing cherry-picking as selection of participants according to their actuarial risk when healthier individuals are preferred).

71. See Melhado, supra note 34, at 241 ("The tax system subsidizes insurance in several ways, principally by excluding employer contributions to the health benefits of
Medicare and Medicaid are examples of governmental policy exceeding an indirect subsidy and providing a direct subsidy for health coverage for the elderly, the poor, and the disabled. These groups would be the most likely to have difficulty procuring adequate health coverage in the market. To deal with negative externalities, Congress has passed laws that prohibit discrimination in the provision of health coverage on the basis of a disability. Congress has also limited the use of pre-existing limitations clauses in insurance policies, and mandated certain benefits. However, given the fact that forty-four million people are not covered by any type of health coverage, it is clear that the present level of governmental intervention in health care financing has not adequately addressed the problem of externalities in the provision of health coverage.

III. PROBLEMS WITH THE INSURANCE MODEL OF HEALTH COVERAGE

There is a real question about whether it is appropriate to provide health coverage pursuant to an insurance model at all, let alone to provide it through an insurance model in the market.

In an insurance arrangement, the insured buys protection against risk from the insurer. The insurer is willing to assume such risk if it can set its premiums at a level that will cover the claims employees from employee's taxable income and by allowing (at least partial) deduction of individuals' premium payments from their taxable income.

See also Sage, supra note 32, at 1746.


See generally 26 U.S.C. § 9811 (a)(1)(A) (West Supp. 1998) (mandating coverage for at least forty-eight hours of inpatient hospital care following a normal vaginal delivery and ninety-six hours following delivery by caesarean section). This federal law was passed to address the problem of “drive through deliveries” wherein managed care entities “routinely required that new mothers be discharged from the hospital shortly after giving birth.” Elizabeth C. Price, The Evolution of Health Care Decision-Making: The Political Paradigm and Beyond, 65 TENN. L. REV. 619, 626 (1998); see also 29 U.S.C. § 1161-1167. Commonly referred to as COBRA, this federal law mandates continuation of coverage under group health plans for employees and their dependants who lose coverage by termination of employment or otherwise. Id.

See supra note 7 and accompanying text.

Scott A. Taylor, Taxing Captive Insurance: A New Solution for an Old Problem, 42 TAX L. 859, 875 (1989) (describing risk transfer aspect of insurance as a situation wherein “[a] person facing the possibility of a loss can purchase insurance . . . and thereby shift some or all of the financial consequences of the loss . . . to the insurer”).
presented by the insured (plus administrative expenses and a profit). Generally, the insurance company cannot predict with accuracy what loss will result from a particular individual. However, the insurer can reduce their risk somewhat by collecting premiums from large numbers of insureds. This enables the insurer to take advantage of the Law of Large Numbers.

The Law of Large Numbers, a postulate of probability theory, states that the larger the number of insureds in a pool with uniform expected losses from the risk insured against, the greater the likelihood that aggregate experience of the group will reflect the expected loss of an individual member of the group multiplied by the number of members of the group. For example, assume that one person has an expected loss of $50 (calculated by multiplying the probability of the loss by the value of the loss). If the insurer insured just that one individual, the insurer would be taking quite a risk by charging only $50 because of the possibility that the insured could incur greater expenses than $50. However, if the insurer covers 10,000 individuals, each with an expected loss of $50, the Law of Large Numbers posits that a premium of $50 per insured is more likely to cover the aggregate loss experienced by the group.

Principles of insurance require the existence of four conditions in order for the Law of Large Numbers to work: "(1) objectivity (occurrence of [the] event is readily discernible), (2) mass (sufficient number of insureds selected on a random basis), (3) homogeneity (probability of each exposure unit is equal), and (4) independence (one event does not affect the outcome of another)." Life insurance meets most of these conditions and the Law of Large Numbers works well for life insurance. When insuring against health risks, however, the...
insurer faces several obstacles to implementing an insurance pool that takes advantage of the Law of Large Numbers.

One problem with the operation of the Law of Large Numbers on health insurance is condition number three, the requirement of homogeneity. It is important that the insureds have a similar risk experience in order for the insurer to benefit from the Law of Large Numbers. This is because homogeneity of the insured group allows the insurer to predict its exposure to liability and establish its premiums accordingly. Secondly, uniformity of risk exposure protects against the problem of adverse selection. Adverse selection occurs because when persons have a higher exposure to risk, they are more likely to purchase insurance against that risk. In a consensual insurance model, where all insureds pay the same premium, this means that high-risk individuals will purchase insurance and low-risk individuals will not. This would threaten the stability of the pool of insureds and, in turn, weaken the utility of the Law of Large Numbers for the health insurer.

Persons seeking health coverage do not have a uniform expected exposure to risk. For example, the elderly have more exposure than young adults. Lifestyles, health status, income levels, education, etc. all appear to cause variation in the expected loss. Due to the

85. Anbari, supra note 80, at 575.
86. Id. at 575-76.
87. Id. at 576.
88. Id.
89. Id. ("Obviously, as low-risk members drop out, a pool will consist more predominantly of high-risk members, requiring the premium to be raised and placing greater pressure on the remaining low-risk members of the pool. At the limit, the pool may unravel altogether." (quoting George L. Priest, The Current Insurance Crisis and Modern Tort Law, 96 YALE L.J. 1521, 1541 (1987))).
90. See, e.g., Thomas S. Ulen, The Law and Economics of the Elderly, 4 ELDER L.J. 99, 135 (1996) (reviewing RICHARD A. POSNER, AGING AND OLD AGE (1995)) ("Those persons in the United States aged sixty-five and older, while accounting for about thirteen percent of the population, account for slightly more than thirty-three percent of all our medical expenditures."); see also Fred R. Garzino, Undue Economic Influence on Physician-Assisted Suicide, 1 DE PAUL J. HEALTH CARE L. 537, 558 (1997) ("As the percentage of elderly in the population increases, more health-care services will be required.") (footnote omitted); George P. Smith, II, Essay, Patient Dumping: Implications for the Elderly, 6 ELDER L.J. 165, 180 (1998) (noting that the "elderly are more susceptible to illness and disability than any other age group").
91. See Alan J. Widiss, To Insure or Not to Insure Persons Infected With the Virus that Causes AIDS, 77 IOWA L. REV. 1617, 1644 n.114 (1992) (noting "[i]ndividuals may be classified according to age, health, sex, occupation, habits (for example, the use of tobacco or alcohol), and hobbies"); see also Paul J. Donahue, Federalism and the Financing of Health Care in Canada and Switzerland: Lessons for Health Care Reform in the United States, 21 B.C. INT'L & COMP. L. REV. 385, 425 n.330 (1998) ("[H]ealth care costs for females under 30 years of age are three times higher than for males within this same age group."); Hoffman & Kincaid, supra note 79, at 715-16.
A MAN ON THE MOON

phenomenon of adverse selection, this variation effectively prevents operation of the Law of Large Numbers in the health insurance market.

The health insurance market reacts to the inability to pursue the Law of Large Numbers by adopting measures that either lessen the risk assumed by the insurer or increase the premiums. As described above, these measures—individual risk underwriting, cherry picking, exclusion of pre-existing conditions, and ultimately genetic testing—all generate negative externalities. Therefore, attempting to provide coverage against health risk pursuant to an insurance model is probably a flawed enterprise. Coupling that endeavor by attempting to wed it to the dynamics of the market only exacerbates the problem.

Another casualty of the use of the insurance model in the market is the demise of the socializing aspects of insurance. Insurance is basically socialized risk sharing. Individuals pool their risk in order to spread the risk across greater numbers of people. This has the beneficial effect of guaranteeing that no one individual will suffer the full impact of the loss. However, when the insurance model is subjected to the dictates of the market, the model yields corrupted results. Profit maximization creates an interest in preventing high-risk individuals from obtaining membership in the insurer's pool of insureds. In this light, the demise of Blue Cross' use of community ratings in the face of individual risk underwriting tactics of private health insurers takes on greater significance. It becomes less possible and less profitable to socialize risk across categories of individuals who have dissimilar expected losses to health risk. As persons of like exposure are grouped together, those individuals are required to bear the bur-
den of their own conditions. While some of their conditions may be attributable to lifestyle choices, most of these conditions are not a result of the individual. In effect, allowing the insurance model to operate in the free market undermines the socialized risk sharing aspect of insurance because it creates fragmented insurance pools wherein the persons in the pool must share similar characteristics.

The market will allocate most goods and services fairly well, particularly if the good or service involved does not raise issues of distributive justice (for example the distribution of compact discs). However, the market cannot allocate health coverage in a manner that is beneficial to society. Reliance on the market as the vehicle by which to allocate health coverage simply ignores the negative externalities inherent in application of insurance principles to health coverage.

IV. THE MARKET'S FLIGHT FROM HEALTH INSURANCE

Private actors will consume goods and services with positive externalities at a sub-optimal level and overindulge in activities that generate negative externalities. The appropriate governmental response to externalities in the market would be to implement laws to ameliorate the impact of externalities. However, the federal government has inadequately responded to externalities in the private health coverage market. In fact, federal policy has ineptly aided and abetted the private health insurance industry's flight from the business of insuring against health expenditures. This flight from

---

96. See Arrow, supra note 33, at 963-64. Arrow posits "insurance requires for its full social benefit a maximum possible discrimination of risks. Those [individuals] in groups of higher incidences of illness should pay higher premiums. . . . [E]qualization [of premium costs for groups with dissimilar incidents of illness] could not in fact be carried through if the market were genuinely competitive." Id. Arrow further explains that in a competitive market "insurance plans could arise which charged lower premiums to preferred risks and draw them off, leaving the plan which does not discriminate among risks with only an adverse selection of them." Id. at 964.

97. See Elhauge, supra note 54, at 1479 (citing growing evidence that health is influenced more by behavior than by health care).

98. See generally J. Michael McGinnis & William H. Foege, Actual Causes of Death in the United States, 270 JAMA 2207, 2207 (1993) (listing ten leading causes of death). According to death certificates filed, the leading causes of death are: heart disease, cancer, cerebrovascular disease, accidents, chronic obstructive pulmonary disease, pneumonia and influenza, diabetes mellitus, suicide, chronic liver disease and cirrhosis, and human immuno-deficiency virus infection. Id. at 2207. The conditions leading to death include a "combination of inborn (largely genetic) and external factors" (including behavior and lifestyle). Id.; see also Mark A. Rothstein, Employee Selection Based on Susceptibility to Occupational Illness, 81 Mich. L. Rev. 1379, 1384 (1983) (examining factors that could increase susceptibility to illness caused by exposure to toxic substances in the workplace including genetics, age, race and ethnicity, geography, diet, tobacco use, alcohol use, medical drugs, radiation, and lifestyle).


100. See id.
health insurance risk is reflected in employers' expanded use of self-funded health benefit plans ("self funding") and the insurance industry's increased use of risk sharing arrangements with health care providers. Under each of these arrangements, the private health insurance industry avoids the business of insuring against health risks by passing that function onto other actors—employers and health care providers. This flight from insurance risk underscores the flaw inherent in attempting to provide health coverage through the insurance model in the private market. Insuring against health risk is a poor business proposition which depends upon exploitation of externalities for its success. Efforts to curb the exploitation of externalities inevitably lead to a flight from health insurance risk by the private insurance industry.

Employers have increasingly moved to self-funding to cover the costs of their employees' health care. Under a self-funded plan, an employer covers its employees' health care costs with the employer's own funds rather than purchasing group health coverage from an insurer or health maintenance organization. Under a self-funded plan, the employer covers the first dollar amounts of its employees' health care expenses. The employer agrees to be responsible for some combination of the first X dollars of its employees' aggregate health expenses during a year and the first X dollars of expenses per employee. Once the aggregate or individual expense level is reached, an insurer begins to cover the excess claims pursuant to a stop-loss, or reinsurance agreement with the employer.

Under a self-funded plan, the employer operates as if it has an insurance policy that is subject to a large deductible. Over forty percent of all employees who receive their insurance through their em-

101. See infra note 102 and accompanying text (describing the most recent growth in self insurance) and infra notes 133-63 and accompanying text (describing risk sharing arrangements).

102. See Maria O'Brien Hylton, Insurance Risk Classification After McGann: Managing Risk Efficiently in the Shadow of the ADA, 47 BAYLOR L. REV. 59, 72 (1995) (stating "[n]umerous commentators have noted the recent growth in self-insurance"). Self-insurance rose 19.4% between 1988 and 1990, whereas conventional market premium volume rose by only 3.8%. Id. at 72 n.43. Self-insurance was projected to reach 30% of the market by the end of 1993. Id.

103. Schacht, supra note 73, at 311.

104. Id. at 312.

105. Id.

106. Id. at 313. Schacht explains:

[Self-funded] plans often purchase stop-loss insurance, a form of reinsurance. Two forms of stop-loss insurance are available. Aggregate stop-loss insurance covers aggregate claims for the employer if claims exceed a specified amount. Specific stop-loss insurance covers claims in excess of a specified amount during a particular period for a covered individual.

Id.
ployment are covered by a self-funded plan. Moreover, nearly ninety percent of all large employers have self-funded plans.

Self-funding is a reaction to states efforts to address externalities in the private health coverage market. The problems with externalities, as described in Part II, include employers who choose sub-optimal health coverage for their employees and insurers' attempts to avoid covering high risk individuals. A government could react to these problems by intervening in the private sector provision of health coverage. In order to respond to the sub-optimal level of health coverage induced by "public goods" attributes of health coverage, a state could, for example, mandate that employers provide health coverage for their employees. A state could also constrain the insurance industry's predilection for behavior which induces negative externalities by, for example, prohibiting individual risk underwriting and cherry-picking. A state that passed laws addressed at these activities could induce more optimal consumption of health care coverage within the state. To varying degrees, the states have shown a desire to undertake such measures.

The states' ability to address the problems of externalities in the private health coverage market, however, has been undermined by the Employee Retirement and Income Security Act of 1974 ("ERISA"). ERISA is a federal law which governs employer provided pension and welfare benefit plans. ERISA, however, with limited exceptions, does not dictate to an employer the benefits that must be provided in any employer's benefit plan. Furthermore, ERISA preempts any and all state laws which relate to an employee pension or welfare benefit plan. Therefore, it preempts any state law which would dictate that an employer provide any health benefit or any level of benefit for its employees. Under ERISA, states are prohibited from regulating the content of any employer provided

107. Id. at 311 (noting that by 1991 64% of all employers were self-insured and over 40% of all employees were covered by a plan of self-insurance).

108. Id. at 305 (stating "ninety percent of Fortune 500 companies self-insure their health plans").

109. See infra Section II.

110. See Hylton, supra note 102, at 77 (describing doubling of state-mandated health insurance benefits between 1979 and 1989). Mandated benefits included maternity coverage, mental health coverage, prosthetic devices, and alcohol and drug treatments. Id. at 75.


112. Id.

113. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 91 (1983) (discussing that ERISA does not require employers to provide any particular benefits, holding "ERISA does not regulate the substantive context of welfare-benefit plans").

benefit package.\textsuperscript{116}

Although ERISA preempts state laws related to employee benefit plans, it does not preempt state laws regulating the business of insurance.\textsuperscript{116} This would seem to leave states with a viable avenue by which to address insurance industry practices which generate negative externalities. However, this method of addressing externalities in the private sector provision of health coverage is weakened by the proliferation of employer self-funded health plans. The significance of self-funding as an obstacle to state's efforts to address externalities in the health coverage market is underscored in the Supreme Court decision \textit{Metropolitan Life Insurance Co. v. Massachusetts}.\textsuperscript{117} \textit{Metropolitan Life} is instructive because it reveals how inept federal policy has undermined states' efforts to address externalities. It also illustrates that federal policy has aided and abetted the flight from insurance risk by the private insurance industry.

In \textit{Metropolitan Life}, the Court decided whether ERISA preempted a Massachusetts law that mandated that insurance policies issued in the state contain coverage for mental illness.\textsuperscript{118} Massachusetts implemented this law to address a symptom of externalities in the private health coverage market arising from private insurers' predictable response to problems inherent in the insurance model. Insurers would not offer mental health coverage because of the problem of adverse selection—the persons likely to purchase such insurance are the very ones who are likely to need it.\textsuperscript{119} By mandating coverage for mental illness, Massachusetts attempted to place mental illness in the shared risk pool for all illnesses and attempted to require the industry to make such coverage available at a less expensive price.\textsuperscript{120} Massachusetts's response to the lack of private sector

\textsuperscript{115} See Shaw, 463 U.S. at 98.
\textsuperscript{116} ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). This provision states, "[e]xcept as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." \textit{Id.}
\textsuperscript{117} 471 U.S. 724 (1985).
\textsuperscript{118} \textit{Id.} at 727.
\textsuperscript{119} \textit{Id.} at 731.
\textsuperscript{120} \textit{Id.} This rationale for the Massachusetts law appears to be used by state legislators generally to justify state-mandated benefit provisions. See Hylton, \textit{supra} note 102, at 76. Hylton explains:

Insurers and purchasers may unknowingly undervalue the benefits of some type of care, such as chemical dependency treatment, resulting in a demand for coverage which is "too low" from a societal perspective . . . . [W]ithout mandates, adverse selection might occur which drives up employers' cost of particular coverages. This happens if individuals with chronic conditions tend to enroll in plans offering more extensive coverage . . . and healthier individuals opt for low-benefit plans . . . . [A]dverse selection creates a market shortcoming, which a mandate may be partially able to correct.
provision of mental health coverage was an appropriate strategy for addressing the problem of externalities in the private health coverage market.\textsuperscript{121}

In \textit{Metropolitan Life}, the Court upheld the state's imposition of the mandated benefit requirement on insurers selling health insurance policies.\textsuperscript{122} On the other hand, the Court noted that the state could not impose such a requirement on any employer if the employer chose to provide health coverage through self-funding.\textsuperscript{123} The self-funded/purchased policy distinction described in \textit{Metropolitan Life} illustrates that if an employer provides health coverage to its employees by purchasing a group health insurance policy or HMO coverage, the resulting benefit will include state law mandated options and benefits. Many of these options and benefits address problems of externalities in the private sector provision of health coverage. On the other hand, employers may self-fund their health coverage and thereby design benefit packages that do not reflect state policymaking. This self-funded/purchased policy distinction accounts for the continuing problem of externalities in the private health coverage sector.

Self-funding also allows the insurance industry to extricate itself from the business of insuring health risk. Unlike the situation where an employer purchases a group health policy or health maintenance organization coverage, under self-funding the employer, not the insurance company, is at risk for the health expenditures of the employer's employees. Self-funding allows the insurance industry to thrive in a capacity other than as the first dollar insurer of health risks.

Rather than operate as the first dollar insurer of health claims, the industry pursues other less risky roles in the health care financing system. The industry offers stop loss or reinsurance coverage, provides claims processing and utilization management services, and network management through administrative services only ("ASO") contacts.\textsuperscript{124} Finally, the movement toward self-funded benefit ar-

\textsuperscript{121} Id. (quoting Gail A. Jensen & Jon R. Gabel, \textit{State Mandated Benefits and the Small Firm's Decision to Offer Insurance}, 4 J. REG. ECON. 379, 380 (1992)).

\textsuperscript{122} See Metro. Life Ins. Co., 471 U.S. at 731.

\textsuperscript{123} Id. at 744.

\textsuperscript{124} See Mary Anne Bobinski, \textit{Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured}, 24 U.C. DAVIS L. REV. 255, 295 (1990) (noting that self-insured employers "may turn to an insurance company to provide administrative services or stop-loss coverage"); see also John J. Munnelly, \textit{Administrative Services Contracts}, 17 FORUM 987, 988-89 (1982). Munnelly explains:

Under the ASO contract, the insurance carrier assumes no risk, ... [it] only provides claims and other administrative services to the contract holder. Through such an arrangement, the insurer can make its expertise in claims
rangements contributes to undermining the socialized risk aspects of insurance. Being able to adopt tailor-made health coverage plans allows employers to opt-out of the common risk pool for health expenditures.

Risk sharing is another example of the flight from health insurance risk by the insurance industry. Instead of fully assuming risk for health expenditures in exchange for collected insurance premiums, under risk sharing arrangements, the insurance industry transfers some of the risk to health care providers. The insurance industry implements risk sharing through compensation arrangements with health care providers which deviate from fee for service arrangements. Such alternative compensation arrangements include capitation payments, risk pools with fee withholds, and percentages of premium arrangements. The key feature of these alternate compensation arrangements is that the insurance company decreases the risk that the expenditures it is obligated to cover exceed the premiums it has collected. The risk is instead borne by the health care providers to varying degrees. To the extent that federal policy allows the industry to export risk, such federal policy lowers the uncertainty inherent in insuring against health expenses. This encourages a private sector presence in the provision of health coverage. In fact, a lenient posture toward risk sharing is actually a form of subsidy granted to the private health insurers. Although the need for subsidies in health care is inevitable, the subsidy provided to the private health insurance industry in the United States is inadequate and inefficient to produce optimal health coverage.

Under the traditional system in which indemnity insurance was the dominant financing mechanism, health care providers primarily received payment on the basis of "fee-for-service." Fee-for-service handling, cost control, benefit development and design and actuarial science available to self-insured programs.

Id; see also David A. Engel, ERISA, To Preempt or Not To Preempt, That Is a Question!, 22 TORT & INS. L.J. 431, 433 (1987) (describing types of administrative services that insurance companies provide to self-insured employers, including claims processing, benefit calculation, enrolling members and making rulings on claim denial appeals).

125. See Jacobi, supra note 23, at 317 (stating "[i]n order to avoid furthering the socialization effects of shared pooling, large employers increasingly avoided formal insurance . . . opting to self-fund their health plans").

126. See id.

127. For a discussion of these risk-sharing arrangements, see infra notes 133-63 and accompanying text.

128. See id.

129. See id.

130. See infra Part V.

131. See Alan Meisel, Managed Care, Autonomy, and Decisionmaking at the End of
means there is a particular payment associated with each unit of service delivery (for example an hourly charge or a charge per procedure performed).\textsuperscript{132} The modern health care environment, which is dominated by managed care, is characterized by compensation arrangements that deviate from retrospective fee-for-service.\textsuperscript{133} Under managed care, providers may be compensated pursuant to a number of different methodologies: (1) resource based relative value scale;\textsuperscript{134} (2) diagnosis related groups;\textsuperscript{135} (3) capitation;\textsuperscript{136} and (4) percent of


132. \textit{See Edward P. Richards, Symposium Introduction Past as Prolog: Can Managed Care Overcome the Conflicts Inherited from Fee-for-Service Medicine?}, 66 Univ. Mo. Kan. City L. Rev. 735, 735 n.6 (1998) ("Fee-for-service is the general term used by health care economists to refer to payment systems that pay health care providers based on the specific services they provide."); see also Lisa Axelrod, \textit{The Trend Toward Medicaid Managed Care: Is the Government Selling Out the Medicaid Poor}, 7 B.U. Pub. Int. L. J. 251, 257 n.52 (noting a "[f]ee-for-service is a physician payment method where a doctor is paid for each service he provides, rather than a set fee for all services he provides"); Julie Y. Park, \textit{PHOs and the 1996 Federal Antitrust Enforcement Guidelines: Ensuring the Formation of Procompetitive Multprovider Networks}, 91 Nw. U. L. Rev. 1684, 1685 n.6 (noting that under fee-for-service there is a separate price paid for every medical service).

133. \textit{Mark V. Pauly et al., Paying Physicians, Options for Controlling Cost, Volume, and Intensity of Services} 104 (1992) (noting increase in use of capitation payments during the 1970s and survey results indicating use of capitation payments by 46% of all HMOs in 1987).


135. \textit{Chris Rauber, De-Capitating Managed-Care Contracts: Some Providers Say Global Capitation Has Tied a Noose Around Their Finances}, Mod. Healthcare, Sept. 6, 1999, at 52 (noting that the 1998 survey indicated 50% of all HMOs surveyed used
A resource based relative value scale ("RBRVS") is a prospective fee schedule for physician's services, wherein the fee is determined by multiplying a relative value for the service provided times a conversion factor. Diagnosis Related Groups ("DRG") is a form of prospective reimbursement for hospital services. Under a DRG DRG-based payments); see also Richard C. Seaberg et al., Planning and Implementing Total Laboratory Automation at the North Shore-Long Island Jewish Health System Laboratories, MED. LABORATORY OBSERVER, June 1, 1999, available at 46 WL 12963073 (noting managed care companies' use of DRG-type reimbursement for outpatient services).

136. Ericka L. Rutenberg, Managed Care and the Business of Insurance: When Is a Provider Group Considered to Be at Risk?, 1 DEPAUL J. HEALTH CARE L. 267, 292 (1996) (describing capitation as a system "where the PSO [physician sponsored organization] provides its services in return for a fixed payment per month for each patient assigned to it").

137. Id. (describing percentage of premium arrangement as the situation where "the PSO [physician sponsored organization] is paid a fixed percentage of the premium paid to the HMO").

138. Ruskin, supra note 134, at 419. According to Ruskin:

[T]his mechanism pays physicians a rate based on the number of relative value units earned through their services. These units are determined by a physician's use of "physical and mental effort, technical skill, and practice experience." Thus, more arduous tasks are rewarded with higher reimbursement. After setting this baseline rate, HCFA makes adjustments for geographic practice costs. It then multiplies this figure with a conversion factor that turns each service into a dollar figure. "If expenditures are excessive, relative to the congressional standard, in any given year the update in the fee schedule's dollar conversion factor will be reduced." Id.; see also Ruskin, supra note 134, at 419 (noting "overutilization one year results in a lower conversion factor the next year").
spective reimbursement for hospital services. Under a DRG system, the payment for hospital services is prospectively determined based on the patient's diagnosis upon admission to a hospital. Regardless of how long the patient is in the hospital receiving treatment, the hospital will receive the same amount of reimbursement. Under a capitation arrangement, a physician (or physician group) is paid a lump sum payment on a periodic basis (typically monthly). The amount of the payment is determined by the number of patients assigned to the physician. The payment is the same regardless of whether or not the patients actually receive services from the physician during the month. Capitation may be specific to the services for which the physician (or physician group) is responsible (for example, PCP services). Capitation may otherwise be global or all inclusive, in which case the capitation would be specified to cover not only the physician's services, but other services as well. For example, capitation may cover services of physicians outside of the group, hospital expenses, and costs of drugs. Managed care entities may also compensate a physician group under a percentage of premium arrangement. Pursuant to such an arrangement, the payer pays the provider a designated percentage of the insurance premiums collected by the insurer.

Managed care entities share the financial risk associated with

139. See Beard, supra note 138, at 468 (describing DRG, as fixed hospital prices assigned to each of 470 medical diagnoses pursuant to which, hospitals receive a preset reimbursement); see also Richards, supra note 132, at 747 (noting the "DRG system pays hospitals the average cost of caring for a patient with a given diagnosis"). DRGs were implemented by Medicare to control hospital cost. See id.

140. See Beard, supra note 138, at 468; see also Richards, supra note 133, at 747. As described by Richards:

[I]f a Medicare patient is admitted with bacterial pneumonia, the hospital gets a fixed payment based on the diagnosis . . . . For this fixed payment, the hospital has to provide all of the care the patient needs—tests, drugs, nursing care except for physician services . . . . If the hospital spends more than the DRG payment on the patient, then the amount the hospital goes over the DRG is a loss. If the hospital can treat and discharge the patient for less than the DRG, the hospital gets to keep the difference as profit.

Id.

141. Id.

142. PAULY, supra note 133, at 101 ("[A] capitated payment . . . is a fixed 'per head' payment to a health care provider for . . . a defined period of time.").

143. Id.

144. Id. at 105. For example, capitation may be specific to primary care services. Id.

145. Id. (noting 40% of HMOs responding to a survey published in 1987 required PCPs to pay for laboratory tests from their capitation payments or from a fund that included their capitation payments).

146. Rutenberg, supra note 136, at 292.

147. Id.
insuring against health expenditures with physicians and other providers through the above-referenced compensation arrangements. We can understand how a managed care entity shifts financial risk to a provider by examining the financial risks imposed upon traditional indemnity insurers. Under an indemnity arrangement, the risk-bearing entity (the insurer) collects insurance premiums from the insureds. Its goal is to collect enough premiums to be able to cover: (1) the costs of claims for which it will be responsible; (2) its administrative expenses; and (3) a profit. The traditional indemnity insurer was at financial risk that the insurance premiums it collected would not be sufficient to cover the items mentioned above. In order to limit the risk, the insurer could also engage in risk underwriting (screening individuals), bar coverage for preexisting conditions, and exclude certain conditions and treatments from coverage. The item which was least subject to the insurers' control and posed the greatest financial threat was the expenses for claims submitted by a provider who rendered services for the insured. The problem with this system was that the provider's actions were uncontrollable. Under a fee-for-service arrangement, doing everything possible for a patient was consistent with the provider's own financial interests.

148. Gil B. Fried, Punitive Damages and Corporate Liability Analysis in Sports Litigation, 9 Marq. Sports L.J. 45, 55 (1998) (noting that insurers attempt to set premiums through experience rating at a level which would cover all claims paid in a prior period with an additional amount to cover unusually large claims and insurance company administrative expense and profit); see also Roberta M. Berry, The Human Genome Project and the End of Insurance, 7 U. Fla. J.L. & Pub. Pol'y 205, 216 (1996) (describing premium establishment mechanism as involving desire for profit and need to cover administrative costs and claims incurred).

149. See supra notes 55-60 and accompanying text for a description of insurance industry practices.

150. See Brian A. Liang, De-Selection Under Harper v. Health Source: A Blow for Maintaining Patient-Physician Relationships in the Era of Managed Care?, 72 Notre Dame L. Rev. 799, 853 (1997) (describing physician's unlimited discretion during days of indemnity insurance which meant that "[t]here were no financial or other limitations or controls exercised by the insurance company over the physician under this blank check approach"); see also Price, supra note 75, at 620 ("Traditionally, health care decisions in the United States were made according to the provider paradigm, in which providers—primarily physicians—held virtually unfettered authority to recommend and treat patients . . . .").

151. See Meisel, supra note 131, at 1408. Meisel explains that under a fee-for-service system, the financial incentives were skewed in favor of the doctor treating the patient. Doctors made money when patients were sick, and they made more when patients were sicker . . . when patients were in need of treatment, the financial incentives of fee-for-service/indemnity insurance medicine were generally aligned with patients' interest in getting the medical treatment they needed. The financial incentives for doctors were also consistent with their long-standing professional duty to heal.

Id. (footnotes omitted).
To the extent that an insurer utilizes fee structures that deviate from retrospective, fee-for-service arrangements, it is able to (1) introduce more predictability in its expenses; (2) disrupt the providers’ inclination to assume that more services are better and; (3) shift financial risk from itself to the providers. This ability strengthens the argument for a system the furtherest away from any type of fee-for-service arrangement that the insurer can institute. Under any type of fee-for-service arrangement, whether the fee is determined retrospectively or prospectively, the insurer still remains at risk for the total expenses that it will be called upon to cover. Although it knows what it will pay for any unit of service delivered, it will still not be able to control the volume of services. Therefore, any of the fee-based compensation mechanisms still leave the insurer at financial risk, for example, discounted fee-for-service arrangements, RBRVS, and DRGs. Payment arrangements that sever the relationship between the unit of service provided and the compensation provide an insurer with greater insulation from financial risk. For example, an insurer knows what it will have to pay for services

---

152. See, e.g., PAULY, supra note 133, at 102 (noting that a physician’s financial responsibility for ancillary services and consultation creates a strong incentive for physicians to control those services).

153. Id. at 101. Under capitation the provider receives the same predetermined payment regardless of the costs of providing the services covered by the capitation payment. Id. According to Pauly:

When actual costs of care are less than the captitated payment, the provider keeps the “profit”; if actual costs are more than the payment . . . the provider is financially responsible. This payment method in effect merges some of the insurance function with the provider function in that a portion of the financial risk is borne by the provider.

Id.

154. See Thomas Bodenheimer, Reimbursing Physicians and Hospitals, 12 JAMA 971, 971 (1994). As Bodenheimer explains:

Methods of payment lie along a continuum that extends from the least to the most aggregated unit. Under fee-for-service reimbursement, the unit of payment is the visit or procedure: the physician or hospital is paid a fee for each office visit, ECG, intravenous fluid, or other service or supply provided. All other reimbursement modes aggregate or bundle together several services into one unit of payment. Reimbursement by episode of illness pays physicians or hospitals one sum for all services delivered during one illness, for example, global surgical fees to physicians and DRGs for hospitals. Per diem payments to hospitals bundle all services delivered to a patient during 1 day. A further bundling of services is accomplished by capitation payment, in which one payment is made for each patient’s treatment during a month or year . . . . Payment based on all services delivered to all patients within a certain period includes global budget reimbursement of hospitals and salary payment of physicians.

Id. (footnote omitted). “As a general rule, the more that services are bundled into one payment, the more the financial risk of illness shifts from the payer to provider.” Id. at 973.
rendered by a primary care physician ("PCP") receiving capitation payments for patients assigned to the PCP. The expense does not vary with the unit of services actually provided by the PCP. In fact, if the entity can globally capitate a provider or group of providers, it achieves total predictability of expenses and hence, zero financial risk.

Insurers may manage some of the financial risk inherent in fee-for-service arrangements or nonglobal capitation by the use of fee withholding. Under fee withholding, some percentage of the provider's compensation is withheld by the insurer and put at risk for services not provided by the providers. The typical situation involves a PCP. PCPs are responsible for coordinating health care of patients assigned to them. Inpatient hospital admissions and services provided by specialists require the approval of the patient's PCP. If the PCP receives compensation on a fee-for-service basis or receives nonglobal capitation, the compensation only covers the PCP's services. However, the PCP's decisions with respect to referrals to specialists, inpatient hospital admissions, and drug prescription will have an impact on the insurer's expenses as well. Under a fee withholding arrangement, the insurer is able to align the PCP's

155. *See PAULY, supra* note 133, at 105 ("By setting the level of payment per person prospectively, it is true by definition that total expenditures will be affected only by the number of persons at risk, not by variations in the volume and intensity of services provided.").

156. *See, e.g., Rauber, supra* note 135, at 52 (noting that under global capitation model monthly "payment is expected to cover any and all healthcare services provided by a hospital, physicians and ancillary services").

157. *See PAULY, supra* note 133, at 105 (noting that in a 1987 survey, "two-thirds of all HMOs appear[ed] to use withholding[s]").

158. *See id. at 103. Fifty-four percent of HMOs responding to a survey in 1987 indicated that they withheld a percentage of PCPs fees "in case their use of actuarially budgeted funds for referral to specialists was too high." Id. at 105.


160. *See PAULY, supra* note 133, at 106 (distinguishing between partial and comprehensive (global) capitation). “Capitation payment to physicians is usually restricted to any services provided directly by the primary care physician.” *Id. at 105; see also Rutenberg, supra* note 136, at 292 (distinguishing between capitation which involves payment to a physician organization for the services the organization provides versus global capitation which is designed to cover services provided by the organization and by providers outside of the organization).
financial interests with the insurer's financial interests vis-a-vis the expenses for specialists, inpatient hospital admissions, and drugs. This is achieved by placing a portion of the PCP's fees at risk for these expenses. Under a typical scenario, the managed care entity will retain a designated percentage of the fees earned by the physician. The fees are set aside in a withhold fund. At the end of the year, if the managed care entity expenses for designated services exceed what the managed care entity's had budgeted for such expenses, the physician's withheld fees would be used to reimburse the managed care entity for the excess expenditures. If, on the other hand, the actual expenditures were less than the budgeted amounts, the physician would recoup the withheld fees.

These alternative compensation arrangements allow insurance companies to escape from the business of insuring against health risk. The industry's ability to engage in such arrangements was aided and abetted by federal policies which undermined state laws that would prohibit such arrangements. State laws prohibited the corporate practice of medicine and fee splitting. Under these laws, a physician was required to maintain financial autonomy from laypersons which meant the physician could only accept the physician's professional fees as compensation for the physician's services. This meant the physician could not accept salaries or other alternative means of compensation (e.g., capitation payments). Under the insurance codes of most states, only licensed insurers could assume the financial risk associated with health expenses. The cost containment environment of the 1980s and 1990s led to a relaxation of these considerations. In fact, under the Federal HMO Act, federally qualified HMOs were exempt from restrictive state laws.

161. PAULY, supra note 133, at 103 (discussing the frequent practice of withholding a percentage of a physician's fees).
162. Id.
163. Id.
164. Id.
166. See id. at 468 (discussing the reluctance of courts to distinguish between the professional services of a physician and the administrative duties of a layperson employed by a corporation that employs physicians).
Trade Commission prohibited the American Medical Association from issuing ethical proscriptions against the corporate practice of medicine and fee splitting.\(^\text{170}\) Federal policy also endorsed risk sharing as a means to reduce health care expenditures.\(^\text{171}\) These actions all contributed to a flight from health insurance risk by the private insurance industry via the mechanism of risk sharing.

It is important to see this movement towards risk sharing in the appropriate light. It is yet another example of the interplay between the use of the market as a means to allocate health care coverage and the inherent problems with the insurance model of health care coverage. The uncertainty inherent in insuring against health expenditures pursuant to established insurance principles causes the industry to undertake risk sharing as a means to avoid that risk. This is the same phenomenon that accounts for the industry's desire to utilize individual risk underwriting and engage in cherry-picking.

The federal government has slowly responded to activities that result from the flight from health insurance risk by the private insurers. The Americans with Disabilities Act ("ADA") limits employers' ability to discriminate against individuals on the basis of a disability when designing health benefits under self funded arrangements.\(^\text{172}\) The ADA also arguably prohibits insurers from engaging in such discrimination in connection with employer's sponsored health insurance.\(^\text{173}\) The federal government has also established limited mandated benefit requirements,\(^\text{174}\) restricted the

---

914 (codified as amended at 42 U.S.C. § 300e (1996)).


171. See 42 U.S.C. § 300e(c)(2)(D) (1994). HMOs may make "arrangements with physicians or other health professionals, health care institutions . . . to assume all or part of the financial risk on a prospective basis for the provision of basic health services." Id. Furthermore, federally qualified HMOs dealing with the Medicare program must have "effective procedures to monitor utilization and to control cost of basic and supplemental health services and to achieve utilization goals, which may include mechanisms such as risk sharing, financial incentives, or other provisions agreed to by providers." 42 C.F.R. §417.103(b) (1999).

172. See Jacobi, supra note 23, at 385. Jacobi notes:

[In advancing a "comparative fairness" application of the ADA to health coverage, the EEOC permits the exclusion or severe limitation of coverage for the disabled only if actuarially similar conditions are similarly treated. The effect of this policy will be to reduce risk segmentation. Employers and plans will find that public opinion bars them from limiting those with "favored" conditions, such as heart disease or cancer. As a result, they will also find themselves barred by law from limiting those with "disfavored" conditions such as AIDS.

\textit{Id.}

173. See id. at 351-52 (noting the ADA prohibits discrimination of fringe benefits whether administered by the employer or by an entity operating under a contract for the employer).

174. See supra note 75 and accompanying text for a description of federally-
application of pre-existing condition limitations,¹⁷⁵ and the use of genetic testing.¹⁷⁶ Notwithstanding these efforts, however, self-funding and risk sharing remain vital avenues by which the private health insurance industry extricates itself from the business of insuring against health risk. More importantly, greater intervention by the federal government in the private sector market for health coverage is likely to meet the same fate as state level intervention. Faced with increased federal mandates, employers will be inclined to decrease the availability of benefit packages they offer. The lesson is simple: a government cannot prohibit activities that result in externalities without also addressing the inevitable flight from health insurance risk that will result from the inability to exploit those externalities. Curtailing externalities causes insurers to withdraw from the market for coverage and employers to reduce health benefits offered to employees.

The flight from insurance risk betrays the limitations of “Patient Bill of Rights” legislation.¹⁷⁷ Democrats have called for greater inter-

mandated minimum inpatient hospital coverage following childbirth delivery.


¹⁷⁶. See Health Insurance Portability & Accountability Act, § 102(a) ("A health plan or insurer may not establish rules for eligibility based on health status, medical condition, claims experience, receipt of health care, genetic information, evidence of insurability or disability.").

¹⁷⁷. "Patients' Bill of Rights" was a phrase adopted by President Clinton in his 1997 State of the Union Address. See Michael Misocky, The Patients' Bill of Rights: Managed Care Under Siege, 15 J. CONTEMP. HEALTH L. & POL'y 57, 60 (1998). However, “Patients’ Bill of Rights” (also known as “Patient Protection Act”) legislation has been the subject of much activity at the state level both prior to and subsequent to President Clinton’s speech. See, e.g., Georgia: Gov. Miller Signs Four Bills Aimed at Managed Care Enrollees, 5 BNA HEALTH L. REP. 16, 24 (Apr. 18, 1996) (describing Patient Protection Act of 1996 signed into law by Georgia Governor Zell Miller); Minnesota: Governor Signs Managed Care Bill, MinnesotaCare Expansion Tobacco Sales, 6 BNA HEALTH L. REP. 24, 19 (June 12, 1997) (describing Patient Protection Act signed into law by Minnesota Governor Arne Carlson); New Jersey: Sweeping Patient Protection Act Will Build on Comprehensive HMO Act, 6 BNA HEALTH L. REP. 33, 23 (Aug. 14, 1997) (describing “Patient Protection Bill” signed into law by New Jersey Governor Christine Whitman); Texas: Governor Bush Signs Legislation Expanding Managed Care Protections, 6 BNA HEALTH L. REP., 27, 29 (July 3, 1997) (describing consumer protection act signed into law by Texas Governor George W. Bush, Jr.); Hawaii: Gov. Cayetano Signs Patient Protection Bill with Gag Clause Ban, Grievance Process, 7 BNA HEALTH L. REP. 1163 (July 23, 1998) (describing Patient’s Bill of Rights legislation signed into law by Hawaii governor). Of course, state action in this area may be of limited utility because of the ERISA preemption doctrine discussed in this article. Under ERISA, a court may find that state “Patients’ Bill of Rights,” “Patient Protection Act,” and “consumer protection” laws are preempted as relating to an employee benefit plan and not saved from preemption by the insurance savings clause. See, e.g., Corporate Health Ins., Inc. v. Tex. Dept' of Ins., 12 F. Supp. 2d 597, 630 (S.D. Tex. 1998) (in-
vention in the health coverage market by in making managed care organizations accountable for medical necessity determinations by allowing lawsuits against them. This provision is required because validating provisions of Texas Patient Protections Act which (1) established an independent review process for review of medical necessity determinations, (2) prohibited health plan from removing provider for advocating on behalf of the client and (3) prohibited managed care companies from including indemnification clauses on contracts with providers). This ruling, if followed by other courts, "will have a chilling effect on patient protection legislation in all the states considering managed care reform." Brenda T. Strama, Did Court in Texas Split the Baby in HMO Liability Decision, 7 BNA HEALTH L. REP. 1694 (Oct. 22, 1998).

178. See Misocky, supra note 177, at 85 (describing Democratic response to health care). This liability provision is the most salient of the differences between the Democratic backed Patient Bill of Rights (S. 1344) and the Republican Bill of Rights Plus Act (S. 326, S. 300). See Comparison of Major Provisions of Democratic, Republican Patient's Bill of Rights Legislation, 8 BNA HEALTH L. REP. 1145 (July 15, 1999). According to the BNA Health Law Reporter, the differences noted in the two pieces of legislation were:

Liability. The Democratic bill would allow patients to sue health plans for damages in state courts for denied or delayed benefits. Employers could be sued if they were involved in the benefits decision, but would be shielded if they were not involved. Republicans oppose this.

Medical necessity. Democrats would require health plans to pay for medical care that the treating physician believes to be "medically necessary." Republicans oppose this.

Scope of coverage. The Democratic bill would cover all 161 million Americans with private health insurance. The GOP bill would cover only the 48 million Americans in self-insured health plans, which are beyond the reach of state regulation, and let the states cover the rest. The exceptions are the external review and information disclosure provisions, which would apply to the 123 million Americans in self-insured and fully insured plans.

Access. Democrats say the GOP bill does not provide a strong enough guarantee of access to specialists and continuity of care, and is missing other protections like access to clinical trials.

External review. While both bills would provide external appeals of health plan decisions, Democrats say the Republican bill is too limited because only disputes over medical necessity or experimental or investigational treatments could be appealed.

Medical savings accounts. The Republican bill would attempt to give patients a greater choice of health plans by lifting the restrictions on the medical savings accounts demonstration project. Democrats oppose this.

Id. The BNA Health Law Reporter also notes the areas of agreement between the two bills:

While there are significant differences in the details, both ... allow patients to appeal coverage denials to an external review board; guarantee broader coverage of emergency room services; give patients direct access to specialists without going through "gatekeeper" physicians; give women direct access to obstetrician-gynecologists; provide continuity of care for pregnant women, patients receiving institutional care, and the terminally ill when their specialist leaves the network; provide a point-of-service option, allowing patients in a closed managed care network to pay extra to see providers outside the network; require health plans to disclose a greater amount of information
under ERISA's preemption of state laws affecting employee benefit plans and the self funded environment, there is an absence of legal liability for improper medical necessity determinations. If there is no consequence for making an improper medical necessity determination, there is no cost to the decision maker. This is yet another opportunity to exploit a negative externality. The measures proposed by the Democrats would foreclose exploitation of this negative externality. The Republicans have responded to these proposals, arguing they will drive up the costs of health care and cause employers to drop benefits coverage. The Republican response echoes the lesson of the

179. See Misocky, supra note 177, at 80-81 (noting that many courts interpret ERISA's broad preemption language to preempt liability suits against ERISA plans). See id. at 81 n.124 (collecting authority); see also Corcoran v. United HealthCare Inc., 965 F.2d 1321, 1339 (5th Cir. 1992) (finding ERISA preempted wrongful death claim under circumstances where death to fetus was attributed to managed care entity's refusal to approve inpatient care for pregnant mother against the recommendation of her treating physician). It appears that this particular liability shield may be yielding to judicial inclination to entertain lawsuits against ERISA entities as long as the plaintiff's claim involves the quality of benefits received as opposed to claims based on a denial of benefits resulting from the benefit determination process. See Corporate Health Ins. Inc., 12 F. Supp. 2d. at 620 (noting claims challenging the quality of a benefit received are not preempted, but that claims based on a failure to treat are preempted where failure was the result of a determination that the requested treatment was not covered by the plan) (citing Pacificare, Inc. v. Burrage, 59 F.3d 151, 154 (10th Cir. 1995) (finding that a medical malpractice claim was not preempted by ERISA when issue of doctor's negligence required assessment of admittedly covered treatment or giving professional advice)); Corcoran, 965 F.2d at 1331 (determining that medical determinations made by an HMO were preempted by ERISA because made in context of benefits determination under the plan). Of course, the result of this distinction is that there is no liability for an improper denial of benefits, a point that was poignantly addressed in Corcoran:

The result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake. This is troubling for several reasons. First, it eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. With liability rules generally inapplicable, there is theoretically less deterrence of substandard medical decisionmaking. Moreover, if the cost of compliance with a standard of care... need not be factored into utilization review companies' cost of doing business, bad medical judgments will end up being cost-free to the plans that rely on these companies to contain medical costs.

Corcoran, 965 F.2d at 1338 (emphasis added).

180. See, e.g., Congressional Roundup: Senate Approves GOP Managed Care Reform Plan; Focus Turns to House, 8 BNA HEALTH L. REP. 1189 (July 22, 1999) (quoting Senate Majority Whip Don Nickles (R-Okla.)). Senator Nickles, referring to the passage of the Republican Patient's Bill of Rights Plus Act which does not include liability for erroneous benefit denial, stated "[w]e wanted to improve the quality of healthcare without increasing costs or increasing the number of uninsured."
flight from insurance risk: Curtailing opportunities to exploit externalities will be met by resistance and reduced or eliminated health coverage. The problem with the Patient Bill of Rights debate is that it ignores the problem of externalities. In order to contain externalities, the government must also prevent a flight from health insurance risk. Such is not possible when infatuation with the market blinds policy makers to the merits of comprehensive and substantial intervention by the government in the health coverage market.

V. WATER, WATER EVERYWHERE

There are problems associated with using the insurance model in the market as the means of allocating health coverage. Markets cannot effectively allocate health coverage because the market does not effectively address the problems of externalities. The insurance model is defective because it depends upon exploitation of externalities for its success. The result of the use of the insurance model to allocate health coverage in the market is fragmented coverage for some individuals and no coverage for many others. Efforts to intervene in the market in an incremental piecemeal fashion result in a flight from insurance risk and threatened additional reductions in the availability of health coverage.

Given the problems inherent with the insurance model combined with the allocation of health coverage through the market, most countries have abandoned either the insurance model, reliance on the market, or both in order to achieve universal health coverage. The United States alone remains beholden to the twin inadequacies of the insurance model and the market to allocate protection against health risks. Countries which have achieved universal health coverage have used a number of options to achieve this goal: socialized medicine, socialized insurance, or mandatory private insurance. However, one feature of each of these systems is that ultimately the society provides some sort of social subsidy for health care.

The inevitable fact of health care is that, if a government fails to subsidize health care, the citizens will not consume health care at socially optimal levels. Disparities in the health condition, age, and income of the citizens will mean that some individuals will be priced out of the necessary coverage. With the introduction of the Medicare and the Medicaid programs, the United States has acknowledged the need for a subsidy for health care for persons whose condition would price them out of the market for health coverage. Persons who receive their insurance through their employers benefit from another social subsidy for health care—the tax deductions offered to employ-

---

181. See supra note 32 and accompanying text for discussion of role of Medicare and Medicaid in American health coverage system.
ers for their expenses for their employees' health care. 182 Therefore, 
even in the United States the inevitability of a need to subsidize 
health care is evident, if not fully appreciated. The problem that we 
have is the failure to commit to the additional subsidy required to 
fully cover the total population.

Some countries have opted for pure socialized medicine. 183 Under 
a system of socialized medicine, the government not only pays for 
health services but it also owns the means of delivery and employs 
the providers. 184 These systems abandon both the insurance model 
and the market and replace them with explicit public subsidies. The 
right to health coverage is not based on the ability to pay for insur-

182. See supra note 71 and accompanying text for discussion of tax and deductions 
available for health expenses.

183. The term "socialized medicine" has various connotations depending on the 
speaker or the listener, and the use of the word is predominately undefined, but fre-
quently pejorative. See, e.g., Julie Marquis & Dave Lesher, California and the West, If 
Education is 1st, 2nd, and 3rd, Where's Health Care?, L.A. TIMES, Mar. 1, 1999, at A3 
(quoting Republican state legislator as indicating Republicans' preference for reform-
ing healthcare through the private sector because "[o]therwise we're marching down 
the path toward socialized medicine"); see also Senate Cuts Some Slack to Beleaguered 
HMO Industry, MEDICINE & HEALTH, July 19, 1999 (quoting Senator Don Nickles as 
saying "[l]ook at other countries that have really tried socialized medicine, govern-
ment-controlled medicine, government dictates from A-Z"); Laurie McGinley, In Other 
Wards: Republicans Don't Feel Too Good as Doctors Cut Across Party Lines, WALL ST. 
J., Sept. 28, 1999, at A1 (describing how Senator Edward Kennedy was "[d]emonized 
for years by the AMA as a promoter of socialized medicine"); Joseph Lee Pugh, BROKER 
WORLD, Sept. 1, 1999 available at 1999 WL 124128 (referring to "socialized medicine" 
as "a national health care program run by bureaucrats and worse"). As used in this 
article, "socialized medicine" means a health financing and delivery system wherein 
the government owns the health care system and the services are financed through the 
tax system. See, e.g., Uwe E. Reinhardt, Reforming the Health Care System: The Uni-
versal Dilemma, 19 AM. J.L. & MED. 21, 22 (1993) (noting that under socialized medi-
cine, "the production of health care is substantially owned by the government"). Sys-
tems wherein the government owns the health care system are also referred to as the 
"National Health Service" model. See Saunders, supra note 31, at 722 n.49 (equating 
"National Health service model" with "universal coverage, national general tax financ-
ing and national ownership"). Socialized medicine, or the National Health Service 
Model, is associated with the "Beveridge Model" of financing through general taxation. 
See, e.g., Christopher Newdick, Public Health Ethics and Clinical Freedom, 14 J. 
such as the U.K., Sweden, Norway, Italy, and Spain commit themselves to a system 
under which health care is financed by the treasury from general taxation."); see also 
Kieke G. H. Okma, European Health Care Reform: Analysis of Current Strategies by 
Richard B. Saltman and Joseph Figureas, 24 J. HEALTH POL. POLY & L. 835, 836 
(1999) (book review) (describing Beveridge Model as funding through "earmarked gen-
eral taxation"). The Beveridge Model derives its name from William Beveridge, a 
[S]tate was based." Carolyn Hughes Tuohy, Principles and Power in the Health Care 

184. See Reinhardt, supra note 183, at 22.
ance but is rather a form of entitlement attached to citizenship.\textsuperscript{185} Britain, Italy, Sweden, and Kenya are examples of nations that provide health coverage through socialized medicine.\textsuperscript{186}

Other countries have opted for a system of socialized insurance.\textsuperscript{187} Pursuant to such a system, the government or agencies of the government provide health coverage for individuals.\textsuperscript{188} These systems also abandon the insurance model and the market and replace them with explicit public subsidies. Canada, Australia, Norway and New Zealand are examples of countries that utilize a system of socialized health insurance.\textsuperscript{189}

\begin{itemize}
  \item \textsuperscript{185} See Tuohy, supra note 183, at 206; Saunders, supra note 31, at 723.
  \item \textsuperscript{186} See William C. Cockerham, Medical Sociology 285, 289-91, 311 (7th ed. 1995) (describing the formation of the British National Health Service in 1948 as an instance of the government “becom[ing] the employer for health workers, maintain[ing] facilities, and purchas[ing] supplies and new equipment”; describing Swedish national health services wherein physicians are employed by county councils and general hospitals; describing the Italian National health service, the Servizio Sanitario Nazionale (SSN), established in 1978; describing Kenyan National Health Service that employs physicians and owns hospitals); see also Saunders, supra note 31, at 716-17 (describing health system in Denmark which abolished health insurance funds as independent services organization and provides the total administration by municipal authorities).
  \item \textsuperscript{187} “Socialized insurance” is often confused with “socialized medicine.” See Reinhardt, supra note 183, at 23 (“"D"istinction between socialized insurance and socialized medicine is often lost on American critics of foreign health care systems."). As used in this Article, “socialized insurance” means a system where the government directly pays physicians and other providers for services rendered to the citizens, but the physicians and other providers are part of the private sector. This needs to be distinguished from programs where the citizens are covered by private or quasi-public insuring entities referred to herein as “mandatory private insurance.” See note 190 infra and accompanying text for description of “mandatory private insurance.”
  \item \textsuperscript{188} See Reinhardt, supra note 183, at 23.
  \item \textsuperscript{189} See Cockerham, supra note 186, at 283 (“Canada essentially has a private system of health care delivery paid for almost entirely by public money. Private health insurance is generally prohibited except for covering only some supplemental benefits such as semiprivate room accommodations.”); see also Vibeke Erichsen, Health Care Reform in Norway: The End of the “Profession State”? 20 J. Health Pol'y, Pol'y & L. 719, 720-21 (1995) (describing Norwegian health care system which provides health care through a system of public hospitals which employ one-half of the physicians and a system of state health insurance); Gwen Gray, Access to Medical Care Under Strain: New Pressures in Canada and Australia, 23 J. Health. Pol'y, Pol'y & L. 905, 925 (1998) (noting Australia introduced its Medicare program in 1984). The Australian Medicare program is a publicly administered national health insurance program which provides free hospital service for all Australians, which covers all hospital care. \textit{Id.} Hospitals pay physicians for the costs of physician services rendered to hospital inpatients, therefore, Australians receive no bills for services provided in hospitals. \textit{Id.} at 933. Physicians may bill patients for out-patient services for which the public insurance plan will reimburse the patient up to 85% of the national fee schedule amount. \textit{Id.} Doctors are allowed to exceed the fee schedule amount, however. \textit{Id.} There is also a bulk billing process pursuant to which physicians bill the national health plan instead of the patients if the physicians agree to make no charges to the patients. \textit{Id.} 71.8% of
Finally, some countries utilize a tightly regulated system of mandatory “private” insurance.190 Such countries maintain the insurance model. However these countries maintain tight governmental control over the insurance industry.191 The control exercised over the all out-patient doctor bills are billed pursuant to the bulk billing process. Id; see also Robert H. Blank, Rationing Medicine: A Comparative Analysis, 21 W. St. U. L. Rev. 11, 20-23 (1993) (describing the health system of New Zealand). In New Zealand, health care is financed through the tax system. Id. at 22. “Four Regional Health Authorities . . . [are] responsible for purchasing health care for their populations.” Id.

190. Mandatory “private” insurance as used herein combines compulsory universal coverage financed by employer, individual, and governmental contributions to private or quasi-public insurance entities. This arrangement is sometimes referred to as the “Social Insurance model.” See Saunders, supra note 31, at 722 n.49.; see also GLASER, supra note 56, at 4 (“Social insurance funds are based on an obligatory membership by entire social classes.”). This system is also referred to as the “Bismarck model.” See, e.g., Newdick, supra note 183, at 362 (“In Bismarck systems . . . health care is financed through compulsory social insurance in which entitlements to care are based on standards and criteria agreed between the insurance providers and the government.”); see also Dana Derham-Aoyama, U.S. Health Care Reform: Some Lessons From Japanese Health Care Law and Practice, 9 Temp. Int’l & Comp. L. J. 365, 374 (1995) (noting that Japan followed the Bismarck model by “form[ing] ‘mutual aid’ trade associations to finance health care for some Japanese workers”); Okma, supra note 183, at 836 (referring to social health insurance as the Bismarck model). The Bismarck model derives its name from Chancellor Otto Van Bismarck who pioneered the system in 19th century Germany. See Derham-Aoyama, supra, at 373 n.94.

191. See, e.g., Done, supra note 23, at 748-49 (“German laws mandate that all persons participate in the sickness funds, and that sickness funds provide comprehensive benefits to all members for the same premium regardless of health, age, or economic status.”); see also Blank, supra note 189, at 27. In Japan, “[a]lthough the health care delivery system is dominated by the private sector, unlike the U.S. it is not market-oriented. While providers compete for patients and consumers have broad freedom of choice, all funders and providers are strictly regulated by the government.” Id.; see also David Chinitz, Israel’s Health Policy Breakthrough: The Politics of Reform and the Reform of Politics, 20 J. Health Pol’Y & L. 909, 917 (1995) (noting that under reforms in Israeli health system, health insurers are not “allowed to practice biased selection, exclude persons with pre-existing conditions, or place any conditions or restrictions on membership”). In addition, the health insurers would need to provide a uniform “basic benefits package.” Id. at 916; see also Richard B. Saltman and Joseph Figueras, Analyzing the Evidence on European Health Care Reforms, Health Aff. 85, 93 (1998) (“Countries with Bismarck-style funding systems (Austria, Belgium, France, Germany, Luxembourg, and Switzerland) typically have long-established, statutory insurance-based systems. . . . Nearly all are subject to close regulation by government, which has been growing, on grounds either of cost containment (by, for instance, putting a ceiling on premiums) or of equity and solidarity.”); Victor G. Rodwin & Simone Sandier, Health Care Under French National Health Insurance, Health Aff. 111 (Fall 1993) (describing the French health system). As noted by Rodwin and Sandier: [T]he French active population is covered by statutory, occupation-based, national health insurance schemes that are part of the social security system. All dependents are automatically covered, as are the unemployed and the retired. National health insurance funds are organized into regional and local funds, all of which are, in French administrative law, private organizations charged with the provision of public service. However, . . . the funds are
industry curtails the influence of the market on insurers' behavior. The government prohibits the insurers from denying coverage to any eligible individual, establishes the premiums insurers can charge, prescribes the benefits they must cover and prohibits individual risk underwriting. Therefore, although such systems may rely on the insurance model to provide health coverage, they do not rely on the unfettered action of the market to provide such coverage. Examples of systems that utilize a system of tightly regulated mandatory private health insurance are Germany, Switzerland, Japan, the Netherlands, France, and Belgium.

Closely supervised by the Ministry of Social Affairs as well as the Ministry of Finance and are therefore, in practice, quasi-public organizations. Health insurance premiums (payroll tax rates) are set by the government, as are the range of benefits, which are, with minor exceptions, uniform across national health insurance schemes. In addition, the central government oversees a process of national negotiations between the three principal national health insurance funds and representatives of health care providers. It thereby assures that all providers are subject to uniform reimbursement policies irrespective of the schemes under which patients are covered.

Id. at 116.

192. See Rodwin & Sandier, supra note 191, at 116-17.
193. See Cockerham, supra note 186, at 294 (noting that in Japan not all Japanese are covered by the national health insurance plan and that virtually all Japanese are covered by some form of health insurance, which is provided by large employers, small and medium sized employers, and public and quasi-public institutions). Germany has utilized a health system which is dependent on compulsory insurance since 1883. Id. at 296. Under the German system, all employees, self-employed, unemployed, old-age pensioners and certain categories of domestic workers are required to belong to one of the 1317 public health insurance groups. Id. Ten percent of the population, consisting of civil servants, the self-employed and white-collar workers with annual income “above the governmental ceiling,” may opt for private insurance. Id. at 297, 299 (describing the health system in the Netherlands pursuant to which 68% of the population is enrolled in public insurance funds and 32%, consisting of civil servants, the self-employed, and people with the highest income, maintain private insurance). “[T]here is no single organization providing health insurance on a nationwide basis. Rather, the French insurance system is divided between occupational groups. Professionals, businessmen, craftsmen, civil servants, farmers, and other occupations have their own organizations.” Id. at 300. The insurance organizations in France are nonprofit and are supervised by a government agency. Id. at 301; see also Chinitz, supra note 191, at 909 (describing Israeli health system). Up until the 1990s, Israel had relied on voluntary health coverage through four sickness funds pursuant to which 96% of the population was covered by health insurance. Id. at 911-12. During the 1990s, however, the government instituted a series of reforms which would (1) maintain “[c]ompetition among regional, decentralized sickness funds”; but (2) “[c]entraliz[e] collection of health system revenues and risk-based capitation”; (3) provide for a “standard, minimum benefits package”; and (4) prohibit selective enrollment by the sickness funds by providing for “[u]niversal access and open enrollment.” Id. at 916; see also Patrice R. Wolfe & Donald W. Moran, Global Budgeting in the OECD Countries, 14 Health Care Financing Review 55, 67 (1993) (“Belgium has a compulsory health insurance system that provides coverage to the entire population. The system is administered by one public fund and five mutualities and is funded by both social security contributions
Pursuant to these strategies that abandon the insurance model for a form of social entitlement or which abandon reliance on the market, nearly all of these countries have achieved universal coverage for their citizens. Their citizens generally are allowed to pick their own physicians, and they appear to be generally more satisfied with their health system than people in the United States.

The price for this universal coverage is a public subsidy provided for health care which is an integral part of the health financing arrangements. In this connection, subsidy is narrowly defined as additional dollars used to cover an individual's health care needs that are not attributable to the collection of money paid by such individual. In countries with socialized medicine or socialized insurance, the subsidy is approximately 100% because there are no insurance premiums. In countries with mandatory private or quasi private insurance, a subsidy might take the form of a direct payment from the government to an insurance fund in order to adjust for the risk assumed by that insurance fund. Sometimes the subsidy is provided by other insurance funds through a system of cross subsidization. The idea
is that some form of public subsidy is required to finance adequate health coverage. The subsidy has two major effects: (1) it induces consumption of health care to levels which exceed non-subsidized levels and (2) helps to socialize risk across larger segments of the population.

VI. THE COST CONTAINMENT CONUNDRUM

As described above, countries with universal health coverage achieve such coverage through explicit public subsidies. However, a government may also encourage private conduct by permitting private parties to exploit externalities associated with such conduct.199 Health coverage in the United States appears to be uniquely dependent on the ability of employers and insurers to exploit externalities associated with their decisions regarding financing health coverage. As described above, in the United States any governmental action to curtail exploitation of externalities is met with a threatened or potential flight from health insurance risk. Thus, governmental policies which allow private parties to exploit externalities are justified because they keep the cost of health care down and thereby increase access to health care. Unfortunately, "playing the Market" in this fashion not only undermines universal health coverage, but also yields ineffective cost containment.

All countries have had to deal with the specter of increasing health care costs.200 Despite their increased access to health care, countries with universal coverage spend less of their GNP on health care than the United States, notwithstanding the explicit social subsidy provided for health care in such countries.201 The United States

199. See, e.g., Colin Crawford, Some Thoughts on the North American Free Trade Agreement, Political Stability and Environment Equity, 20 BROOK. J. INT'L L. 585, 616 (1995) (discussing OECD's "polluter pays" principle as a mechanism to "eliminate what might be viewed as hidden subsidies in the form of clean up costs that would otherwise be borne directly by the government or subsequent property owners"); see also Peter J. Hammer, Free Speech and the "Acid Bath": An Evaluation and Critique of Judge Richard Posner's Economic Interpretation of the First Amendment, 87 MICH. L. REV. 499, 527 (1988) ("Inaction in the face of external costs ... has the same effect as providing a subsidy for the activity causing the harm.").

200. David Wilsford, States Facing Interests: Struggles over Health Care Policy in Advanced, Industrial Democracies, 20 J. HEALTH POL. POL'Y & L. 571, 573 (1995) ("[E]very health system of the developed world faces severe cost problems. The entire postwar period is characterized by an increasingly large share of GDP needed to pay for health care every year in every country.").

201. See Saunders, supra note 31, at 733 ("Under the current health care system in the United States, health care expenditure is the highest in the world."). "As a percent of GNP in U.S. dollars, the United States leads the world in cost of health care at 11.2% versus 6% in Denmark (the lowest percent). Id. n.86. "In 1990, per-person
also does far worse in controlling health care inflation than other countries. This may be attributable in part to how the systems approach physician compensation.

All health care systems must deal with the impact of physician decision making on the volume and kinds of health expenditures. It is paradigmatic that, if left unchecked, physician decision making could bankrupt the economies of all nations. This is not because of any greed attributable to physicians. It is because of the simple fact that the costs of medically feasible services far exceed the GNP of any economy. The manner by which the health care system compensates physicians influences the volume and type of services provided and ordered by physicians for their patients. Capitation arrangements lead to lower utilization. Fee withholding is associated with lower rates of admissions to hospitals or referrals

health care costs in the United States were more than double the OECD average." Id.; see also George Schieber, Health Spending Delivery, and Outcomes in OECD Countries Data Watch, HEALTH AFF. 120, 120-21, 125 (1993). In 1991, as a percentage of gross domestic product, the United States spent 13.2%. Canada spent 10% and no other OECD country spent over 10%. Id. The average percentage for OECD countries was 7.9%. See id. at 121. Spending per capita in the U.S. was $2868 compared to OECD average of $1305. Id.

202. See Schieber, supra note 201, at 125 ("Excess health care inflation is a far more serious problem in the United States than in other countries . . . . [B]etween 1985 and 1991 U.S. Nominal per capita health spending each year increased 70% faster than nominal per capita. GDP . . . compared with only 35% in Canada, 19% in France, 13% in the United Kingdom and 10% in Japan. Nominal per capita health spending increased 12% less rapidly than nominal per capita GDP in Germany.").

203. See JOHN M. EISENBERG, M.D., DOCTORS' DECISIONS AND THE COST OF MEDICAL CARE 3 (1986) ("Although physicians' fees represent only about 20 percent of health care costs, as much as 80 percent of expenditures for medical care are for services prescribed by physicians."). Dr. Eisenberg notes:

Physicians serve a dual role in the provision of personal health services. Like the player-manager of an athletic team, the physician is responsible for calling the plays in medical care as well as working with others to carry them out. In the parlance of economics, this dual role means that the physician influences the cost and quality of medical care in two ways: first, by organizing and directing the production process; and second, by providing some of the productive input.

Id.

204. Elhauge, supra note 54, at 1459 ("Most knowledgeable observers believe we could today easily spend 100% of our GNP on health care without running out of services that would provide some positive health benefit to some patient."); see id. at 1458 n.15 (collecting authority).

205. PAULY, supra note 133, at 102 ("Under both salary and capitation, if physicians provide more services, they simply work harder with no additional income; these methods would thus be expected to exert more control over the volume of services delivered than would fee-for-service."); see also COCKERHAM, supra note 186, at 287 (noting that the capitation system under the British system gave rise to a "serious concern and some evidence that medical care was being provided in quantity rather than quality"). A payer may decide to implement a capitation arrangement with an individual physician or with a group of physicians. Under either system, the incentive created
with lower rates of admissions to hospitals or referrals specialists. Fee-for-service has been associated with excess utilization.

Given the association between physician compensation and the volume and kinds of health services, altering physician compensation has been an important strategy in the cost containment effort in the United States. As indicated above, under managed care, physicians in the United States have been moved toward more risk sharing arrangements and less fee-for-service arrangements. These arrangements attempt to hold down health care costs by placing physicians at financial risk for some portion of the medical expenses that their patients incur as a result of the physicians' decision making.

On the surface it appears that financial risk sharing has contributed to slowing the growth of health care expenditures in the United States. However, these savings have been achieved at the
cost of ever increasing dissatisfaction with our health care system, disruption of the patient physician relationship, and increased levels of distrust.\textsuperscript{210} It is also apparent that the cost saving may only be temporary as insurers announce the imminence of increases in health insurance premiums within the next couple of years.\textsuperscript{211}

In contrast to the prevalence of financial risk sharing in the United States, financial risk sharing is virtually absent in foreign countries in which the government explicitly subsidizes health care. Because such governments have supplanted or controlled the market for health coverage they are able to adopt explicit and direct cost containment measures. They do not need to induce private sector insurers into providing coverage by offering them opportunities to exploit externalities. More importantly, the governments do not need to worry about a flight from insurance risk. Thus, these systems had a motivation to explore financial risk sharing. Although some physicians are compensated on a capitated basis like physicians in HMOs in the United States,\textsuperscript{212} there are no situations outside the United States where physicians are put at financial risk for services that they themselves do not provide.

Most of the countries that have universal health care continue to

\begin{quote}
\begin{itemize}
\item at 62 (noting that managed care saved between $150 billion and $250 billion in 1997); Larry J. Pittman, "Any Willing Provider" Laws and ERISA’s Saving Clause: A New Solution for an Old Problem, 64 TENN. L. REV. 409, 415 n.23 (1996) (citing KPMG Peat Marwick study which found that in areas with high concentration of managed care, hospitals costs were 11\% lower than the national average).
\item 210. See supra note 24 and accompanying text for discussion on rising dissatisfaction with managed care.
\item 211. HMO Premium Hikes Likely Next Year, ASSOCIATED PRESS, available at 1999 WL 28125567 (Oct. 6, 1999) ("HMO consumers next year can expect premiums to increase by an average 11 percent, up from an 8 percent hike this year, according to a survey of health plans . . . ."); see also Stephanie A. Forest, No More False Alarms: HMO Rates Are Really Rising, BUS. WK., Sept. 27, 1999, at 52 (noting that HMOs were locking in contracts for 2000 which have premium increases of as much as 15\% of six times the general inflation rate).
\item 212. See Cockerham, supra note 186, at 286 ("[British] [g]eneral practitioners are paid an annual capitation fee for each patient on their patient list as part of a contractual arrangement with the National Health Service."). In Italy, general practitioners receive capitation. See id. at 291. In the Netherlands, general practitioners receive capitation payments from public insurers. See id. at 300; see also Blank, supra note 189, at 18 (noting that Ireland moved to payment of general practitioners on the basis of capitation). "[T]ax funded health care systems tend to employ primary care practitioners directly and pay them a salary. However, PCPs in Denmark, Norway, Italy, and the United Kingdom are self-employed and paid by capitation or by a mix of salary, capitation, and fee-for-service." Id. "Nearly all western European countries had put in place some form of publicly accountable payers for all of nearly all of their citizens prior to the current reform period, and all remain committed to universal access and sustainable financing. Despite occasionally heated debates, none has shifted from publicly to privately accountable funding." Id. at 101.
\end{itemize}
\end{quote}
compensate physicians on a fee-for-service basis, a compensation method which is associated with excess utilization or on a salary basis. The fee schedules, however, differ from fee schedules established in the United States health care market. The payers of health services (some branch of the government or a quasi-governmental body) negotiate the fee schedules with a collective organized medical organization which represents all of the physicians in the jurisdiction. Some countries combine this negotiated fee schedule with a

213. See Cockerham, supra note 186, at 283 ("[P]hysicians in Canada are generally private, self-employed, fee-for-service practitioners."). In Sweden, physicians are paid by the hour and obligated to work a fixed number of hours per week. Id. at 290. In Italy, specialists receive salaries or fee for service. Id. at 291. In Japan, physicians in private practice (about one third) are compensated on a fee-for-service basis and the rest are salaried employees of hospitals. See id. at 293. In Germany, payment is based on a fee schedule agreed upon by a doctor's association and a public health insurance plan. Id. at 298. In the Netherlands, general practitioners receive fee-for-service compensation from private insurers and specialists receive fee-for-service compensation from private or public insurers. Id. at 300; see also Saltman & Figueras, supra note 191, at 95 ("In insurance-based countries, primary care practitioners are usually independent contractors, mainly paid by fee-for-service tied to a negotiated schedule, often with some form of earnings ceiling."); Rodwin & Sandler, supra note 191, at 118 ("French physicians and other health professions in private practice are paid directly by patients on a fee-for-service-basis."). "All physicians in public hospitals are compensated on the basis of salary payment and sessional fees." Id. at 119.

214. See Cockerham, supra note 186, at 283 (noting that Canadian physician fee schedule is negotiated between the provincial government and medical association). In Japan, fees are negotiated by an organization comprised of representatives of health care providers, insurers, management, labor, the public and governmental officials. Id. at 294; see also Done, supra note 23, at 752-53 (describing Germany's system wherein physicians are compensated pursuant to a national relative value scale which "is negotiated at the national level between the national association of sickness funds and the national medical association"); Blank, supra note 189, at 28 (noting that in Japan, "[p]roviders are paid on a fee-for-service basis with the price of each service determined by a uniform point fee system. The government's Central Social Medical Care Council negotiates changes in the fee schedule with representatives of providers, payers and public interest groups"); Rodwin & Sandler, supra note 191, at 118 ("Charges for services provided by health professionals—whether in office-based private practice, in outpatient services of public hospitals, or in private hospitals—are negotiated every year within the framework of national agreements concluded between representatives of the health professions and three principal health insurance funds. These agreements establish the terms of payment according to a fee schedule. The process of updating the relative value scale (RVS) to account for new procedures, changing technologies, and their effects on the costs of production is also the result of negotiations among the health professions, the national health insurance funds, and the government .... Once negotiated, the charges must be respected by all physicians, except for the one-third (sector 2 physicians) who either have chosen or have earned the right to engage in extra billing."); Wolfe & Moran, supra note 193, at 72 (describing establishment of fees in the Netherlands). In the Netherlands, "[p]hysician fee levels and capitation rates are set by negotiations between physician associations, the sickness funds, and private insurers. All negotiations take place under the scrutiny of a quasi-governmental body ...." Id. "Specialists ... set their own fees," however, "[e]ach spe-
national or regional budget which sets an overall cap on expenditures for physician services. The government does not arbitrarily determine the cap, but establishes it in the light of historical cost data and political reality. The penalty suffered by the physicians if they exceed the cap is a further reduction in next year's national fee schedule. The fortunes of all of the physicians in the nation depend on specialist's billings are totaled at the end of the year and compared with the negotiated norm income. Specialists exceeding the norm must pay back one-third of the first $15,000 excess, and two-thirds of any income above that level. See supra note 23, at 754. According to Done, in Germany, the negotiation process between the regional associations and the medical associations results in "a fixed budget for all physician payments in a region." Id. at 753. Although the national organizations negotiate a relative value scale, the regional organizations negotiate the monetary value of a RVS point. Id.

Physicians are paid on the basis of the negotiated fee schedule and fixed budget. A physician's revenue (R) is a function of the number of services (S) rendered, the average number of points (P) for those services, and monetary value (V) of one point: R = SPV. V is derived from the fixed budget (B) and the sum of all points billed by all physicians in a certain region: V = BEP. According to these formulas, if the physicians in a region provide more services than expected, the amount of money assigned each point value will decrease. If they provide less services than expected, point value (V) will increase. Thus, the fixed budget acts as a cap on total physicians' fees. See e.g., PAULY, supra note 133, at 120 (noting that in Canada, excess spending is recouped through reductions in unit prices in either the current or next year, and in Germany, per unit prices are determined retrospectively to account for volume in the current year); Wolfe & Moran, supra note 193, at 66 (noting that a "common outcome of budget overruns is a reduction in the rate of budget increase for the following year").

"If physicians exceed predetermined levels of utilization, the provinces may do the following: [a] adjust the next year's fee increase downward accordingly; ... [f]orce physicians to work at temporarily reduced fees for a set period of time; ... [p]ay current fees at a discounted rate to counteract the anticipated size of the utilization increase for the year." Id. at 68-69.

See PAULY, supra note 133, at 121 ("Determining the optimal level of health spending is ordinarily a policy or political decision . . . . In Germany, . . . the target for any one year is based on the previous year's expenditures, increased by the rate of growth in the wage rates received by the members of the sickness fund."); see also Wolfe & Moran, supra note 193, at 68 ("Physician expenditures are controlled in a number of different ways in Canada . . . in [some provinces], levels of utilization are set that are usually based on the previous year's levels, with some adjustment for factors such as changes in population, the volume of practicing physicians, and new technology.").
their aggregate performance. If physicians perform inefficiently as a group, the group suffers. Therefore, physicians have an incentive to police each other in their exercise of individual professional judgment. Researchers have determined that fee targets are effective mechanisms for controlling the costs of medical services.

On the surface, it may appear that expenditure caps should be subject to the same criticism as the financial risk sharing that is prevalent in the United States. Each attempts to influence physician behavior by use of financial inducements. Each may be accused of fostering a conflict of interest between physicians and their patients. Notwithstanding this surface similarity, there are however, significant differences between the two approaches.

First, fee caps result from a highly visible process of negotiation. Under the private system, the financial risk borne by physicians results from secret bargaining. Under the public system, there is open access to the data that informs the negotiation process. Hence, there is less chance that the caps are based on flawed data or erroneous assumptions. Under the private system, this data is proprietary and secret, and more subject to abuse and misuse. Under the public system, the physicians negotiate with the payer collectively. As such, there is less of a chance that the cap is the result of unequal bargaining power. Under the private system, physicians negotiate individually or in groups which must compete with other groups. The bargaining power is diffused and there is a greater chance that the risk sharing arrangement is the product of unequal bargaining power.

Therefore, although there may be some surface similarity between the two systems of cost containment, public systems of cost containment are less subject to the exploitation of externalities that the private systems appears to depend upon for its viability.

A nation’s cost containment policy resolves the “perennial eco-

218. See, e.g., Done, supra note 23, at 754 (Regional medical associations in Germany review physician services retrospectively for over treatment abuse. “Physicians whose practice patterns deviate from the norm . . . are contacted every year to discuss their practices with the medical associations ‘Economic Review’ committee . . . . [R]epeat offenders . . . are denied claim payments and have their practice patterns publicized.”).

219. See id. at 754 (noting the U.S. General Accounting Office findings that Germany’s use of RVS and caps on physician services reduced physicians fees by at least 17% between 1977 and 1987).

220. In fact, the capped expenditure arrangements appear a lot like situations in the United States when an HMO contracts with a medical group or IPA pursuant to a global capitation or percent of premium arrangement. Under such a system, the physician’s financial destinies are intertwined, as is the case under an expenditure cap. If the physician group has power to control physician decision making, it will attempt to do so in order to keep costs within the budget available. This sounds a lot like what happens in countries where physicians are subject to a cap on physician expenditures.
nomic conflict" \textsuperscript{221} between the desire to receive all medically necessary services and the providers' desire for "a healthy slice of the gross national product." \textsuperscript{222} When the resolution of that conflict is left to private parties dependent on exploitation of externalities, the result is ineffective cost containment, as well as sub-optimal health coverage. In other words, reduced coverage for increased payments. This is yet another byproduct of blind infatuation with markets.

VII. CONCLUSION

The United States health care system is a tragic product of our national infatuation with the Mythology that the market will always do a more efficient job of allocating resources than the government. This infatuation has caused us to inappropriately assign to the market an endeavor which is more appropriate for the government—the provision of health coverage. Given the significant externalities inherent in the private insurance model, attempting to provide health coverage through this model in the market results in inadequate health coverage and ineffective cost containment. It is simply "Bad Business" to attempt to provide health coverage pursuant to the private insurance model through market mechanisms. Our infatuation with the Mythology has locked us into somewhat of a Faustian bargain. To the extent that we collectively seek to curtail their exploitation of externalities in the health system, insurers and employers engage in or threaten a flight from health insurance which threatens to leave even fewer people protected by health coverage. In effect, our health policy is being held hostage by our blind distrust of government and our unquestioning faith in markets.

\begin{itemize}
  \item \textsuperscript{221} Reinhardt, \textit{supra} note 183, at 21.
  \item \textsuperscript{222} \textit{Id}.
\end{itemize}