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Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform

Allison K. Hoffman[†]

ABSTRACT

The 2010 federal health insurance reform act includes an individual mandate that will require Americans to carry health insurance. This article argues that even if the mandate were to catalyze universal health insurance coverage, it will fall short on some of the policy objectives many hope to achieve through a mandate if implemented in a fragmented insurance market. To uncover this problem, this article sets forth a novel framework that disentangles three different policy objectives the individual mandate can serve. Namely, supporters of the mandate might hope for it to: (1) facilitate greater health and financial security for the uninsured (“paternalism”); (2) eliminate inefficiencies in health care delivery and financing (“efficiency”); and/or (3) require the healthy to buy insurance to help fund medical care for the sick (“health redistribution”). Health redistribution – the primary focus of this article – is a shifting of wealth from the healthy to the sick through the mechanism of risk pooling. Many see health redistribution as a means to enable all Americans to more equitably access medical care on the basis of need, rather than on the basis of ability or willingness to pay.

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Drawing on evidence from the implementation of an individual mandate in Massachusetts's health reform in 2006, this article reveals that the fragmented American health insurance market will thwart the mandate's ability to achieve these objectives— in particular the goal of health redistribution. Fragmentation is an atomization of the insurance market into numerous risk pools that has been driven by market competition and regulation. It prevents Americans from sharing broadly in the risk of poor health and, in doing so, entrenches a system where access to medical care remains tied to ability to pay and individualized characteristics. The final section of this article examines how various policies, including some in the new law (e.g., insurance regulation and exchanges) and others not (e.g., expanded public insurance), can reduce fragmentation so that the mandate can successfully serve all desired objectives and in the process gain greater legitimacy over time.

I. INTRODUCTION

Driving the 2009-2010 federal health reform debate has been a widely-shared desire to address the problem of an estimated 46 million uninsured Americans.¹ At the heart of the newly enacted federal health insurance reform legislation ("Health Reform Law") is an "individual mandate," which will attempt to address this problem by requiring Americans to carry health insurance.²

The individual mandate has been held up as the "American" way to achieve universal coverage, where every citizen can choose her own insurance, and commercial insurers can compete for profit. By laying claims to coverage, choice, and competition, the mandate has garnered a strong and diverse set of supporters. Hillary Clinton and John Edwards championed the individual

¹ US CENSUS BUREAU, CURRENT POPULATION REPORTS, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007 20 (2008). Contentious efforts at health reform seeking universal coverage have been woven throughout 20th Century politics. Efforts began in the Progressive Era, when the American Association for Labor Legislation introduced legislation requiring insurance for all workers. President Franklin Roosevelt proposed national health insurance in 1934, but dropped it in response to resistance by medical professionals. President Truman rekindled the push for national insurance in 1945, which resulted in Medicare and Medicaid under President Johnson in 1965. Recently, the Clinton administration made a famous failed attempt at health reform in the 1990s. See Paul Starr, *What Happened to Health Care Reform?*, 20 THE AMERICAN PROSPECT 20 (1995) (an analysis of the Clinton administration's health reform failure). For discussion of the history of health reform, see TOM DASCHLE ET AL., CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH CARE CRISIS 49-51 (2008); Theodore R. Marmor & Jonathan Oberlander, *Paths to Universal Health Insurance: Progressive Lessons from the Past for the Future*, 2004 U. ILL. L. REV 205 (2004).

² On March 23, 2010, President Barak Obama signed into law the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010), available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590eas.txt.pdf (last accessed Feb. 14, 2010). The final health reform act will almost certainly include a companion bill, The Health Care and Education Reconciliation Act of 2010, H.R. 4872, which was passed by both the Senate and House on March 25, 2010. At times throughout this draft, I refer to the House Bill, the Affordable Health Care for America Act, H.R. 3962, 111th Cong. § 501 (2009), which the House passed on November 7, 2009 and was superseded by the Senate version of legislation that was enacted into law, available at <http://thomas.loc.gov/cgi-bin/query/z?c111:H.R.3962>: (last accessed February 14, 2010).

mandate during the 2008 Democratic primary race. Former Governor of Massachusetts Mitt Romney, a Republican, proposed it as a key element of the Commonwealth's health reform, which was enacted into law by an overwhelmingly Democratic legislature in 2006.³ The health insurance industry, historically resistant to national reform, has supported an individual mandate and has even offered concessions in return for inclusion of the mandate in legislation.

Much attention by scholars, think tanks, and the media on the individual mandate has focused on whether the mandate can achieve the goal of insuring all Americans and at what cost.⁴ Proponents of the mandate argue a mandate is necessary to achieve universal coverage.⁵ Opponents say it is a very expensive way to pursue only modest gains in coverage at an unacceptable insult to individual autonomy.⁶

Yet, there is no clear expression of, or consensus as to, why we would want to increase coverage through an individual mandate. What would we hope to accomplish by requiring every American carry health insurance?

I suggest in this article that there are three primary reasons that drive support for the individual mandate. First, some people are worried about the

³ 2006 MASS. ACTS CHAPTER 58, An Act Providing Access to Affordable, Quality, Accountable Health Care, MASS. GEN. LAWS ch. 111M, § 2 (2008) [hereinafter CHAPTER 58].

⁴ See, e.g., REPUBLICAN STUDY COMM., RSC POLICY BRIEF: AN INDIVIDUAL MANDATE TO PURCHASE HEALTH INSURANCE 2-4 (2008); LINDA BLUMBERG & JOHN HOLOHAN, URBAN INST., DO INDIVIDUAL MANDATES MATTER? 1-3 (2008); Sherry A. Glied et al., *Consider It Done? The Likely Efficacy of Mandates for Health Insurance*, 26 HEALTH AFF. 1612, 1615 (2007); Jonathan Gruber, *Covering the Uninsured in the U.S.*, 46 J. ECON. LIT. 571, 601 (2008) (analyzing approaches to health reform and making budgetary efficiency targeting argument for mandates); David A. Hyman, *The Massachusetts Health Plan; The Good, the Bad, and the Ugly*, 55 U. KAN. L. REV. 1103, 1111 (2006); Peter D. Jacobson & Rebecca L. Braun, *Let 1000 Flowers Wilt: The Futility of State-Level Health Care Reform*, 55 U. KAN. L. REV. 1173 (2007) (summarizing past state efforts at reform with an emphasis on discussion of individual and employer mandates); Timothy Stoltzfus Jost, *The Massachusetts Health Plan: Public Insurance for the Poor, Private Insurance for the Wealthy, Self-Insurance for the Rest*, 55 U. KAN. L. REV. 1091 (2007) (arguing that the MA plan results in three tiers of health insurance); Alan B. Krueger & Uwe E. Reinhardt, *The Economics of Employer Versus Individual Mandates*, 13(2) HEALTH AFF. 34, 40 (1994); C. Eugene Steuerle, *Implementing Employer and Individual Mandates*, 13(2) HEALTH AFF. 54 (1994) (discussing administrative challenges in terms of collection and enforcement); MICHAEL TANNER, CATO INST., INDIVIDUAL MANDATES FOR HEALTH INSURANCE: SLIPPERY SLOPE TO NATIONAL HEALTH CARE (2006); GLEN WHITMAN, *Hazards of the Individual Health Care Mandate*, CATO POLICY REPORT, SEPT./OCT. 2007, at 1 (outlining potential adverse effects on policy and benefit design and on free riding); Sherry Glied, *Mandates and the Affordability of Health Care* (Economic Research Initiative on the Uninsured Working Paper Series, Paper No. 59, 2008) (describing the economics of the affordability exemption); Jonathan Cohn, *Mandate Overboard*, THE NEW REPUBLIC (Dec. 7, 2007), <http://www.tnr.com/article/politics/mandate-overboard>; Einer Elhauge, *Coverage v. Coercion*, HUFFINGTON POST (Mar. 3, 2008), http://www.huffingtonpost.com/einer-elhauge/coverage-v-coercion_b_89686.html (questioning whether coercion of mandates is validated by effect on free rider problem); JONATHAN GRUBER ET AL., NEW AMERICA FOUNDATION, HEALTH DEBATE REALITY CHECK: THE ROLE OF INDIVIDUAL REQUIREMENTS (2007), <https://www.policyarchive.org/bitstream/handle/10207/8824/Health%20Debate%20Reality%20Check.pdf>.

⁵ See, e.g., BLUMBERG & HOLOHAN, *supra* note 4; Gruber, *supra* note 4; GRUBER ET AL., *supra* note 4.

⁶ See, e.g., REPUBLICAN STUDY COMM., *supra* note 4; TANNER, *supra* note 4; Whitman, *supra* note 4.

wellbeing of the uninsured themselves, motivated by the uninsured individual whose cancer or heart disease will go undiagnosed and lead to premature death or, if diagnosed, will cause him to choose between his financial and physical wellbeing because of the high costs of his medical care. Validating such concerns, a recent report by Harvard researchers reports lack of health insurance is associated with 45,000 deaths a year in the United States.⁷

Alternatively, some are interested in their own bottom line, angry that the uninsured don't "pay their share," making insurance more expensive for everyone else. Their support for the mandate is animated by the stories of the 28 year-old who decided he was healthy enough to "go bare" without insurance coverage and then has a mountain biking accident that results in tens of thousands of dollars of emergency room care he can't afford.

Others struggle morally with the fact that nearly 1/5 of all Americans lack insurance, particularly if they are poor or sick, and what such a reality says about us as a nation of people.⁸ They want to ensure that we create a system that enables all members of their community – locally and nationally – to have equitable access to good medical care when in need.

In this article, I contend that by failing to look closely at these different objectives and what it would take to achieve them, policy debates about the individual mandate have obscured the fact that even if the mandate were to lead to 100 percent coverage, it could fail to achieve what many people envision and hope it to do. By untangling the different policy objectives supporters intend an individual mandate to serve, it becomes clear that the mandate will face serious barriers to success in our current "fragmented" health insurance markets, by which I mean insurance markets that divide people and groups up on the basis of risk.

This article tells the story of the individual mandate and fragmentation in three parts. First, it sets forth a novel framework to examine the three objectives an individual mandate can serve – which I characterize as paternalism, efficiency, and health redistribution – that each justify use of a mandate for some of its supporters. Second, it brings past research on fragmentation of health insurance markets, often discussed within the realm of economics, into the legal and policy debate to define and shine a light on the critical problems fragmentation will cause for implementation of a mandate, particularly with respect to the goal of health redistribution.⁹ Finally, it considers how policy solutions, including prohibition of risk selection in the private market or creation of public insurance alternatives, could ameliorate fragmentation and perhaps in doing so also enhance the long-term political legitimacy of an individual mandate.

As context for this story of the challenges the individual mandate will face in a fragmented market, Part II describes how the individual mandate differs

⁷ Andrew P. Wilper et al., *Health Insurance and Mortality in U.S. Adults*, 99 AM. J. PUB. HEALTH 2289, 2292 (2009).

⁸ U.S. CENSUS BUREAU, *supra* note 1, at 23.

⁹ Fragmentation is present in different forms throughout the system of health care delivery and financing and thus has received, in one form or another, considerable attention from scholars. See, e.g., EINER ELHAUGE, *THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS* (forthcoming 2010); Nan Hunter, *Risk Governance and Deliberative Democracy in Health Care*, 97 GEO. L.J. 1, 17-27 (2008) (discussion of health law as a field of risk-centered governance).

from the policy approaches other industrialized countries have taken toward the goal of universal coverage. It also explores the mechanism by which the individual mandate works and how it can affect the uninsured as both consumers of insurance and (for some) as “financiers,” who will pay more for premiums than they consume in care and thus help finance medical care for others. This second influence supports the mandate’s ability to affect distributive goals.

Part III detangles how an individual mandate can serve three different policy objectives. It describes how some support the mandate for paternalistic reasons; their objective is that all Americans have insurance that protects them from poor health and financial insecurity. Others, including many of the health economists defining the health reform policy elements, see the mandate as a tool to reduce inefficient use of care by the uninsured or to promote more efficient health insurance markets by addressing the problem of adverse selection. Finally – and the primary focus of this paper – some support the mandate for redistributive reasons so that the risk of poor health is shouldered more equally by all Americans.

The mandate promotes such redistribution by requiring the uninsured who have arguably rationally opted out of the insurance market (because they are healthy and unlikely to need medical care) to buy health insurance nonetheless to finance care for those sicker or less lucky than themselves. When the healthy and the sick pool risk, it creates a redistribution of wealth from the healthy to the sick, which I call “health redistribution” in contrast to “income redistribution,” whereby wealthy are taxed to provide health care for the poor (e.g., in Medicaid).

Advocates of expanding health insurance coverage, in general, and of the individual mandate, in particular, have explored political, pragmatic, and moral benefits of health redistribution that I discuss in Part III.C below. They argue, for example, that health redistribution enhances the political feasibility of funding subsidies for insurance coverage for the poor and sick, by facilitating subsidies within the bounds of a defined program and among a broader base, thus avoiding the sharp division between haves and have-nots created by income tax-based subsidies.¹⁰ Scholars also have argued health redistribution might address distributive justice concerns with less labor distortion than an income tax might.¹¹ Effective health redistribution might also unlock greater insurance market efficiency by reducing practices of medical underwriting and risk selection.

Finally, I show that some scholars see health redistribution as a means to institutionalize a more solidaristic regime of health insurance in the U.S., where access to health care can be divorced from market forces or individual wealth.¹² In other words, for some, implementing an individual mandate

¹⁰ See *infra* Part III.C.

¹¹ Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1455 (1994).

¹² For examinations of health and solidarity, see Tom Baker & Jonathan Simon, *Embracing Risk*, in *EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY* 1, 6 (Tom Baker & Jonathan Simon eds., 2002); Tom Baker, *Risk, Insurance, and the Social Construction of Responsibility*, in *EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY* 33, 47 (Tom Baker & Jonathan Simon eds., 2002); Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 73 (2005); Lawrence O. Gostin, *Securing Health or Just Health Care? The Effect of the Health*

would be tantamount to asking Americans to act collectively so that everyone – rich, poor, sick, or healthy – can access medical care when in need, regardless of income or health status. This notion of health solidarity has deep roots in health care provision historically in the U.S., through mutual aid societies and religious organizations, and is a central attribute of health care in all other advanced nations.¹³ I explore whether a mandate that affects health redistribution might indeed not only institutionalize a more solidaristic form of insurance but, perhaps in the long term, help to generate popular and political support for a more solidaristic system of insurance.¹⁴

Yet, in Part IV, I contend that the individual mandate will not be able to realize such benefits that rely upon its ability to promote health redistribution if it is implemented in a fragmented health insurance market. Fragmentation is an atomization of the health insurance market into numerous risk pools – a complex process that has been fueled by private market competition and exacerbated by regulation in both intentional and unintentional ways. Commercial insurers' profit relies upon their ability to segment people into groups of predictable or similar risk and price according to risk or to select out good risks (i.e., cherry picking). To better manage risk and profit, insurers have carved up the insurance market into submarkets – large group, small group, and individual. Risk is not pooled among these three markets. This means that if healthy individuals are disproportionately insured in one market and sick in another, they don't share in risk and medical costs. Furthermore, in the individual market (and somewhat the small group market), risk pooling may be limited among individual insureds to the extent insurers are permitted under state law to design premiums and coverage based on projections of individual risk.¹⁵ One often examined driver of fragmentation, for example, is

Care System on the Health of America, 39 ST. LOUIS U. L. J. 7, 9 (1994); Sharon Hoffman, *Unmanaged Care: Towards Moral Fairness in Health Coverage*, 78 IND. L. J. 659, 668 (2003); Hunter, *supra* note 9, at 48-50 (promoting health solidarity within the workplace by creating a system of deliberative democracy to manage employer sponsored plans and increase citizens' ability to "infuse risk allocation discourse with moral values"); John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 363-66 (1997); Timothy Stoltzfus Jost, *Health Care Access in the United States: Conflicting Concepts of Justice and Little Solidarity*, 27 MED. & L. 605, 605-07 (2008); Wendy Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 CONN. INS. L. J. 199, 201-03 (2008); Amy Monahan, *Health Insurance Risk Pool and Social Solidarity: A Response to Professor David Hyman*, 14 CONN. INS. L. J. 325, 325-26 (2008); Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155, 155 (2004); Anja Rudiger, *From Market Competition to Solidarity? Assessing the Prospects of U.S. Health Care Reform Plans from a Human Rights Perspective*, 10 HEALTH AND HUM. RTS. 123, 125-27 (2008); Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL'Y & L. 287, 290-92 (1993) (describing the history of solidarity and health).

¹³ See KIEKE OKMA, NAT'L ACAD. OF SOC. INSUR., RECENT CHANGES IN DUTCH HEALTH INSURANCE: INDIVIDUAL MANDATE OR SOCIAL INSURANCE? 6-7 (2009), available at <http://www.rwjf.org/files/research/okma.pdf>; Richard B. Saltman & Hans. F.W. Dubois, *The Historical and Social Base of Social Health Insurance Systems*, in SOCIAL HEALTH INSURANCE SYSTEMS IN WESTERN EUROPE 21, 29, (Richard B. Saltman et al. eds., 2004); Stone, *supra* note 12, at 291.

¹⁴ See *infra* note 196 for studies and articles that explore conditions that generate mutual aid.

¹⁵ Some states have enacted laws that in essence require risk pooling through community rating, rate bands, mandated benefits or guaranteed issue of insurance. See discussion *infra* note 228. Cf. Economists Mark Pauly and Bradley Herring have shown evidence that there may be some risk pooling in the individual market even in unregulated states. See discussion *infra* note 231.

risk classification and selection practices used by private insurers.¹⁶ By creating such crevasses that limit the scope of risk pooling, fragmentation makes it impossible to distribute costs of poor health broadly among both healthy and sick, even as the mandate compels more healthy people join risk pools.

Channeling an individual mandate through this fragmented insurance infrastructure may prove counterproductive. First, for some, the purpose of compelling the healthy to buy insurance is in part so they help fund care for the sick. Participation by healthy Americans is futile when the healthy and sick don't pool risk with each other. Further, if poorer and sicker Americans must bear more of the cost of their own risk, they may have a harder time affording necessary medical care – a result antithetical to what many hope to achieve with an individual mandate.

To illustrate this story of the thorny interplay between the individual mandate and fragmented markets, this article draws from evidence from the 2006 health reform in Massachusetts that requires most Massachusetts residents over 18 to carry health insurance.¹⁷ The Massachusetts individual mandate significantly increased insurance coverage levels in the state¹⁸ and has been increasingly popular,¹⁹ yet simultaneously exhibits the challenges an individual mandate will face if implemented in a fragmented insurance market. Although Massachusetts has made some strides to address fragmentation, implementing many of the same policies that are included in the federal Health Reform Law, remaining fragmentation contributes to problems such as exemption of some residents from the mandate on “affordability” grounds and variable quality of coverage among the insured.²⁰

Fragmentation is not an easy problem to fix. The most elegant solution may be a single payer system designed to completely eliminate fragmentation. However, a single payer model has not been contemplated as part of current federal reform efforts, and most would say is politically unlikely in the near term. Thus, while recognizing its benefits, I focus in Part V on evaluating solutions that may prove more politically feasible in the near term because of compatibility with preservation of private insurance markets. I consider both elements that have been enacted as part of the Health Reform Law (e.g., regulation of private insurers and creation of exchanges for the sale of

¹⁶ E.g., Regina Austin, *The Insurance Classification Controversy*, 131 U. PA. L. REV. 517, 517 (1983); Baker, *supra* note 12, at 33-35; Donald Light, *The Practice and Ethics of Risk-Rated Health Insurance*, 267 JAMA 2503, 2503-05 (1992). See Jonathan Simon, *The Ideological Effects of Actuarial Practices*, 22 L. & SOC. REV. 771, 772-73 (1988); Stone, *supra* note 12, at 292-95.

¹⁷ CHAPTER 58, *supra* note 3.

¹⁸ Prior to reform, ~10% of the Massachusetts population was uninsured (650,000). Recent estimates are that 2.6% remain uninsured. SHARON K. LONG & MINDY COHEN, THE URBAN INST., GETTING READY FOR REFORM: INSURANCE COVERAGE AND ACCESS TO USE OF CARE IN MASSACHUSETTS IN FALL 2006 2-3 (2006); SHARON K. LONG ET AL., THE URBAN INST. & THE MASS. DIV. OF HEALTH CARE FINANCE AND POL'Y, ESTIMATES OF THE UNINSURANCE RATE IN MASSACHUSETTS FROM SURVEY DATA: WHY ARE THEY SO DIFFERENT? 9 (2008).

¹⁹ Robert J. Blendon et al., *Massachusetts Health Reform: A Public Perspective from Debate Through Implementation*, 27 HEALTH AFF. (WEB EXCLUSIVE) w556, w558 (2008), <http://content.healthaffairs.org/cgi/reprint/27/6/w556>.

²⁰ See, e.g., Jost, *supra* note 4.

insurance) and also elements that are not part of this initial reform but could be pursued, consistent with the shape of the new Law, over the coming years to further address fragmentation as the law is implemented. Finally, I posit whether softening the current, finely-drawn boundaries of insurance markets and programs might not only reduce fragmentation but begin to shape a broader public and political interest in programs that rely upon health redistribution to increase equitable access to medical care.

II. THE INDIVIDUAL MANDATE, THE UNINSURED, AND INSURANCE

A. MODELS OF UNIVERSAL COVERAGE AND THE INDIVIDUAL MANDATE

Most industrialized countries treat health insurance as social insurance, where people contribute toward financing based on ability to pay, where risk of poor health is pooled broadly, and where access to care is provided on the basis of need.²¹ It is often remarked that many of these countries achieve health outcomes equal to or better than the United States at lower costs per person.²²

These countries have relied upon several different models to achieve universal coverage, which differ based upon the role of public and private entities in the financing, purchasing, and delivery of care. For example, in some countries, the government finances health care through tax revenue. Such a model might leave the production of the medical care primarily to a mix of public and private entities (e.g., Canada, United States Medicare). Or in system of socialized medicine, such as in the British National Health Service or the Veterans Administration in the United States, the government both finances care and also controls the delivery of care (i.e., owns hospitals and pays physician salaries).²³ Government-financed and owned medical care is often called a Beveridge system, after Lord Beveridge, who designed the British health system after World War II.²⁴

A competing model of social insurance system relies not on the state but rather upon highly-regulated private entities (for-profit and non-profit) to administer compulsory health insurance; these entities are sometimes called sickness funds and are often organized by profession, region, or religion and funded through targeted funding, often separate from general tax revenue.²⁵

²¹ TIMOTHY STOLTZFUS JOST, DISENTITLEMENT? 14-15 (2003). See Posting of Uwe. E. Reinhardt to N.Y. Times Economix Blog, *Health Reform Without a Public Plan: The German Model*, <http://economix.blogs.nytimes.com/2009/04/17/health-reform-without-a-public-plan-the-german-model> (April 17, 2009, 07:02 EST).

²² CONGRESSIONAL RESEARCH SERVICE, U.S. HEALTH CARE SPENDING: COMPARISON WITH OTHER OECD COUNTRIES 50-51 (2007), available at http://assets.opencrs.com/rpts/RL34175_20070917.pdf; JOST, *supra* note 21, at 3.

²³ See JOST, *supra* note 21, at 204-34; Posting of Uwe E. Reinhardt to N.Y. Times Economix Blog, *What is 'Socialized Medicine'? A Taxonomy of Health Care Systems*, <http://economix.blogs.nytimes.com/2009/05/08/what-is-socialized-medicine-a-taxonomy-of-health-care-systems/> (May 8, 2009, 06:48 EST).

²⁴ JOST, *supra* note 21, at 235; Timothy Stoltzfus Jost, *Why Can't We Do What They Do? National Health Reform Abroad*, 32 J.L. MED. & ETHICS 443, 443 (2004).

²⁵ Richard B. Saltman, *Social Health Insurance in Perspective: The Challenge of Sustaining Stability*, in SOCIAL HEALTH INSURANCE SYSTEMS IN WESTERN EUROPE 3 (Richard B. Saltman et al. eds., 2004); JOST, *supra* note 21, at 235-264.

Origins of this model of health insurance are often attributed to Germany, which legislated mandatory (for some), state-supervised sickness funds in 1883, under Chancellor Otto von Bismark, to seize power from Marxist-influenced labor unions.²⁶ But its roots reach back further to medieval guilds, churches, and, later, unions that collectivized financing of medical care for members.²⁷ Although this model of social insurance often incorporates individual choice of provider and sickness funds, it differs from commercial insurance in that it is designed to achieve social ends and, in particular, to be redistributive in nature (across ages, health status, income, and individuals and families).²⁸ Richard Saltman describes this model as “the administrative embodiment of a set of values deeply rooted in the society as a whole ... and grounded in the historically generated principles of collective responsibility and social solidarity.”²⁹ In many systems that follow this model, the government still plays an active role in financing, by determining premium costs and providing subsidies for the poor, even if purchasing is delegated to insurers or sickness funds. More recently, some countries – including Germany, the Netherlands, and Switzerland – have introduced some level of competition between funds or insurers for enrollees.³⁰ Even though the competition occurs within a highly regulated environment to preserve the goals of social insurance,³¹ some are concerned that competition has led to rising costs and increased risk selection and might undermine the foundation of social insurance within these countries’ systems.³²

Current discussions of reform in the United States have not seriously considered a centrally-financed insurance model (often referred to as “single payer”). In fact, even mention of such an approach has historically proven to be a political lightning rod in the United States, provoking claims of “socialized medicine” (often inaccurate since centralized financing can exist with private delivery of medical care) and anti-reform media that quickly quashes reform efforts.³³

Instead, 2009 reform efforts and the resultant Health Reform Law envision using government mandates to achieve universal coverage without fundamentally restructuring the existing payment and delivery systems. The proposed reform does not fundamentally change the primarily private delivery

²⁶ Saltman, *supra* note 25 at 21-23.

²⁷ *Id.* at 27.

²⁸ *Id.* at 5.

²⁹ Saltman, *supra* note 25, at 6.

³⁰ *E.g.*, Timothy Stoltzfus Jost, *The Experience of Switzerland and the Netherlands with Individual Health*

Insurance Mandates: A Model for the United States? 1, <http://law.wlu.edu/deptimages/Faculty/Jost%20The%20Experience%20of%20Switzerland%20and%20the%20Netherlands.pdf> (last visited Mar. 7, 2010); ROBERT E. LEU ET AL., THE COMMONWEALTH FUND, THE SWISS AND DUTCH HEALTH INSURANCE SYSTEMS: UNIVERSAL COVERAGE AND REGULATED COMPETITIVE INSURANCE MARKETS 8-11 (2009); OKMA, *supra* note 13, at 4-7.

³¹ Anna Dixon et al., *Solidarity and Competition in Social Health Insurance Countries*, in SOCIAL HEALTH INSURANCE SYSTEMS IN WESTERN EUROPE 170, 170-71, 174-76 (Richard B. Saltman et al. eds., 2004).

³² *Id.* at 176-77; *see also* Jost, *supra* note 30.

³³ *See, e.g.*, DASCHLE ET AL., *supra* note 1, at 49, 53, 78; Reinhardt, *supra* note 23.

of health care and mix of public and private financing.³⁴ The government's overarching role in reform is simply as a catalyst. The contemplated approach would create a system that looks more like that in Germany, Switzerland, or the Netherlands, where participation is compulsory, and insurance is administered by private entities and funded through a mix of public and private sources. Yet the United States is building on a framework of actuarially-rated commercial insurance, whose end goal is profit, rather than on a system of social insurance directed toward the goals of collective benefit and universal access to care. This contradiction complicates the use of the mandate in the U.S., as explored below.

There are several different types of mandates that the government could rely on to expand coverage. One such mandate could require all employers provide or subsidize insurance coverage for employees; currently, U.S. employers have no such obligation.³⁵ This type of "employer mandate" was included in the Clinton reform proposals, is part of the Massachusetts health reform of 2006, and is included in a light version in the Health Reform Law. Alternately, the government might mandate that insurers include certain people or conditions within their health plans (a "mandated benefit"). While I will discuss the impact of both of these types of mandates in Part IV below, neither of these is the primary subject of this article.

The focus of this article is the "individual mandate" that requires Americans to carry health insurance and is a cornerstone of the Health Reform Law.³⁶ Individual mandates can be distinguished from other mandates such as employer mandates or insurer mandates based upon their mechanism for compliance – individual action. We have seen individual mandates that require drivers hold motor vehicle insurance, parents vaccinate children against contagious diseases, motorists wear seatbelts, and 18-year-old men register for the draft. A legal mandate compels each individual to use his or her own resources (money and/or time) in a way he or she might not without government intervention. In the case of health insurance, the individual mandate will require Americans to navigate the current patchwork of public and private coverage options to obtain coverage.

The individual mandate is intriguing in part because it blurs distinctions between social and commercial insurance. The defining characteristic of this

³⁴ Professor Ted Marmor describes how Americans' schizophrenia toward health care entitlement has resulted in five "Americas." First, the VA is socialized medicine, where because of veterans' sacrifice, we provide comprehensive, specialized benefits. Second, in Medicare Part A or disability coverage, contributory financing during the working life offers later protection against financial threats to well-being resulting from poor health; there is no connection between proportional/progressive financing and later distribution of benefits. Third, Medicaid is a means-tested program akin to European poor law. Fourth, in employment-related private insurance, the insured pay directly for the benefits you receive. Fifth, we provide some charity care at the individual level, which we have required with respect to emergency care under the Emergency Medical Treatment and Active Labor Act (EMTALA). Cf. THEODORE R. MARMOR ET AL., *AMERICA'S MISUNDERSTOOD WELFARE STATE* 22-31 (BasicBooks 1990).

³⁵ Some states have tried to impose a participation requirement on employers through "pay or play," requiring employer contribution to its employees' coverage or payment of a penalty to the state. The legality of such laws, which face risk of preemption under the federal Employee Retirement Income Security Act (ERISA), will possibly be determined by the Supreme Court this session. I discuss employer mandates further in Part IV below.

³⁶ H.R. 3590, *supra* note 2.

approach to expanding coverage by individual mandate is that it largely leaves the current structures of the commercial insurance market intact, while requiring more people to participate in it.³⁷ Yet, the mandate is intended to achieve policy goals typically pursued through social insurance. Ensuing conflict between the policy goals of the mandate and commercial health insurance forms much of the basis of discussion in Part III below about impediments fragmentation pose for the individual mandate.

B. THE FRAGMENTED AMERICAN HEALTH INSURANCE MARKET

The individual mandate will channel the uninsured into what has become a fragmented American health insurance market. Fragmentation is a word often used to characterize American health care, describing the decentralization of decision makers, payers, providers, or regulation.³⁸ In this article, I use the term fragmented to describe the splintering of insurance markets into smaller parts to divide people and groups up on the basis of risk. Insurance markets have become atomized into smaller sub-markets in the name of managing and avoiding risk. This process of insurance market fragmentation has reduced the breadth of risk pooling and lays the groundwork for inequities among markets and insureds. I provide a brief overview of the end result here. In Part IV, I examine in greater depth how fragmentation has occurred, through both competition and regulation, and why it creates critical problems for the individual mandate.

The primary divide in American health insurance is between public and private insurance with public insurance often covering more high-risk enrollees.³⁹ Roughly 100 million Americans have publically-subsidized insurance, including the elderly, poor, disabled, and veterans, each group in a discrete public program.⁴⁰ Public health insurance mimics some goals of social insurance and accounts for nearly 50 percent of all health spending in the country but is by no measure a cohesive system.⁴¹

Medicaid, which is the largest program, currently insures about 61 million low-income or disabled beneficiaries through both state and federal funds.⁴² Medicare covers 45 million elderly or disabled.⁴³ Other public programs provide benefits for children whose families' incomes are too high for Medicaid (State Children's Health Insurance Program, "SCHIP"), American

³⁷ It is likely, of course, that any policy built upon an individual mandate will impose a number of additional regulations on commercial insurers. Such regulations are discussed in Part V below.

³⁸ See ELHAUGE, *supra* note 9.

³⁹ Cf. Deborah Stone, *Protect the Sick: Health Insurance Reform in One Easy Lesson*, 36 J.L. MED. & ETHICS 652, 652-53 (2008).

⁴⁰ For a description of this patchwork, see DASCHLE ET AL., *supra* note 1, at 29-38.

⁴¹ SUSAN JAFFE, HEALTH POLICY BRIEF: A PUBLIC HEALTH INSURANCE PLAN 2 (2009), available at http://www.healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_4.pdf.

⁴² *Id.*

⁴³ Medicare covered thirty-eight million people aged sixty-five and older and seven million people under sixty-five with disabilities in 2008. THE HENRY J. KAISER FAMILY FOUND., MEDICARE: A PRIMER 1 (2009), <http://www.kff.org/medicare/upload/7615-02.pdf> [hereinafter KFF MEDICARE: A PRIMER].

Indians and Alaskan Natives (Indian Health Services, “is”) and the military and veterans (“CHAMPUS” and “TRICARE”).

The rest of the insured (~150 million) are covered by private insurance, which is divided loosely into three markets – large group (which is itself divided into fully and self-funded insurance, as described below), small group, and individual. Health insurance is sold differently in each of these three markets, and, for the most part, carriers who sell insurance operate in only one of these three markets.⁴⁴ Furthermore, as discussed below, the health insurance market is regulated at the state level, and the number and type of carriers differ state-by-state.

The majority of privately insured Americans still obtain their health insurance coverage through an employer, even as the prominence of employer-sponsored insurance (“ESI”) declines.⁴⁵ ESI is carved up into large group and small group insurance (2-50 employees). Large group plans can be “fully insured,” where an insurer bears risk under the plan. This means that an employer pays the insurer premiums, and if medical costs for the year exceed premiums, the insurer is at risk for such losses.⁴⁶ In contrast, some large employers have “self-funded” plans, where they bear the risk themselves.⁴⁷ They create a reserve for medical claims, design and administer a coverage plan, with the help, usually, of an insurer as a third-party administrator (“TPA”), and then pay for medical losses under the plan out of the reserve.

The frequency of self-funded health plans has increased dramatically over the past two decades, so that now 55 percent of covered workers (over 30 percent of the total non-elderly population) are members of self-funded plans, for reasons discussed in Part IV below.⁴⁸ Each self-funded plan acts as an isolated risk pool, extracting its members from larger insurance risk pools.

A small, but not insignificant, number of people (6-7 percent of the non-elderly) obtain insurance directly through the individual market, which is typically considered more unstable and more expensive dollar-per-dollar, as discussed further in Part IV.⁴⁹

The remaining 16-17 percent of the total non-elderly population is uninsured.⁵⁰ Under an individual mandate, the uninsured could seek

⁴⁴ Katherine Swartz, *Justifying Government as the Backstop in Health Insurance Markets*, 2 YALE J. HEALTH POL’Y L. & ETHICS 89, 95-96 (2001).

⁴⁵ *Id.* at 94. Sixty percent of all firms offer health benefits, down from a recent high of 69% in 2000. KAISER FAMILY FOUND. ET AL., EMPLOYER HEALTH BENEFITS: 2007 ANNUAL SURVEY 36 (2007), <http://www.kff.org/insurance/7672/upload/76723.pdf> [hereinafter KFF EMPLOYER HEALTH BENEFITS: 2007].

⁴⁶ In reality, most insurers buy reinsurance policies that limit their exposure.

⁴⁷ If at the end of the year, employee health costs are higher than the reserve, the company must cover these costs. If employee health costs are lower than projected, the company retains the surplus in the plan. *See infra* Part B (explaining how ERISA preemption rules have created incentives for employers to self insure).

⁴⁸ KFF EMPLOYER HEALTH BENEFITS: 2007, *supra* note 45, at 147.

⁴⁹ THE HENRY J. KAISER FAMILY FOUND., HEALTH INSURANCE COVERAGE IN AMERICA: 2007 1 (2007), <http://facts.kff.org/chartbooks/Health%20Insurance%20Coverage%20in%20America,%202007.pdf> [hereinafter KFF HEALTH INSURANCE COVERAGE IN AMERICA].

⁵⁰ *Id.*

coverage through any of these sub-markets, as they have done in Massachusetts following the 2006 reform.⁵¹

C. THE UNINSURED AS CONSUMERS AND FINANCIERS

The individual mandate could inject into this fragmented market some 46 million uninsured, and in doing so it will influence these uninsured in two ways.⁵² The first influence, which has been well-explored, is that the mandate converts all uninsured to policyholders (or consumers) of insurance. The second, less-examined influence is that the mandate causes some uninsured to pay more for insurance than they spend in care. By so doing, it converts them into “financiers” of others’ care, which is critical to the mandate’s ability to achieve redistributive objectives and to promote solidarity.

An understanding of why people are uninsured helps bring these two distinct influences to light.⁵³ Many of the uninsured are lower-income workers for whom insurance is arguably “unaffordable” or unattainable.⁵⁴ Over 60 percent of the uninsured earn less than 200 percent of the Federal Poverty Level (FPL).⁵⁵ An estimated 25 percent of the uninsured qualify for Medicaid or SCHIP but have not enrolled.⁵⁶ Some, eligible for insurance through the individual market, may have previously been rejected for coverage.⁵⁷ For this part of the population, the concern is making insurance policies accessible and almost certainly subsidizing the purchase of such policies.

Yet as many as a third of the uninsured could in theory afford to buy insurance but are nonetheless uninsured. Studies estimate as many as 17 million uninsured Americans are such “voluntary opt-outs.”⁵⁸ This segment of the uninsured is growing faster than the low-income uninsured.⁵⁹

⁵¹ See *infra* Part V.B.

⁵² THE HENRY J. KAISER FAMILY FOUND., *THE UNINSURED, A PRIMER: KEY FACTS ABOUT AMERICANS WITHOUT INSURANCE 1* (2009), <http://www.kff.org/uninsured/upload/7451-05.pdf> [hereinafter KFF *THE UNINSURED*].

⁵³ For an overview of problems of uninsurance and underinsurance, see TIMOTHY STOLTZFUS JOST, *HEALTH CARE AT RISK 1-16* (Duke Univ. Press 2007). For a study on the duration of being uninsured for different populations, see Pamela Farley Short & Deborah R. Graefe, *Battery-Powered Health Insurance? Stability in Coverage of the Uninsured*, 22 *HEALTH AFF.* 244, 250-51 (2003) (finding that the wealthy tend to be uninsured for shorter period of time and less frequently).

⁵⁴ *Id.*

⁵⁵ *Id.* at 250.

⁵⁶ The reasons for not having enrolled are varied, including lack of awareness of the programs and their eligibility criteria and cumbersome enrollment procedures. JOHN HOLAHAN ET AL., *KAISER COMM. ON MEDICAID AND THE UNINSURED, CHARACTERISTICS OF THE UNINSURED: WHO IS ELIGIBLE FOR PUBLIC COVERAGE AND WHO NEEDS HELP AFFORDING COVERAGE? 1, 6* (2007), <http://www.kff.org/uninsured/upload/7613.pdf>.

⁵⁷ SARA R. COLLINS ET AL., *THE COMMONWEALTH FUND, SQUEEZED: WHY RISING EXPOSURE TO HEALTH CARE COSTS THREATENS THE HEALTH AND FINANCIAL WELL-BEING OF AMERICAN FAMILIES 4* (2006), http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2006/Sep/Squeezed%20Why%20Rising%20Exposure%20to%20Health%20Care%20Costs%20Threatens%20the%20Health%20and%20Financial%20Well%20Being%20of/Collins_squeezedri singhltcarecosts_953%20pdf.pdf.

⁵⁸ THE COUNCIL FOR AFFORDABLE HEALTH INSURANCE, *UNDERSTANDING THE UNINSURED AND WHAT TO DO ABOUT THEM 5* (2007), http://www.cahi.org/cahi_contents/resources/pdf/UnderstandingTheUninsured0307.pdf

These voluntary opt-outs have made a decision not to purchase insurance, presumably because they perceive the cost to be higher than the benefits.⁶⁰ Their choice may reflect a legitimate trade-off between health insurance and other needs they deem more important (relatively high costs). For others, it may be rooted in a perception that they don't need insurance (relatively low benefits). For the young uninsured, this way of thinking prompted the nickname "invincibles." If invincibles are seen as making an *irrational* decision not to purchase insurance, paternalism may be a particularly important reason for a mandate, as discussed below. But many voluntary opt-outs could rationally decline insurance because premiums exceed the value of insurance to them individually, in which case paternalism cannot argue for compelling them to buy insurance.

Considering this dichotomy of uninsured (involuntary vs. voluntary), we can see how the mandate influences the uninsured in two distinct ways – first as potential consumers and second as potential financiers of health care.

First, the mandate, by definition, attempts to convert each of the 46 million uninsured from a non-consumer into a consumer of health insurance; this fact underlies strong insurance industry support of both the mandate and also of high penalties for noncompliance.⁶¹ This goal is simply that everyone carries health insurance, regardless of the form of insurance or who pays for it. A non-consumer might become a consumer by enrolling in coverage available through a public source (e.g., Medicare or Medicaid), if eligible, through an employer's health plan, or on their own in the individual market. Further, they might pay for all, part, or none of the cost of their plan, depending on what level of public or employer subsidies is available.

Second, and importantly, for a subset of the uninsured population, the government also compels them to be financiers of health care. While this aspect of the mandate has gone largely unexamined, it is critically important to redistributive objectives for the mandate as discussed in Part II.

When the mandate compels the 17 million voluntary opt-outs to buy insurance, they not only become consumers of health insurance, many will also become financiers of health care for others. Many voluntary opt-outs currently make decision not to buy health insurance based on low expected medical costs, at least in the short-term. To the extent their expectations are correct, when the mandate requires them to buy insurance, many are likely to

[hereinafter CAHI UNDERSTANDING THE UNINSURED]. Recent estimates suggest that "young invincibles," who comprise a large part of the voluntary opt-outs, were 13.2 million in 2007. Cara Buckley, *For Uninsured Young Adults, Do-It-Yourself Medical Care*, N.Y. TIMES, Feb. 18, 2009, at A1 (citing the Commonwealth Fund study).

⁵⁹ CAHI UNDERSTANDING THE UNINSURED, *supra* note 58, at 5.

⁶⁰ These opt outs might either have decided not to purchase insurance on their own or may have declined an offer of employer-sponsored insurance. Take up rates on employer-sponsored insurance are 82%. THE HENRY J. KAISER FAMILY FOUND. ET AL., EMPLOYER HEALTH BENEFITS: 2008 ANNUAL SURVEY 47, available at <http://ehbs.kff.org/pdf/7790.pdf> [hereinafter KFF EMPLOYER HEALTH BENEFITS: 2008].

⁶¹ America's Health Insurance Plans (AHIP), the insurance lobby, and the Blue Cross and Blue Shield Association have advocated for an individual mandate. See Press Release, America's Health Insurance Plans, America's Health Ins. Plans, Health Plans Propose Guaranteed Coverage for Pre-Existing Conditions and Individual Coverage Mandate (Nov. 19, 2008), available at <http://www.ahip.org/content/pressrelease.aspx?docid=25068>; Robert Pear, *Insurers Offer to Soften a Key Rate-Setting Policy*, N.Y. TIMES, Mar. 25, 2009 at B1.

pay premiums in an amount greater than what they consume in care (plus administrative expenses and profit).⁶² When this occurs, some part of their premium payment will pay for someone else's medical expenses. Mandating these uninsured, the "financiers," to purchase insurance cannot be for paternalist reasons because such purchase is in fact *not* in their own individual best interest. Rather, as explained in Part III, the mandate's influence over the financiers is central to redistributive objectives and can, by promoting redistribution, also unlock greater insurance market efficiency.

Any surplus that the voluntary opt-outs pay in premiums over expenses is the contribution they make as financiers of health care. Because they are healthy (rich in terms of the resource of health), they are compelled to bankroll care for people sicker than themselves. This investment may pay back in a year when they are sick and consume more care than what they pay in premiums, or it may not.

While I use the term "financier" to describe these net contributors, I do so with a sense of irony and caution. Economist Jon Gruber notes that we understand very little about this population.⁶³ Yet, it is clear that we would not consider many "financiers" rich. They are often young and just beginning their careers or at an income level where the cost of insurance deters purchase, raising questions about the fairness of compelling them to finance others' care, as addressed in Part III.

In addition, while it is easiest to conceptualize the financiers as a static population, they are ever-changing and difficult to identify. The population of financiers will shift over time; someone may be a financier in one year and a beneficiary of other financiers in another as he ages or if he experiences, for any number of reasons, an increased risk of poor health. The point of using the term financier is to recognize explicitly that in health financing, every year some people can reasonably anticipate being net contributors, subsidizing other peoples' premiums and medical care. The mandate does not differentiate financiers from non-financiers. It simply requires that someone participate both in the years that he expects to be a net contributor as well as when he is likely to be a net beneficiary.

There are no good estimates on the dollar amount that financiers' premiums might provide to subsidize others' care. And in fact, it is quite difficult to measure this moving target, which depends on the design and range of plans available for purchase and how much premiums are allowed to vary based upon individual characteristics. The more financiers have access to plans that are priced based upon their expected low risk (i.e., low cost, high deductible health plans), the less surplus they will pay in premiums above expenditures. This calculus also depends on whether opt-outs use more care once insured because they are able to access necessary care or because they become cost-insensitive once insurance pays for care – a phenomenon referred to as moral hazard.⁶⁴

Nonetheless, I offer a conservative ballpark estimate, based upon the world of insurance pre-reform and intended for illustrative purposes only, to

⁶² If reform lowers the price of insurance or if once insured, they consume more care (i.e., moral hazard), the gap between consumption and premiums paid will narrow.

⁶³ Gruber, *supra* note 4, at 581.

⁶⁴ See e.g., Steven Shavell, *On Moral Hazard and Insurance*, 93 Q. J. ECON. 541 (1979).

suggest that their contribution is significant. Let us assume that under an individual mandate the voluntary opt-outs will buy insurance and pay premiums on average of \$4000 per person, per year.⁶⁵ This means 17 million people newly insured would pay on average \$4000 per person, or nearly \$70 billion in premium revenue. They will of course incur some expenses to pay for medical care, overhead, and insurer profit. Yet virtually half of the population experiences essentially no medical care costs in any one year.⁶⁶ Presumably, many voluntary opt-outs fall into this category for the reasons discussed above. Even if we assume conservatively that half of the newly insured population's premiums go toward expenses, there would still be an over \$35 billion infusion of financing into risk pools. While this estimate is extremely rough, it illustrates the potential of voluntary opt-outs as financiers. While insufficient to fund the entire cost of covering the uninsured (estimates are about \$100-150 billion per year⁶⁷), this surplus could nevertheless be quite significant.

Thus, in summary, the individual mandate is a tool to compel the heterogeneous population of uninsured into existing insurance markets and, in the process, will compel all to be consumers of insurance and a subset also to be financiers of others' medical care.

III. PATERNALISM, EFFICIENCY, AND HEALTH REDISTRIBUTION

By compelling the 46 million uninsured to carry insurance, the individual mandate can serve three primary types of policy objectives that I will characterize as paternalism, efficiency, and health redistribution.⁶⁸ Failure to clearly identify and consider each of these three types of objectives independently in policy discussions has obscured the fact that the individual mandate will face critical problems in achieving certain objectives, particularly health redistribution. Support for the mandate is rooted in all three objectives (although not all supporters care about all objectives), as

⁶⁵ The average premium per individual is roughly \$5000 and per family is roughly \$12,000 for group coverage. The Henry J. Kaiser Family Found., *Average Health Insurance Premiums and Worker Contributions for Family Coverage, 1999-2008* (2008), <http://facts.kff.org/chart.aspx?ch=706>. About 1/3 of the uninsured are individuals and the other 2/3 are part of families. KFF HEALTH INSURANCE COVERAGE IN AMERICA, *supra* note 49, at 6. With an average family size of 3 in the U.S., those buying family plans will pay \$4000 per person. U.S. Census Bureau, Fact Sheet: 2006-2007 American Community Survey 3-Year Estimates, <http://factfinder.census.gov/servlet/ACSSAFFacts> (last visited Mar. 9, 2009). A rough weighted estimate is \$4300 per person. Yet, if average premiums decrease when more healthy people enroll or if these healthy people pay lower than average premiums, these estimates may be high; thus, I use \$4000 to be conservative.

⁶⁶ Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures, Revisited*, 20(2) HEALTH AFF. 9, 12 (2001).

⁶⁷ Jonathan Oberlander, *Great Expectations - The Obama Administration and Health Care Reform*, 360 NEW ENG. J. MED. 321, 322 (2009).

⁶⁸ *C.f.* Gruber, *supra* note 4 (outlining arguments for universal coverage in general, which includes these three categories, among others).

reflected in legislative records in Massachusetts⁶⁹ and in proposals for a mandate as part of national reform.⁷⁰

While different, these objectives are often not completely distinct. Rather, they are interrelated, interdependent, and undoubtedly blur at times. For example, an individual mandate would serve paternalistic and efficiency ends simultaneously if it compels people to behave in their own best interest and in doing so results in greater efficiency. In fact, some scholars argue that efficiency gains provide justification for paternalistic action.⁷¹ Similarly, a law such as compulsory vaccination may result in an efficient outcome, protect the vaccinated individual himself, and more equally distribute the cost of preventing disease.

The purpose of disaggregating these three objectives with respect to the individual mandate is not to argue that they are completely distinct. Rather, it is to expose where the mandate will most likely fall short – in particular on redistributive aims – if implemented in a fragmented health insurance market.

A. PATERNALISM

Paternalism motivates law based on a belief that the government knows what is best for an individual and, thus, will compel the individual to act in a particular way for his or her “own good.”⁷² In doing so, policymakers substitute their own preferences for an individual’s actuated preference. Because paternalistic mandates attempt to compel individuals to make choices that are in their own best interest, the paternalistic objective of the mandate should only apply to uninsured who are in fact making an irrational decision to be uninsured at a particular point in time.⁷³

There is a long history of mandates motivated by paternalism. Mandatory use of seatbelts aims to protect drivers and passengers in a car from injury. Mandatory waiting periods on contracts intend to protect someone from agreeing in haste or under pressure to something that he will later regret. Even mandates that are intended primarily to serve other objectives may be partially motivated by paternalism. Compulsory vaccinations, while perhaps primarily intended to promote herd immunity (an efficiency goal), also serve to prevent an individual from being vulnerable, herself, to contracting polio or

⁶⁹ See HEALTH CARE ACCESS AND AFFORDABILITY CONFERENCE COMMITTEE REPORT 2006, <http://www.mass.gov/legis/summary.pdf> [hereinafter CONFERENCE COMMITTEE REPORT].

⁷⁰ See, e.g., SEN. MAX BAUCUS, CALL TO ACTION: HEALTH REFORM 2009 (2008), <http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf>.

⁷¹ “Asymmetric paternalism” justifies paternalistic interventions so long as they help irrational people avoid making costly mistakes while causing little or no harm to rational people. Colin Camerer et al., *Regulation for Conservatives: Behavioral Economics and the Case for ‘Asymmetric Paternalism,’* 151 U. PA. L. REV. 1211, 1212 (2003); see also Eyal Zamir, *The Efficiency of Paternalism,* 84 VA. L. REV. 229, 230 (1998) (efficiency analysis can “provide[] a central justification for paternalism”).

⁷² See, e.g., Duncan Kennedy, *Distributive and Paternalist Motives in Contract and Tort Law, with Special Reference to Compulsory Terms and Unequal Bargaining Power,* 41 MD. L. REV. 563 (1982) (discussing paternalism and retribution in the law).

⁷³ Of course, policymakers could misjudge best interest and create a harmful paternalistic intervention. See, e.g., Christine Jolls et al., *A Behavioral Approach to Law and Economics,* 50 STAN. L. REV. 1471, 1543 (1998).

measles.⁷⁴ Automobile insurance mandates, while primarily aiming to ensure victims of accidents access to remedy, also prevent an uninsured injurer from personal liability for the cost of harm to others.

Scholars have long wrestled with the question of when, if ever, legal paternalism is justified, making the case for a limited set of circumstances in which it might be most appropriate.⁷⁵ The earliest defense was for laws serving to protect groups of people who might not be able to make good decisions for themselves, such as children and the mentally handicapped.⁷⁶ More recently, behavioral psychologists and economists have justified broader paternalistic intervention to remedy actual behavior that deviates from what is considered fully-informed, rational behavior.⁷⁷ That is, paternalism is justified so long as it corrects for cases of systematic decision-making errors or “bounded rationality.”⁷⁸ Such errors might occur when a decision maker has access to incomplete information, fails to understand complex information, or is biased in a way that leads her to an irrational decision.⁷⁹ Commonly discussed types of bias include over-optimism, over-pessimism, or myopia in the case of discord between immediate preferences and future preferences.⁸⁰ In such cases, paternalistic intervention would prompt an individual to make the decision he would make if perfectly informed and rational.

The paternalistic objective for an individual health insurance mandate concerns the mandate’s ability to convert the irrationally uninsured into consumers of health insurance as a gateway to their own improved health and greater financial security.⁸¹ Individuals often make an irrational decision not to buy health insurance, in large part due to individuals’ optimism bias with respect to their future health, sometimes called the “superman effect,” that prevents them from acknowledging their own vulnerability.⁸² Even with the

⁷⁴ Some believe the risk of side effects from vaccination in fact outweigh the potential benefits, making vaccination contrary to best-interest. For example, early polio vaccinations had a high likelihood of infecting someone with the disease and, more recently, some are concerned that vaccinations have caused an increased incidence of autism. *See, e.g.*, Generation Rescue, <http://www.generationrescue.org/> (last visited Mar. 23, 2009).

⁷⁵ Even for those who would not object to legal paternalism, mandates may be too strong of a tool. Some advocate for “soft paternalism,” such as default rules, information disclosure requirements, or cooling off periods to shape behavior by encouraging people to behave in their own best interest rather than mandating they do so. Camerer et al., *supra* note 71, at 1224; *see generally* Richard H. Thaler & Cass R. Sunstein, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2008) (promoting choice architecture to influence choices with greater subtlety).

⁷⁶ *See* Camerer et al., *supra* note 71, at 1213 (2003) (providing a brief history of justification for paternalism); Zamir, *supra* note 71, at 229.

⁷⁷ Camerer et al., *supra* note 71, at 1212.

⁷⁸ Christine Jolls, Cass Sunstein, and Richard Thaler explored such phenomena of bounded rationality, bounded willpower, and bounded self interest. Jolls et al., *supra* note 73; *see also* HERBERT A. SIMON, *Rationality and Administrative Decision Making*, in *MODELS OF MAN: SOCIAL AND RATIONAL* 196-207 (1957).

⁷⁹ Jolls et al., *supra* note 73.

⁸⁰ *See* Zamir, *supra* note 71, at 251.

⁸¹ *See, e.g.*, Gruber, *supra* note 4, at 582. *Cf.* MICHAEL J. GRAETZ & JERRY L. MASHAW, *TRUE SECURITY: RETHINKING AMERICA’S SECURITY* 171-72 (1999) (explaining the purpose of social health insurance as protecting against the dual risks of inadequate income and “unacceptably steep” decline in living standards due to medical expenses).

⁸² Tom Baker & Peter Siegelman, *Tontines for the Young Invincibles*, *REGULATION*, Winter 2009-2010, at 20, available at <http://www.cato.org/pubs/regulation/regv32n4/v32n4-4.pdf>.

best intentions, consumers may have difficulty estimating the complexity of medical risk and thus undervalue the benefit of insurance.⁸³ While health insurance does not guarantee good medical care, research shows that the inverse is true; the lack of health insurance results in worse care and health outcomes for many, including increased mortality.⁸⁴ Further, studies demonstrate that uninsured Americans are at greater financial risk for problems including insolvency, foreclosure, or bankruptcy.⁸⁵ Thus, it is not surprising that some supporters of the mandate would invoke it to correct for decision-making errors that cause people not to purchase health insurance, leaving themselves vulnerable to these types of health and financial risks.

However, the paternalistic justification for the mandate can only go so far. Most importantly, as noted above, this paternalistic justification deals with a subset of uninsured who are behaving irrationally. Assuming a portion of the uninsured are currently making a rational decision not to purchase health insurance because the cost of premiums exceed the likely benefit to them, compelling them to buy insurance is arguably not in their self-interest and thus, by definition, must be justified by something other than paternalism.⁸⁶ In particular, in a market where someone can opt out in his twenties and buy in without penalty in his thirties (so long as his health holds out), twenty year-olds might make a good bet to go bare. Furthermore, the paternalistic potential of a mandate only reaches so far as the value of insurance policies available and affordable to each individual. If policies do not provide sufficient coverage, have cost-sharing levels that deter appropriate use of health care, or provide low coverage limits so that the sick outspend their policies, such policies might not achieve the health and financial security desired by policymakers.⁸⁷ In other words, their value might be low enough that their benefits do not in fact outweigh their costs to some. Finally, paternalism may be insufficient on its own to justify an individual mandate. As noted above, legal scholars often justify paternalistic interventions based upon the coexistence of other intentions, including efficiency goals.⁸⁸ A mandate aimed primarily at paternalistic goals may be more vulnerable to

⁸³ *Id.* at 23; Jeffrey Liebman & Richard Zeckhauser, *Simple Humans, Complex Insurance, Subtle Subsidies*, in *USING TAXES TO REFORM HEALTH INSURANCE: PITFALLS AND PROMISES* 230, 230-51 (Henry J. Aaron and Leonard E. Burman eds., 2009).

⁸⁴ Diane Rowland & Adele Shartzler, *America's Uninsured: The Statistics and Back Story*, 36 *J.L. MED. & ETHICS* 618, 618 (2008). *See also* Gruber, *supra* note 4, at 582 (citing the Institute of Medicine study and others showing impact of insurance on health); Wilper, *supra* note 7, at 2289.

⁸⁵ David U. Himmelstein et al., *Marketwatch: Illness and Injury as Contributors to Bankruptcy*, *HEALTH AFF. (WEB EXCLUSIVE)* w5-63 (2005), <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1>; Christopher T. Robertson et al., *Get Sick, Get Out: The Medical Causes of Home Foreclosures*, 18 *HEALTH MATRIX* 65, 95 (2008).

⁸⁶ Of course, because some of the costs of medical care are unpredictable, it is difficult to tell who is making a rational decision ex-ante. But, as discussed in Part II, with the irregular distribution of medical costs, a significant subset of the uninsured who expect low medical costs will indeed incur low costs.

⁸⁷ *See* Light, *supra* note 16, at 2503-08.

⁸⁸ *See e.g.*, Camerer et al., *supra* note 71; Zamir, *supra* note 71. *Cf.* Anthony T. Kronman, *Paternalism and the Law of Contracts*, 92 *YALE L.J.* 763 (1983) (explaining paternalistic limitation on contractual freedom by considerations of economic efficiency, distributive fairness, personal integrity, or sound judgment).

assertions of excessive intervention into personal choice, as evidenced by resistance to mandates that are perceived as overly paternalistic, such as mandated use of motorcycle helmets or mandated vaccination against the human papillomavirus (HPV).⁸⁹

B. EFFICIENCY

Efficiency motivates law based upon a belief that such a law can increase overall welfare so that, at least potentially, everyone can be made better off according to his or her own preferences. It reflects a situation where the government solves – by mandate – what the market cannot or has not solved. Most of the discussion of the individual mandate to date has focused on its efficiency potential, largely obscuring other objectives under the frame of efficiency.

Mandates have often been used in the name of efficiency. They might, for example, eliminate or reduce negative externalities. Consider the case of motor vehicle insurance. Compulsory motor vehicle insurance laws emerged in the early twentieth century as a way to address the problem of a motorist unable to compensate victims of his negligence.⁹⁰ Such laws compel solvency so that injurers must internalize the costs they generate and, in theory, efficiently invest in cost avoidance.⁹¹ Similarly, a mandate could solve a collective action problem, where inefficiency results either because of “free riding,” when an individual enjoys a shared (public) benefit without bearing any costs of generating it, or when transaction costs thwart coordinated action. A mandate can address both such problems. For example, in the case of compulsory vaccination, any individual might be personally better off avoiding the risks associated with vaccination so long as enough of his community members are vaccinated to produce “herd immunity” and to stop

⁸⁹ While mandatory motorcycle helmet laws offer potential efficiency gains (e.g., reduce costs of emergency response, injury, and death from accidents), they were challenged as overly paternalistic. The federal government eventually lifted financial penalties levied on states without helmet laws, and the once universal laws have since been either repealed or limited to apply to minors in two-thirds of states. See Insurance Institute for Highway Safety, *Helmet Use Laws* (Mar. 2010), <http://www.iihs.org/laws/HelmetUseOverview.aspx>. Even the suggestion that a mandate is paternalistic may weaken its authority, as evinced by the case of mandatory HPV vaccination. Some scholars make a compelling case that compulsory HPV vaccination serves important public health goals. E.g., Sylvia Law, *Human Papillomavirus Vaccination, Private Choice, and Public Health*, 41 U.C. DAVIS L. REV. 1731 (2008); Kyra R. Wagoner, *Mandating the Gardasil Vaccine: A Constitutional Analysis*, 5 IND. HEALTH L. REV. 403 (2008). Opponents argue that an HPV vaccination mandate is overly paternalistic. E.g., Tracy Solomon Dowling, *Mandating a Human Papillomavirus Vaccine: An Investigation into Whether Such Legislation is Constitutional and Prudent*, 34 AM. J. L. & MED. 65 (2008); Gail Javitt et al., *Assessing Mandatory HPV Vaccination: Who Should Call the Shots?*, 36 J. L. MED. & ETHICS 384, 384 (2008). Whether objectors are actually offended by paternalism or resistant to a mandate that they fear implicitly authorizes sexual activity by creating a perception that sex is “safe” post-vaccination, they use rhetoric of paternalism to undermine the validity of the mandate.

⁹⁰ ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, *UNDERSTANDING INSURANCE LAW* 953, 954 (LexisNexis 4th ed. 2007).

⁹¹ *Id.* at 956-57, 960. While debatable how much of the costs are internalized when insurance pays for harm, arguably, paying for insurance premiums that increase with driving incidents provides more incentive for safety than does externalizing all of the costs of an accident.

transmission within the community.⁹² However, if too many in a community free ride on others' vaccinations, the community risks not achieving immunity. When the benefit to all of herd immunity and subsequent eradication of disease is greater than the cost of vaccination to the unvaccinated, compulsory vaccination is efficient.⁹³ Mandatory vaccinations have been found constitutional under the police power to "protect the public health and the public safety,"⁹⁴ even when decisions regarding individual bodies and health were involved.⁹⁵

By compelling everyone to be a consumer of insurance, the individual health insurance mandate might serve several efficiency objectives that I will discuss in turn. First, it may reduce insurance market inefficiency due to adverse selection, regarded as the major market failure of insurance markets.⁹⁶ Second, it could eliminate inefficient use of care by the uninsured in emergency rooms, the cost of which is often externalized (i.e., free-riding).⁹⁷ Third, it can smooth medical care costs over an individual's lifetime.

First, if the individual mandate successfully drives everyone to consume insurance, it would eliminate adverse selection *into* health insurance markets. This is the primary motivation economists cite for the individual mandate.⁹⁸ Adverse selection is a problem of information asymmetry in insurance markets.⁹⁹ Insurers are concerned that those who seek insurance are more likely than average to consume medical care because of something the buyers know about their own health, family history, or behavior that insurers don't know and can't easily discover.

Despite academic disagreement on the true extent of adverse selection into markets, insurers behave as if it is a problem, particularly in the individual market where insurers have greater fear of higher-risk individuals

⁹² See Kevin M. Malone & Alan R. Hinman, *Vaccination Mandates: The Public Health Imperative and Individual Rights*, in *LAW IN PUBLIC HEALTH PRACTICE* 338, 339-40 (Richard Alan Goodman et al. eds., 2007).

⁹³ States with vaccination mandates average 85% immunization rates versus 77% in non-mandate states. Paul E. M. Fine, *Herd Immunity: History, Theory, Practice*, 15 *EPIDEMIOLOGIC REV.* 265, 268 (1983). Vaccination efforts are credited with the eradication of smallpox, near eradication of polio, and control of measles. In the United States, morbidity by vaccine-preventable diseases has been reduced by 87-99%, depending on the disease. See Walter A. Orenstein et al., *Immunizations in the United States: Success, Structure, and Stress*, 24 *HEALTH AFF.* 599, 599-600 (2005); see also Malone & Hinman, *supra* note 92, at 338.

⁹⁴ *Jacobson v. Mass.*, 197 U.S. 11, 25 (1905).

⁹⁵ *Id.* at 26 (citing *Railroad Co. v. Husen*, 95 U.S. 465, 471 (1878); *Missouri, Kansas & Texas Ry. Co. v. Haber*, 169 U.S. 613, 628-29 (1898); *Thorpe v. Rutland & Burlington R.R.*, 27 Vt. 140, 148 (1854)).

⁹⁶ See e.g., Linda J. Blumberg & John Holohan, *The Individual Mandate – An Affordable and Fair Approach to Achieving Universal Coverage*, 361 *NEW ENG. J. MED.* 6 (2009); see also Sherry Glied, *Universal Coverage One Head at a Time – The Risks and Benefits of Individual Health Insurance Mandates*, 358 *NEW ENG. J. MED.* 1540, 1541 (2008).

⁹⁷ See RAND COMPARE, ANALYSIS OF INDIVIDUAL MANDATE, http://www.randcompare.org/analysis/mechanism/individual_mandate (last visited July 8, 2009) (summarizing studies on the effects of expanded insurance coverage on ED care).

⁹⁸ Gruber, *supra* note 4, at 601.

⁹⁹ E.g., David M. Cutler & Richard J. Zeckhauser, *Adverse Selection in Health Insurance*, 1 *FRONTIERS IN HEALTH POLICY RESEARCH* (1998), available at <http://www.nber.org/papers/w6107>.

seeking out insurance, which creates inefficiency.¹⁰⁰ Insurers have little concern of adverse selection with respect to large, employer-sponsored group insurance. Because these groups are formed for non-health reasons and almost all employees enroll in coverage, the distribution of risk in them is reasonably predictable and stable.¹⁰¹ Group risk becomes less predictable as a group becomes smaller and thus the concern of adverse selection increases.¹⁰² In the individual market, every applicant is considered an unmitigated adverse selection risk.

Insurers respond in two ways that drive up the cost of insurance and, as a result, price buyers out. First, insurers charge a higher premium based upon a rational presumption that higher-risk individuals will more often choose to purchase insurance than lower-risk individuals. Even when the premium accurately reflects average risk in the pool, unraveling will occur.¹⁰³ Low-risk individuals become more likely to exit the market as premium prices escalate above what they perceive to be the value of health insurance, leaving more high-risk insureds behind. Reflecting the then higher average medical costs per person in the pool, insurers increase premiums, prompting lower-risk insureds to drop coverage. At its logical extreme, this cycle results in the adverse selection death spiral.¹⁰⁴ This phenomenon is also called the “standard lemons pricing effect,” or “the bad driving the good out of a market.”¹⁰⁵

Second, insurers counter adverse selection through risk selection and classification practices to the extent permitted by state law,¹⁰⁶ driving up overhead costs. For example, insurers use medical underwriting to design and price coverage based upon an individual’s projected risk.¹⁰⁷ If a group or

¹⁰⁰ *Id.*; see also Mark V. Pauly & Len M. Nichols, *The Nongroup Health Insurance Market: Short on Facts, Long On Opinions and Policy Disputes*, HEALTH AFF. (WEB EXCLUSIVE) 325, 327 (Oct. 23, 2002) (arguing that adverse selection is clear in regulated nongroup markets and less clear in unregulated ones but concluding that nonetheless, insurers’ fear of adverse selection is real and drives underwriting and pricing behavior); Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223, 1226 (2004) (arguing that propitious selection, or the preference of risk averse who also tend to be more self-preserving to buy insurance, balances out any adverse selection); Gruber, *supra* note 4, at 577 (discussing economic literature on adverse selection within health insurance markets).

¹⁰¹ Gruber, *supra* note 4, at 574; Swartz, *supra* note 44, at 96.

¹⁰² THE HENRY J. KAISER FAMILY FOUND., HOW PRIVATE HEALTH COVERAGE WORKS: A PRIMER 2008 UPDATE 7, 5 (2008) [hereinafter HOW PRIVATE HEALTH COVERAGE WORKS].

¹⁰³ See generally Cutler & Zeckhauser, *supra* note 99.

¹⁰⁴ *Id.* at 14.

¹⁰⁵ See George A. Akerlof, *The Market for “Lemons”: Quality, Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488, 489-90 (1970) (showing that in the used car market information asymmetry leads to pricing based on the average used car, which causes sellers of a good used cars to leave the market because they cannot get a high enough price, leaving “lemons” behind). See also Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q. J. ECON 629 (1976) (discussing information asymmetry in competitive insurance markets).

¹⁰⁶ See text accompanying *infra* note 228 for discussion of state laws prohibiting risk selection.

¹⁰⁷ See Timothy Stoltzfus Jost, *Risk Selection by Private Health Insurers: Why Regulation Alone Cannot Solve the Problem*, <http://law.wlu.edu/deptimages/Faculty/Jost%20Risk%20Selection%20by%20Private%20Health%20Insurers.pdf> (providing description of different practices insurers use for risk selection). See also sources cited *supra* note 16. See also Kaiser Family Foundation, *infra* note 228, for description of state laws that prohibit such practices.

individual has high expected expenses, the insurer might charge a higher premium or limit coverage through exclusion of certain pre-existing conditions. If a person has already manifested an expensive disease, such as liver disease, the insurer might deny coverage altogether.¹⁰⁸ Insurers also use sophisticated practices of marketing and benefit/network design to guide low-risk and high-risk beneficiaries to different insurance products.¹⁰⁹ That is, they try to get customers to signal their own risk by self-segregating to products on the basis of risk. For example, insurers may try to attract healthy beneficiaries by offering fitness benefits, low-cost preventative care or a low-cost, high-deductible policy. On the flip side, by offering comprehensive cancer coverage, an insurer might steer someone with a family history of cancer to a more expensive policy.¹¹⁰

The use of such practices drives up administrative costs associated with insurance, resulting in higher load factors (administrative costs plus profits) in the small group and individual markets, where the risk of adverse selection is higher and these practices are more intensively used, as discussed further in Part IV.¹¹¹ Estimates are that administrative costs account for as much as 30-40 percent of premiums in the individual market in some states; 25-27 percent in the small group market; and only about 5-10 percent in large group market.¹¹² Because of these costs, some people who would like to buy insurance are priced out of the market and some pay more than they would for insurance in a more efficient market.

If the mandate does in fact eliminate adverse selection into markets by discouraging low-risk individuals from avoiding or dropping health insurance coverage, it might ameliorate some of this inefficiency. In particular, elimination of adverse selection into markets will most likely reduce the standard lemons pricing effect. Following a mandate, insurers can no longer assume that applicants are disproportionately lemons. Rationally behaving insurers in a competitive market would no longer charge “lemons” premiums, based on assumption of higher-than-average risk enrollees, thus making insurance affordable to more people.

While it is also possible that the mandate might reduce administrative costs arising from risk selection practices, it is equally possible the individual mandate might have no effect on or even drive up such costs. As the average risk of applicants decreases post-mandate, it may be less profitable for insurers to use underwriting and marketing to identify and avoid high risks. If such practices were reduced or eliminated, administrative costs would decline and insurance might be affordable for an even larger set of people.

That being said, there is good reason to believe the ability of the individual mandate alone to decrease administrative costs may be limited (I’ll argue below that a mandate that achieves the goal of health redistribution unlocks potential for greater administrative efficiencies). While the mandate eliminates adverse selection into the insurance market as a whole, the potential for adverse selection among insurers or into different insurance

¹⁰⁸ Swartz, *supra* note 44, at 97.

¹⁰⁹ Light, *supra* note 16, at 2504.

¹¹⁰ Swartz, *supra* note 44, at 97.

¹¹¹ Gruber, *supra* note 4, at 574.

¹¹² Pauly & Nichols, *supra* note 100, at 326.

products will remain. And insurers will have lost one signal as to who is high-risk once seeking out insurance can no longer be used as a signal that someone has a higher-than-average risk. Thus, insurers may in fact have more of an incentive to use marketing to attract healthier beneficiaries than their competitors do and to use marketing or benefit design practices to encourage applicants to self-segregate into different products according to risk. There are not yet empirical studies measuring how the individual mandate will affect the use of risk selection practices and thus the administrative costs of insurance; such studies could illuminate the extent of the costs resulting from adverse selection that might be addressed by a mandate alone. What we do know, however, is that when certain practices for identifying risk are banned, insurers tend to rely on other practices – both legal and illegal – to identify higher-risk applicants.¹¹³

A second way the mandate might promote efficiency is by eliminating externalized costs of care by the uninsured; this free-riding, while a much-discussed problem by the popular media, in reality likely offers limited potential in terms of both efficiency and cost savings.¹¹⁴ In our current system, we guarantee everyone access to emergency services regardless of ability to pay under the Emergency Medical Treatment & Active Labor Act (EMTALA).¹¹⁵ This security blanket might be causing some people to opt out of insurance and use free resources for care knowing that if they are in urgent need of medical attention, they can receive it.¹¹⁶ If an uninsured person receives care in the emergency room and does not pay for this care, it is considered “uncompensated” at the point of services, and the costs are folded into premiums paid by the insured.¹¹⁷ Estimates of uncompensated care costs range from \$30 billion to \$56 billion per year in the U.S.¹¹⁸

Elimination of use of ER care by the uninsured is widely cited as a reason for an individual mandate.¹¹⁹ The theory is that if the uninsured could access care in cheaper clinical settings, they could get the same or better services less expensively. In reality, studies conflict on how much of the use of ER care is in fact inefficient, how much efficiency gain is possible, and how much efficiency loss might result from clinical waste in routine services used by the newly insured.¹²⁰

More importantly, this potential of the mandate to reduce the use of ER care by the uninsured is typically erroneously framed as offering potential for overall cost savings due to a mandate. Even if shifting care away from the ER

¹¹³ Jost, *supra* note 107, at 1.

¹¹⁴ Gruber, *supra* note 4, at 582.

¹¹⁵ 42 U.S.C. § 1395dd (2006).

¹¹⁶ Studies conflict on whether the availability of free care is in fact a relevant factor in people’s decision to buy insurance or not. See Gruber, *supra* note 4, at 578.

¹¹⁷ Hadley et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs*, 27 HEALTH AFF. (WEB EXCLUSIVE) 399, 402 (Aug. 25 2008).

¹¹⁸ Gruber, *supra* note 4, at 582 (estimating the cost of uncompensated care at \$30 billion annually); Hadley et al., *supra* note 117, at 399; (estimating uncompensated care at \$56B).

¹¹⁹ See, e.g., William F. Frist, *An Individual Mandate for Health Insurance Would Benefit All*, U.S. NEWS.COM, Sept. 28, 2009, <http://www.usnews.com/articles/opinion/2009/09/28/frist-an-individual-mandate-for-health-insurance-would-benefit-all.html?PageNr=2>.

¹²⁰ RAND COMPARE, *supra* note 97, at 8-9 (citing studies on possible clinical efficiency gains and losses from expanded coverage).

by increasing the number of insured is efficient, it is unlikely to save money. In fact, studies have shown that once the uninsured have insurance, they will use more care than before, which will increase overall health spending by as much as two times.¹²¹ Some of this increase might reflect greater inefficiency due to moral hazard – overuse of care once a third-party payer is subsidizing the consumption.¹²² Some of this increase is also a result of people getting access to much-needed care that they couldn't get before. Even though insuring everyone might lead to better health outcomes and some reduction of inefficient spending, it will increase health care spending overall, at least in the short term.

Finally, the mandate can help smooth an individual's spending for health care over a lifetime. As discussed above, Americans today go to extreme measures to pay for medical care and sometimes end up filing for bankruptcy or in other financial distress.¹²³ Health insurance can prevent such problems by enabling individuals to smooth medical spending in two ways. First, insurance might serve as a way for an individual to borrow from his future self for care needed today. If someone has a skiing accident this year that costs her \$30,000 for medical care, her insurance will pay for this care, but such payment can be conceptualized as a loan from future premium payments she will make in healthy, accident-free years. On the flip side, it might be possible that she pays \$5000 a year for the next fifty years before she needs any expensive care. In this case, her years of paying excess premiums (as compared to her consumption) might be seen as "savings" for this care when old. Thus, efficiency may result from intrapersonal redistribution of health costs over a lifetime.

In sum, primarily by converting the uninsured into consumers of health insurance, many see the individual mandate as a tool to achieve efficiency gains from reducing adverse selection, enabling more efficient use of care, and smoothing health care costs over a lifetime.

C. HEALTH REDISTRIBUTION AND SOLIDARITY

Finally, redistribution – the focus of the remainder of this article – motivates law that promotes a reordering of resources among people. The individual mandate can serve a redistributive objective by compelling the healthy or lucky to buy insurance to help finance care for the sick or unlucky. This redistribution by mandate, which I call "health redistribution," differs from income redistribution, a more common conception of redistribution from the wealthy to the poor.

As subsection 2 examines, health redistribution can generate a number of benefits – political, pragmatic, and moral. For example, through health redistribution, the mandate might enhance the political feasibility of funding universal insurance coverage, address distributive justice concerns with minimal labor distortion, and unlock further insurance market efficiencies.

¹²¹ THE HENRY J. KAISER FAMILY FOUND., COVERING THE UNINSURED IN 2008: KEY FACTS ABOUT CURRENT COSTS, SOURCES OF PAYMENT, AND INCREMENTAL COSTS 11 (August 2008) [hereinafter KFF COVERING THE UNINSURED IN 2008]; RAND COMPARE, *supra* note 97, at 8-9.

¹²² See Shavell, *supra* note 64, at 541.

¹²³ See Himmelstein et al., *supra* note 85, at w5-66.

For many, though, the critical importance of the mandate's ability to promote health redistribution is to institutionalize a more solidaristic regime of health insurance, where access to health care is divorced from factors other than need.¹²⁴

1. Health Redistribution

The final policy objective some hope individual mandate will serve is "health redistribution." In essence, the mandate compels the healthy to finance care for those sicker than themselves.

Because the mandate operates in insurance markets, its ability to effect health redistribution depends on health insurance as a mechanism for risk pooling. When in risk pools together, the healthy and sick can pay for insurance in a way that the healthy majority subsidizes premiums and medical care for the sick or injured minority.¹²⁵

While paternalism and efficiency objectives rely to a large degree on converting the uninsured into consumers of health insurance, the redistributive objective relies as much on the mandate's ability to influence the healthy as potential financiers of care for the sick. This influence over the uninsured reaches beyond what paternalism would justify because the opt-outs' purchase serves another's interest, rather than self-interest. It also reaches beyond what efficiency objectives alone would justify to the extent the goal is shifting dollars from one person to another without increasing the total pie.

Health redistribution can occur in two different ways within the structure of health insurance. First, ex-ante, purchase of insurance by the healthy "financiers" can make it easier for everyone to afford insurance premiums. When more low-risk individuals join a risk pool, the cost of premiums in that pool can be reduced for all members.¹²⁶ Imagine a hypothetical risk pool with two people. The first has expected risk of \$8000 and the second of \$5000. The average expected cost in the pool is \$6500, and each person will be charged a \$6500 premium (plus overhead costs) if all members of the pool pay the average price. Now, imagine a voluntary opt-out with an expected risk of \$2000 joins this pool. The average expected cost drops to \$5000. If all pool members share risk equally, the individual with expected costs of \$2000 and the one with \$8,000 each pay \$5000 this year. In other words, the surplus, as discussed above, that the financiers pay in premiums beyond their own expected costs can subsidize care for those in need of it and lead to lower premiums for others in the pools they join. Support for ex-ante risk pooling that smoothes premium costs among insureds has come in and out of vogue in the American insurance system, as discussed further below, and garners more controversy than the notion of ex-post pooling, which people tend to more readily identify as the type of redistribution we could expect through insurance.¹²⁷

¹²⁴ See *infra* Part III.C.2.a

¹²⁵ See Stone, *supra* note 12, at 292.

¹²⁶ This assumes a competitive markets, where insurers don't capture the benefit of low-cost enrollees as additional profit.

¹²⁷ See, e.g., Baker, *supra* note 12 (discussing of the shifting limits of risk pooling over time).

Second, universal participation helps to distribute wealth ex-post to anyone who experiences a medical loss in any one year to make them whole for that loss. Ex-ante, everyone bears some risk of incurring medical costs, but it is not clear who will actually suffer the loss in any one year.¹²⁸ In other words, imagine we all pay equally into an insurance pool in a year, not knowing to whom this money will be distributed in the form of medical care. Those who are made “poorer” by sickness in any one year will have resources distributed to them to cushion such a decrease in wealth. Imagine in the hypothetical above that the person with estimated risk of \$5000 were in a biking accident and actually incurred a \$10,000 bill for medical care. Even though \$10,000 is more than he was projected to incur in costs this year, ex-post he receives payment out of the pool to make him whole for his bad luck. Thus, regardless of the fact that some people will be financiers, or net payers, in any one year (the healthy or lucky) and others will be net beneficiaries in any one year (the sick or unlucky), everyone pays in and everyone has equal opportunity to draw out funds for care. The mandate requires more people to participate in this type of ex-post sharing of losses.

Health redistribution is normatively complex, and might concern even those who broadly support redistributive goals. First, health redistribution can be regressive. Imagine a mandate requires every American to pay an equal amount for insurance, regardless of income. By doing so, it promotes horizontal equity (the notion that people with the same income should contribute equally) but simultaneously violates principles of vertical equity (the corollary that those with greater income should contribute more). The result is that the healthy poor could subsidize the sick wealthy, a result many would find troubling.

Even in a national social insurance system, as in Canada or the UK, where universal care is funded through progressive taxes, it is still possible that the healthy poor or middle class help fund care for the wealthy sick. Nonetheless, horizontal and vertical equity concerns are addressed more seamlessly in such social insurance systems where all citizens are provided access to medical care that is financed through proportional or progressive forms of taxation. Everyone who is taxable contributes. Those who earn the same pay the same amount so long as the tax law treats them similarly (horizontal equity), and those who earn more will pay more (vertical equity).

Because seeking universal health care through mandate does not have a built-in mechanism to address vertical equity concerns, a policy built upon mandates must rely upon tax-based subsidies to ameliorate its regressive nature. In fact, as advocated by health economist Jon Gruber, it would be imprudent and perhaps infeasible to implement an individual mandate without some degree of income-based subsidies (a “mandate plus subsidies” approach).¹²⁹ Doing so could mean asking some people to pay more for health insurance than they earn in income or to make undesirable tradeoffs in the name of compliance, such as eschewing food, shelter, or safety. Subsidies raised through taxes could be used to cushion costs for lower income insureds, and thus make health reform by mandate less regressive in nature. In fact,

¹²⁸ See Gillian Lester, *Unemployment Insurance and Wealth Redistribution*, 49 UCLA L. REV. 335, 359 (2001), for an exploration of this concept in terms of unemployment insurance.

¹²⁹ See Gruber, *supra* note 4, at 602.

Massachusetts subsidized the purchase of insurance up to 300 percent of FPL,¹³⁰ and the Health Reform Law will provide for subsidies up to as high as 400 percent of FPL.¹³¹

Nonetheless, even with such subsidies, the mandate is still prone to be regressive anywhere above subsidy levels. Imagine someone earning 500 percent of FPL pays the same premium as someone earning 600 percent of FPL. The lower income individual still pays a higher percent of his income for health insurance. This result proves difficult to avoid unless health insurance were provided to all Americans and funded entirely through proportional or progressive taxation.

A second concern with health redistribution, as opposed to income redistribution, is that the weight of health redistribution lies of the shoulders of the financiers, who are likely healthy and, for the most part, young.

There are good reasons to believe it is not fair to ask the young to bear the costs of care for those older and sicker than themselves. Nearly 30 percent of the uninsured are between nineteen and twenty-nine years old.¹³² Many of these uninsured are making a decision not to buy insurance because they are at low risk of incurring medical care costs. In the worst of cases, they can access emergency room care even if uninsured because of legal requirements under EMTALA, as discussed above. Many are not earning particularly high salaries. Further, they are at a point where it is critical to invest in their education and careers. The cost of insurance might thwart opportunities for higher education and might deter the young from careers where health benefits are not standard, such as small businesses and start-ups.

We might address such concerns in part by allowing these “invincibles” to comply with a mandate in less burdensome ways or by limiting the portion of the costs of reform we impose on them. Accordingly, we could create plans for the young that are tailored for low-risk individuals, such as the young adult health plans offered in Massachusetts, which have lower premiums in exchange for higher deductibles. We could also allow them to stay on their parents’ insurance longer, which has been permitted in Massachusetts and some other states and included in the Health Reform Law.¹³³ Alternately, Tom Baker and Peter Siegelman propose reinvigorating a form of insurance from nineteenth century life insurance called the Tontine.¹³⁴ Tontines entice young invincibles to purchase insurance by offering a cash bonus for those who buy insurance and use little or no medical care during the policy term.¹³⁵ They benefit from coverage if necessary and, if not, they get a premium rebate to reduce the cost of insurance.

Yet, this burden on the young might be less troubling if framed differently. For example, it could be seen as participation in a cross-

¹³⁰ See Sharon Long, *On The Road To Universal Coverage: Impacts In Massachusetts At One Year*, 27 HEALTH AFF. (WEB EXCLUSIVE) w270, w270 (June 3, 2008).

¹³¹ H.R. 3590, *supra* note 2.

¹³² KFF THE UNINSURED, *supra* note 52, at 4.

¹³³ H.R. 3590, *supra* note 2. Farhana Hossain & Archie Tse, *Comparing the House and the Senate Health Care Proposals*, N.Y. TIMES, Feb. 23, 2009, <http://www.nytimes.com/interactive/2009/11/19/us/politics/1119-plan-comparison.html#tab=9>.

¹³⁴ See Baker & Siegelman, *supra* note 83, *passim*.

¹³⁵ *Id.* at 3.

generational subsidy; in essence, the young subsidize their parents' insurance. Further, their participation helps to stabilize a regime of more moderate premiums for older insureds that they will enjoy as adults, so their higher payments today could be seen as forced savings for health insurance for their future selves. Finally, the tradeoff of allowing healthy young to pay less for insurance, or to qualify for a rebate when healthy, is diminished potential for health redistribution. It is in essence a form of fragmentation, as discussed below, that thwarts goals of health redistribution.

With health redistribution's less appealing attributes of being regressive and burdening the young, why do some advocate for it? The next section answers this question by probing the particular benefits of health redistribution – political, pragmatic, and moral – and whether such benefits outweigh these potential burdens on the poor and young.

2. Benefits from Health Redistribution

a. Political and Pragmatic Benefits of Health Redistribution

The mandate's ability to promote health redistribution could generate both political and pragmatic benefits.

First, health redistribution may be necessary politically in order to raise sufficient funding for health reform. Subsidizing low-income uninsureds is estimated to cost over \$80 billion per year.¹³⁶ With the unpopularity of increased taxation, relying on it alone to cover subsidies of \$80 billion a year may make reform politically impossible. Successful health redistribution enables some subsidization to occur more discreetly within the bounds of risk pools because participation of the healthy lowers the average cost of premiums. By doing so, it can lessen the subsidies that must be funded through taxes.

Second, some believe health redistribution might offer a less costly way to address distributive justice concerns.¹³⁷ If we conceptualize health as a component of wealth separate from income, we might want to tax it separately for equity reasons.¹³⁸ Income wealth is a crude categorization of wealth and the primary one that we tax. But it might not be a sufficient measure of overall wealth. Imagine two people earn equal income but one has a congenital heart defect that limits his energy and mobility and requires expensive medical care over his entire life. It is reasonable to believe that the sick individual is worse off than the healthy one, despite their equal earned income. Because health can be an important determinant of overall welfare, some advocate treating health as a separate category of wealth that should be

¹³⁶ See CONGRESSIONAL BUDGET OFFICE, PRELIMINARY ANALYSIS OF THE CHAIRMAN'S MARK FOR THE AMERICA'S HEALTHY FUTURE ACT, AS AMENDED: LETTER TO THE HONORABLE MAX BAUCUS 2 (October 7, 2009), available at http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf (estimating a gross total of \$829B over the next 10 years for credits and subsidies to expand insurance coverage, resulting in an estimated net cost of \$518B over the next 10 years after revenues from additional taxes and other sources).

¹³⁷ See Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1490-91 (1994).

¹³⁸ See e.g., NORMAN DANIELS, *JUST HEALTH* (2008) (examining the role of health in social, political, economic policy).

separately taxed; the mandate functions as a flat health tax for such purposes.¹³⁹

Even if health is not considered morally distinct from other core needs, such as shelter, nutrition, or a healthy environment, and thus has no inherent claim to differential treatment, health redistribution may still be appealing as a way to respond to distributive justice concerns while minimizing labor distortion.¹⁴⁰ Professor Einer Elhauge argues that there are fewer reasons to oppose egalitarian distribution of health care because it meets a variable need with less harm to productive incentives than is true for other goods.¹⁴¹ This is because, first, people do not want to be sick and thus will not try to remain sick to continue getting benefits, which are distributed in the form of medical care.¹⁴² And second, there is little bureaucracy necessary to determine who is deserving of benefits as need is determined as part of the provision of medical care.¹⁴³ Thus, health redistribution provides a more efficient way to take care of the poor or vulnerable, and in doing so it may also increase overall labor productivity to the extent healthier people are able to contribute more to society.¹⁴⁴

In line with this argument, health redistribution may be appealing if we believe health tracks more closely to ability to earn income than actual earned income does. If our distributive goal is to provide for people unable to provide for themselves, health redistribution might be a more precise way to distribute resources to those unable to earn sufficient income because they are sick or injured, rather than to those who earn little income by choice.

Finally, by achieving broad health redistribution, the mandate can unlock significant efficiency in insurance markets through more comprehensive elimination of adverse selection than can be achieved through a mandate that does not promote broad health redistribution. This is because broad risk pooling – not the mandate on its own – is what unlocks part of the efficiency gains people anticipate might result from the mandate's effect on adverse selection.

As discussed in Part II.B, high administrative costs arise when insurers try to select out healthy customers and differentially treat higher-risk ones, and the mandate alone will not eliminate such sorting. There are two ways to solve this inefficient and expensive sorting that arises out of informational asymmetry between insurers and customers. First, assuming it were possible, we could provide insurers perfect information on every applicant and allow them to use such information so that insurers could underwrite all applicants with perfect accuracy and little effort. Imagine this approach were possible and that the insurance market were to become more efficient because insurers are able to perfectly gauge an individual's expected risk at no cost. This market would limit an individual's premium costs to his own projected

¹³⁹ *See id.*

¹⁴⁰ Elhauge, *supra* note 137, at 1490-91.

¹⁴¹ *Id.*; but cf. Louis Kaplow & Steven Shavell, *Why the Legal System is Less Efficient than the Income Tax in Redistributing Income*, 23 J.L. STUDIES 667, 667 (1994) (arguing that distribution is most efficient through taxation, rather than through legal rules).

¹⁴² Elhauge, *supra* note 137, at 1488.

¹⁴³ *See id.* at 1487.

¹⁴⁴ Gostin, *supra* note 12, at 28.

risk of sickness in the coming year.¹⁴⁵ The benefit of this type of perfect actuarially-rated system is that the majority of people (who are low-risk) can obtain health insurance for the lowest possible premiums. The problem with this system is that higher-risk individuals bear the full cost of their own risk. There is less smoothing of premiums over a lifetime and among beneficiaries. This approach opts to leave some people uninsured (the more vulnerable or high-risk populations who will face prohibitively high insurance premiums) in return for low cost insurance and an absence of coercion for the majority of insured, who are low-risk.¹⁴⁶ Such a result – while efficient – would likely not appeal to many who support the mandate, even those who would claim their support is in the name of increased efficiency. Furthermore, this approach would require providing genetic information and family health history to insurers in a way that is likely unacceptable to Americans and, not surprisingly, has been prohibited legislatively.¹⁴⁷

Alternatively, and perhaps the only real option in light of our present inability to provide insurers with perfect information even if we wanted to do so, we could blind insurers to risk altogether so that they charge every enrollee the same premium. This approach is health redistribution at an extreme, completely divorcing insurance pricing from individual risk. In a system of perfect health redistribution, we would pool all risk and charge everyone the same prices for insurance (or in a modified system, charge differential prices based upon standardized rules for a limited and objectively-defined population, such as providing 19-25 year olds plans at lower prices). Insurers would no longer benefit from underwriting and risk selection and presumably would stop engaging in these expensive practices. Thus, to the extent the mandate is able to draw people into markets that promote broad health redistribution, it can better unlock health insurance market efficiencies. The mandate's redistributive and efficiency objectives become inextricably linked because achieving the redistributive objective is a gateway to enhancing efficiency.

b. Solidarity through Health Redistribution

Finally, many scholars and policymakers have supported health redistribution as a means to institutionalize a more solidaristic regime of

¹⁴⁵ There will still be ex-post pooling of losses. That is, if I experience a \$2M loss this year, others' premium dollars will help to pay for my loss because even with risk spreading over my lifetime, I will never pay enough to cover my loss this year.

¹⁴⁶ See Len M. Nichols, *State Regulation: What Have We Learned So Far?*, 25 J. HEALTH POL., POL'Y & L. 175, 176 (2000). The approach is not inconsistent with universal coverage. The government could choose to build universal insurance by filling in holes left by the market (and has in some ways done so now with public insurance programs, EMTALA, and publically funded free care) by subsidizing the high-risk people who cannot afford to pay or those who experience unexpected and unaffordable medical costs. Yet, government intervention in this way may create incentives for everyone to buy cheap, low coverage policies and then seek out governmental assistance if they require expensive care.

¹⁴⁷ The Genetic Information Nondiscrimination Act, or GINA, which was signed into law by President Bush in 2008, prohibits insurers from using genetic information in medical underwriting. Pub.L. No. 110-233, 122 Stat. 881 (2008).

health insurance in the U.S.¹⁴⁸ Solidarity manifests when a particular goal is deemed important enough to warrant a coordinated approach to achieving it, even if some people may, in the end, contribute more than they, as individuals, receive in return.¹⁴⁹ Solidarity depends upon people acting from more than simple self-interest, a motivation scholars have identified as “other-regarding behavior” or “altruism.”¹⁵⁰ With respect to health, the goal is often described as ensuring everyone in the community who needs medical care has equitable access to it.¹⁵¹ Professor Deborah Stone notes that “the *ideal* of the solidarity principle is that we should strive to distribute medical care according to medical need and to limit the influence of ability to pay, past consumption of medical care, or expected future consumption.”¹⁵²

This section explores how some supporters of the mandate see it as the key to creating a more solidaristic system of health insurance through health redistribution. The final subsection explores whether creating a system of broad health redistribution might endogenously begin to redefine the level of mutual aid Americans expect to give and receive within a health insurance system.

i. Comparative, historical, political, and popular support for solidarity

Solidarity is a value most industrialized nations identify as key to their systems of health insurance. Uwe Reinhardt describes solidarity as the foundation of social insurance institutions: “In Europe, as in Canada, that social ethic is based on the *principle of social solidarity*. It means that health care should be financed by individuals on the basis of their ability to pay, but should be available to all who need it on roughly equal terms. The regulations imposed on health care in these countries are rooted in this overarching principle.”¹⁵³ Likewise, Richard Saltman similarly calls solidarity the “core animating principle” of European social health insurance systems.¹⁵⁴

¹⁴⁸ See sources cited in *supra* note 12 for examples of scholars who advocate policies of health redistribution, including but not exclusively considering the mandate, in order to institutionalize greater solidarity.

¹⁴⁹ E.g., Stone, *supra* note 12, at 290-91. In order to finance universal coverage, there must be either shared commitment by all citizens to be willing to subsidize others or coercion of some to contribute. See Marmor & Oberlander, *supra* note 1, at 212.

¹⁵⁰ See, e.g., Gillian Lester, Means Testing, Universalism, and the Formation of Social Preferences 20-22 (August 24, 2009) (unpublished draft, abstract *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1461098).

¹⁵¹ For examples of authorities on solidarity and health insurance, see *supra* note 12. “Need” can be defined in any number of ways. It is beyond the scope of this article to determine the level of need that solidarity requires. For this article, it is sufficient for insurance to *equitably* protect all members of a community. In addition, solidarity with respect to health may demand that a community do more than just ensure medical care. It could also demand that the community provide for clean water, shelter, healthy food, and other needs that are key determinants of health. While solidarity could apply to any of these needs, this article focuses solely on medical care since that is the concern of the mandate for health insurance.

¹⁵² Stone, *supra* note 12, at 292.

¹⁵³ Reinhardt, *supra* note 21. Gösta Esping-Anderson describes how “social democracy,” a welfare state model most common in Scandinavian countries, seeks solidarity in the form of “an equality of the highest standards.” GÖSTA ESPING-ANDERSEN, *THE THREE WORLDS OF WELFARE CAPITALISM* 27, 75 (1990).

¹⁵⁴ Saltman, *supra* note 25, at 27.

While not always the dominant or explicit value behind policies in the United States, a desire to collectivize certain risks does influence how we have organized important and highly popular American social welfare programs. Take the example of Social Security. The Federal Insurance Contributions Act (FICA) mandates that all workers contribute FICA, or payroll taxes, for Social Security.¹⁵⁵ These dollars are pooled and then redistributed to eligible applicants (primarily the disabled and those over sixty-five years old) according to a benefits calculation.¹⁵⁶ This benefits determination serves a progressive redistributive function so that workers with low earnings will have sufficient income for retirement. The lowest 1/5 of earners has a ratio of benefits-to-taxes almost three times as high as the top 1/5 of earners.¹⁵⁷ We (or the working majority of us) all are compelled to pay into a system of savings, knowing that we may eventually receive less than we have contributed over our lifetime, and perhaps acknowledging the universal importance of income security in retirement. Our contribution ensures that both we and the members of our community will enjoy such income security.

Professor Bill Sage recently reflected that even though solidarity may not be the most fashionable of American values, it nonetheless weaves through American health policy.¹⁵⁸ American health insurance has early roots in more solidaristic models, and while the industry has moved further away from collective responsibility over the past fifty years, notions of solidarity still underlie key elements of American health insurance.¹⁵⁹ On the private insurance side, group health insurance pools risk among all members of the group, and mandated benefit laws promote broader risk pooling for certain conditions by requiring all insurance policies issued in a state cover a particular condition, as discussed further in III.B.1 below. And the patchwork of social insurance programs discussed in Part I above (e.g., Medicare, Medicaid, SCHIP) are based on the notion of ensuring some Americans access to medical care, regardless of ability to pay.

Many have voiced support for the mandate as a tool that can reignite a more broad-based solidaristic health insurance system in the U.S. Scholars have recognized mandated insurance as a possible means to expand risk pools and spread health risks more collectively.¹⁶⁰

In recent debates, policymakers regularly invoke the value of solidarity in support of the mandate. The Conference Committee report from the Massachusetts reform effort explained: “Requiring those who can afford health insurance to purchase coverage is fair By requiring everyone to have coverage, those who are healthy and currently uninsured will enter the insurance risk pool and thus help to stabilize the cost of premiums for the currently insured.”¹⁶¹ In his speech to Congress on health reform on

¹⁵⁵ 26 U.S.C. § 3101 (2006).

¹⁵⁶ See CONG. BUDGET OFFICE, ECON. AND BUDGET ISSUE BRIEF: IS SOCIAL SECURITY PROGRESSIVE? 2 (2006).

¹⁵⁷ *Id.* at 3. The progressivity is limited by the fact that higher earners tend to live longer. See *id.* at 5.

¹⁵⁸ William M. Sage, *Solidarity: Unfashionable, But Still American*, in CONNECTING AMERICAN VALUES WITH HEALTH REFORM 10, 10-12 (Mary Crowley ed., 2009).

¹⁵⁹ See Part III.A below.

¹⁶⁰ See, e.g., Mariner, *supra* note 12, at 205-06; Monahan, *supra* note 12, at 333-34.

¹⁶¹ CONFERENCE COMMITTEE REPORT, *supra* note 69, at 4.

September 9, 2009, which some credit with reigniting a then diminished support for reform, President Obama spoke of late Senator Ted Kennedy and notions of solidarity as he asked Americans to act together to reform health insurance:

“That large-heartedness – that concern and regard for the plight of others – is not a partisan feeling It, too, is part of the American character. Our ability to stand in other people's shoes. A recognition that we are all in this together; that when fortune turns against one of us, others are there to lend a helping hand

This has always been the history of our progress. In 1933, when over half of our seniors could not support themselves and millions had seen their savings wiped away, there were those who argued that Social Security would lead to socialism. But the men and women of Congress stood fast, and we are all the better for it. In 1965, when some argued that Medicare represented a government takeover of health care, members of Congress, Democrats and Republicans, did not back down. They joined together so that all of us could enter our golden years with some basic peace of mind.”¹⁶²

Obama's appeal invokes the value of solidarity by asking Americans to stand in others' shoes to recognize a common plight and to help create security for everyone against the costs of poor health.

The American populace has expressed willingness to act in solidarity with respect to health reform. Americans are clearly concerned with the high numbers of uninsured in the country. A recent poll reports that 94 percent of people think it is a very or somewhat serious problem that many Americans do not have health insurance.¹⁶³ And while the American public has at times hesitated to embrace health solidarity because of resistance to interpersonal redistribution,¹⁶⁴ this same poll suggests that this trend may be shifting. Nearly 60 percent of those polled said they were willing to pay higher taxes so that all Americans have insurance “they can't lose no matter what.”¹⁶⁵

ii. Normative bases for solidarity and policy design implications

Advocates for a more solidaristic health insurance system might root their support in several different normative justifications.¹⁶⁶ Each of these justifications would lead to a different vision of how solidarity translates into policy, including who and what types of medical care are included within the bounds of a system of solidarity.

Some believe that health is inherently special, and medical care should be treated as a merit good, rather than allocated by the market based upon

¹⁶² Barack Obama, U.S. President, Health Care Speech to Congress (Sept. 9, 2009), *in* N.Y. TIMES, <http://www.nytimes.com/2009/09/10/us/politics/10obama.text.html>.

¹⁶³ CBS News & N.Y. Times Poll, The Debate Over Health Care, at Question 54 (June 12-16, 2009), http://www.cbsnews.com/htdocs/pdf/CBSPOLL_June09a_health_care.pdf.

¹⁶⁴ Stone, *supra* note 12, at 289-90.

¹⁶⁵ CBS News & N.Y. Times Poll, *supra* note 163, at Question 59.

¹⁶⁶ *See, e.g.*, 1 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE: THE ETHICAL IMPLICATION OF DIFFERENCES IN AVAILABILITY OF HEALTH SERVICES (1983) [hereinafter PRESIDENT'S COMMISSION]; Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449 (1994) (providing framework of moral arguments for treating health differently); NORMAN DANIELS, JUST HEALTH CARE 36-58 (Daniel I. Wikler ed., 1985).

ability and willingness to pay.¹⁶⁷ Variations of this argument include, for example, that health is necessary to exercise rights of citizenship,¹⁶⁸ for achieving personal satisfaction or happiness,¹⁶⁹ or to obtain reasonable opportunities in life.¹⁷⁰ In other words, some believe health is a foundational need and for this reason support a norm of more equitable access to medical care.¹⁷¹ This view might align with a Rawlsian conception of factors that should not limit access to benefits of society.¹⁷²

Alternatively, others experience moral guilt from allowing another person to suffer¹⁷³ and thus believe we should act in solidarity out of “empathy-altruism.”¹⁷⁴ For example, as evinced by the existence of EMTALA, many of us would not allow someone to bleed to death after a car accident because he is uninsured or unable to pay for care. A mandate could thus serve to prevent some from suffering from lack of care and others from experiencing distress because of such suffering.¹⁷⁵

These above two justifications would lead to a fairly unbounded conception of health solidarity and thus a broad system of health redistribution. In other words, such views would support a solidaristic system where we collectively fund treatment for sickness or injury for anyone, regardless of the source or cause, if the sickness or injury is an impediment to certain basic opportunities, or if it causes suffering. Yet proponents of each of these views would have a different priority for spending health care dollars. For example, someone who subscribes to health as a means to life’s opportunities might prefer to address health problems that tend to affect the young with a world of opportunity ahead. They might believe we should first focus on vaccination and well-child care before addressing, for example, diseases of the elderly. In contrast, the empathy altruist would want to spend dollars to alleviate the greatest or most visible medically-related suffering.

Finally, a luck egalitarian might support solidarity out of a belief that no one should suffer the arbitrary, expensive misfortune of poor health, which disproportionately burdens a small proportion of all Americans.¹⁷⁶ Circumstances that evoke solidarity for a luck egalitarian could be a result of

¹⁶⁷ See, e.g., PRESIDENT’S COMMISSION, *supra* note 166, at 16-17; DANIELS, *supra* note 166, at 11-18; Gostin, *supra* note 12, at 34-37; Nichols, *supra* note 146, at 176; Stone, *supra* note 12, at 288.

¹⁶⁸ See, e.g., Gostin, *supra* note 12, at 13.

¹⁶⁹ *Id.*

¹⁷⁰ See, e.g., DANIELS, *supra* note 166, at 39-47.

¹⁷¹ Note that access to medical care might not be the only – or even the most important – determinant of health. Solidarity simply grows out of the belief that it is *an* important determinant of good health.

¹⁷² See generally JOHN RAWLS, *A THEORY OF JUSTICE* (1971).

¹⁷³ See Elhauge, *supra* note 166, at 1483-84.

¹⁷⁴ See Lester, *supra* note 150, at 25.

¹⁷⁵ Cf. Allen E. Buchanan, *The Right to a Decent Minimum of Health Care*, 13 PHIL. & PUB. AFF. 55, 69-70 (1984) (making a related argument for enforced beneficence to coordinate health-related charity desires toward the most effective uses in building infrastructure or innovation).

¹⁷⁶ One must believe that to some degree, we cannot control or foresee health risk, which is, of course, only partially true. It might be easiest to believe that health is arbitrary with respect to genetic factors of illness. Cf. Onora O’Neill, *Genetic Information and Insurance: Some Ethical Issues*, 352 PHIL. TRANSACTIONAL: BIOLOGICAL SCI. 1087 (1997) (arguing that it is not reasonable to differentiate premiums on the basis of unavoidable genetic risk).

one's underlying health endowment (e.g., congenital problems or bad genes) or of idiosyncratic health status (e.g., resulting from a car accident). Medical care costs are distributed so that in any year a small number of people experience tremendously high medical expenses, while most people experience little to no expenses.¹⁷⁷ One percent of the population accounts for over 25 percent of total health care spending in a year (\$43,000 per person in 2005), and ten percent of the population are responsible for almost 70 percent of all medical spending in a year.¹⁷⁸ Yet this population of top spenders changes from year to year. One study estimated that 62 percent of the top ten percent of spenders in 1996 were not in the top ten percent in 1998.¹⁷⁹ A luck egalitarian would believe that because any of us might be a top spender in any one year and often for reasons out of our control, we should share communally in the costs of this arbitrary and significant risk.¹⁸⁰

However, luck egalitarianism must lead to a bounded sense of solidarity because notions of solidarity would end when someone chooses to act in a way that increases her health risk. Poor health could be caused by factors ranging from those completely out of an individual's control (e.g., genetics) to those that may be more in his control (e.g., smoking, drinking, eating poorly). A luck egalitarian might be willing to act in solidarity to help someone with a congenital disease or genetic problem. Yet, if two people are born with the same level of risk but the first eats fast food for lunch every day and develops heart disease and the second does not, the luck egalitarian might believe it is unfair to ask the healthy person to subsidize medical care for the fast-food eater's heart disease. Similarly, if one person chooses to live in an area where health care is expensive (e.g., Boston) and another chooses to live in an area where it is not (e.g., Minnesota), they might deem it unfair to ask the person in Minnesota to subsidize the one in Boston's expensive care.

Under a luck-egalitarian's policy, some people would thus bear more cost than others to the extent they make choices that increase the total overall medical care costs for society. Their behavior may be contrary to underlying justifications for redistribution. If we were to deem that certain actions, such as living in an expensive medical care locale or eating poorly, were to disqualify someone from enjoying the full benefits of others' solidarity, we could design insurance plans that charge higher deductibles or premiums if someone engages in a particular risk-increasing behavior. By doing so, we both express social disapproval of certain behaviors or choices and simultaneously might deter them.

¹⁷⁷ Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures, Revisited*, 20 HEALTH AFF. 9, 12 (2001); Hall, *supra* note 177, at 3-4. See, e.g., *47 Million and Counting: Why the Health Care Marketplace is Broken: Hearing Before the U.S. Senate Committee on Finance*, 110th Cong. (2008) (statement of Mark A. Hall, J.D., Fred D. and Elizabeth L. Turnage Professor of Law and Public Health, Wake Forest University) available at <http://finance.senate.gov/hearings/testimony/2008test/061008MHTest.pdf> (testified that the key challenge in reform is to "place people into large groups whose membership is not tied to health risk, and to limit the choice of plans within the group.").

¹⁷⁸ Berk & Monheit, *supra* note 177, at 12; Hall, *supra* note 177, at 3-4.

¹⁷⁹ Berk & Monheit, *supra* note 177, at 12.

¹⁸⁰ Stone, *supra* note 12, at 292. See also Michael J. Graetz & Jerry L. Mashaw, TRUE SECURITY: RETHINKING AMERICAN SOCIAL INSURANCE (1999).

On the other hand, the determinants of such life “choices” or behaviors that increase medical risk may in fact be more complex. Studies on these “social determinants of health” have established that factors such as lack of education, poverty, and characteristics of one’s environment are highly correlated with poor health behaviors.¹⁸¹ Because these factors are largely out of one’s control and make it more likely someone will smoke or eat unhealthy foods, even a luck egalitarian might not want to penalize this person for damage to his health resulting from such actions.

Thus, even those who support health redistribution as a means to promoting health solidarity might disagree on how to define what types of medical risks must be shared within the bounds of a system of solidarity, depending on their underlying normative belief for why health solidarity is important. Although the particular place where we bound solidarity is a complex consideration, it does not bear on the underlying value many see for the individual mandate in terms of promoting solidarity. What is important is that under a solidarity-based system, such limits would be agreed upon communally, rather than delegated to and determined by insurers on the basis of profitability.

iii. Institutional construction of solidarity

This final section briefly explores the notion that implementation of a system of health redistribution, if successful, can endogenously grow solidarity – an idea I will return to briefly in Part IV, even though a full discussion of this idea is beyond the scope of this article. In other words, the question I pose is whether an individual mandate – if able to achieve broad health redistribution and provide all Americans access to medical care when in need– can grow democratic legitimacy for the notion of collectivizing risk in the name of more equitable access to medical care. Long-term and strong public support for similar redistributive programs of shared risk and social benefit, such as Medicare and Social Security, suggest that the notion is at least plausible. If true, the mandate’s ability to promote broad health redistribution might in fact enhance its long-term legitimacy and sustainability.

It is perhaps paradoxical to consider compelling someone to act in solidarity by mandate. Even if a majority would choose to act in solidarity, the participation of the oppositional minority is still necessary for the mandate to achieve its objectives. Use of a mandate coerces the minority in the name of the majority’s collective desire to achieve such objectives.

But longer term, the need for such coercion might diminish if a mandate that institutionalizes solidarity is able to shift norms that have been established by traditions of market-based distribution and individualism toward norms of collective responsibility; that is to say, a mandate might redefine what we consider individual versus collective responsibility. Professor Tom Baker calls this the “social construction of responsibility.”¹⁸² For example, establishing Medicare and requiring participation in it might

¹⁸¹ See generally Jonathan S. Feinstein, *The Relationship Between Socioeconomic Status and Health: A Review of the Literature*, 71 *THE MILBANK Q.* 279 (1993).

¹⁸² BAKER & SIMON, *supra* note 12, at 47.

gradually change how we determine who is responsible for providing health care for the elderly and might even result in growing favor for the program over time.¹⁸³ The institutions may need to come first, and broad support may follow.

At the most basic level, it is reasonable to believe that an individual mandate, because of required high participation, is likely to create investment in the program among participants and other interested parties.¹⁸⁴ Such investment could work to the benefit of the individual mandate if the invested parties are satisfied with the benefits the mandate generates and want to preserve such benefits. For example, in Massachusetts, aligning all interest groups around the initial health reform, aimed at enhancing coverage by individual mandate, has lubricated discussion of cost-cutting efforts, which had historically proven quite thorny, because such efforts are now perceived as necessary to preserve progress made to date on reform.¹⁸⁵ The concentration of interests may have also prompted the media spotlight on anti-competitive behavior among the Commonwealth's insurers and providers that contributed to rising medical costs in the state.¹⁸⁶ With such problems exposed, invested parties have the knowledge and incentive to address them to preserve the fiscal sustainability of reform.¹⁸⁷

But is it possible that a system of collective participation and mutual aid could do more than motivate coordinated political action because of sunk costs? Could it enhance the long-term legitimacy of sharing risk? In describing social health insurance programs in Europe, Richard Saltman calls them a "way of life," engendering great loyalty, suggesting there is at least some level of attachment to, if not deeper connection with, European social insurance programs.¹⁸⁸

Scholars of the sociology of insurance and of the welfare state contend that the way we design our insurance institutions bears greatly on the way that we think about suffering and responsibility¹⁸⁹ and can enhance the perceived legitimacy of using of social programs and insurance to spread

¹⁸³ Over three-quarters of Americans now support Medicare and Social Security, even though many pay more into these programs than they will ever collect in benefits. Harris Interactive, The Harris Poll, Poll #92 (Dec. 21, 2005), http://www.harrisinteractive.com/harris_poll/index.asp?PID=620. Support for Social Security has grown from 68% in 1936, when enacted, to as high as 86% in the late 1990s. MATTHEW C. PRICE, JUSTICE BETWEEN GENERATIONS: THE GROWING POWER OF THE ELDERLY IN AMERICA 82-83 (1997).

¹⁸⁴ Lester, *supra* note 150, at 15. On the flip side, such investment could be seen as stickiness that might preserve a bad program just as easily as a good one.

¹⁸⁵ Jon Kingsdale, *Implementing Health Care Reform in Massachusetts: Strategic Lessons Learned*, 28 HEALTH AFF. (WEB EXCLUSIVE) w588, w592 (May 28, 2009).

¹⁸⁶ Partners HealthCare, the largest group of providers in the Commonwealth, has been accused of demanding high rates from insurers in return for inclusion in the insurer's network. Since insurers have little choice but to include Partners physicians, they have agreed to the demanded rates. Scott Allen et al., *A Healthcare System Badly Out of Balance*, BOSTON GLOBE, Nov. 16, 2008, at A1.

¹⁸⁷ Kingsdale, *supra* note 185, at w589-90 (discussing the importance of cost containment for sustaining the near-universal health care coverage in Massachusetts).

¹⁸⁸ Saltman, *supra* note 25, at 6.

¹⁸⁹ See e.g., EMBRACING RISK (Tom Baker & Jonathan Simon eds., 2002); Hunter, *supra* note 9, at 57; Simon, *supra* note 16, 787-95.

economic risks.¹⁹⁰ Tom Baker calls this the “use of risk in the social construction of reality.”¹⁹¹ He writes:

“The development of insurance institutions shapes, in turn, what is imaginable about the meaning of participation in insurance institutions. The more that insurance institutions adapt to satisfy self-interest, the more the satisfaction of self interest will seem to be the natural role of insurance institutions and the more far-fetched the idea of using insurance to achieve solidarity The debate over the government’s role in the U.S. health insurance is, in significant part, a debate over the nature of health insurance: does it exist to protect me and mine, or does it serves a greater good?”¹⁹²

Deborah Stone suggests that insurance not only shapes our notions of insurance but also shapes larger culture and behavior: “Insurance is a social institution that helps define norms and values in political culture, and ultimately shapes how citizens think about issues of membership, community, responsibility, and moral obligation.”¹⁹³ Conversely, Jonathan Simon suggests that actuarial practices that limit risk pooling “construct groups along dimensions that erode the basis of collective identity and action.”¹⁹⁴

By this logic, the mandate, if successful at health redistribution, might affirm a conception of health insurance as an institution where all should share collectively in risk to achieve a social good. The institution itself might construct a reality in which it is more likely for someone to favor (or at least not oppose) health redistribution.

Gillian Lester’s recent article considers whether universal social welfare programs might be able to actuate altruism endogenously in a way that would ease constraints on redistribution.¹⁹⁵ She considers possible mechanisms through which a universal program might do so, based upon its ability to create the conditions that studies in psychology and economics have identified that tend to invoke altruism.¹⁹⁶ Altruism might grow, for example, from a sense of reciprocal benefit from, and stewardship over, a shared program¹⁹⁷ or from “empathy-altruism,” when someone identifies with needs of another, which is most likely to occur when both people are members of a salient group.¹⁹⁸

In contrast, using means-tested programs and income taxes to effect redistribution may be solidarity-diminishing over time. Sociologist Gösta

¹⁹⁰ Cf. BAKER & SIMON, *supra* note 12, at 46; ESPING-ANDERSON, *supra* note 153, at 66-68; Lester, *supra* note 150, at 40-42.

¹⁹¹ BAKER & SIMON, *supra* note 12, at 18.

¹⁹² *Id.* at 46-47.

¹⁹³ Deborah Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, in EMBRACING RISK 52, 54 (Tom Baker & Jonathan Simon eds., 2002).

¹⁹⁴ Simon, *supra* note 16, at 790.

¹⁹⁵ Lester, *supra* note 150, at 40-42.

¹⁹⁶ *Id.* at 22-31, 43-46; see also Ernst Fehr & Herbert Gintis, *Human Motivation and Social Cooperation: Experimental and Analytical Foundations*, 33 ANN. REV. SOC. 43 (2007); Ernst Fehr & Klaus M. Schmidt, *The Economics of Fairness, Reciprocity and Altruism – Experimental Evidence and New Theories*, in 1 HANDBOOK OF THE ECONOMICS OF GIVING, ALTRUISM & RECIPROCITY 615 (Serge-Christophe Kolm & Jean Mercier Ythier eds., 2006).

¹⁹⁷ Lester, *supra* note 150, at 46.

¹⁹⁸ *Id.* at 25.

Esping-Anderson writes that means-tested programs draw a line between the haves, who are self-sufficient, and the have-nots, who are not.¹⁹⁹ There is no longer one community working toward a goal but rather a clear distinction between those in need and the others who pay to fulfill their need.²⁰⁰ These types of distinctions create potential for devolution into stratification and negative stereotypes, such as the “Welfare Queen,” that erode solidarity and may in fact threaten the legitimacy of social welfare programs in the long-term, as the Welfare Queen did for Aid For Dependent Children (AFDC).²⁰¹

Early public surveys hint at the possibility of slowly shifting norms in Massachusetts. Public support of the individual mandate has grown from 52 percent in 2006, when the reform was passed, to 58 percent in 2008, post-implementation.²⁰² Support for the overall reform grew over the same period from 61 to 69 percent.²⁰³ While the cause of this increased support is not clear, it is possible residents are growing comfortable with the idea of belonging to a shared system under the mandate.²⁰⁴ Thus, by collectivizing risk among all Americans and providing, in return, access to care when in need, it is possible to conceive that the individual mandate might catalyze a more solidaristic way of conceptualizing health insurance. Over time, doing so might grow public legitimacy and durability of a system of universal coverage reliant on interpersonal redistribution.

D. COMPLIANCE AND MEASURING SUCCESS

Evaluations of the individual mandate have relied upon percent compliance, which is a measure of the number of uninsured converted into consumers of health insurance, to gauge whether the mandate is successful.²⁰⁵ When equating compliance with success, most experts project that an individual mandate will in fact succeed,²⁰⁶ as evinced by results in Massachusetts, where three years into implementation of the mandate nearly 98% of the state’s residents are insured.²⁰⁷

¹⁹⁹ ESPING-ANDERSEN, *supra* note 153, at 64-65.

²⁰⁰ *Id.*

²⁰¹ *Id.* This type of concern may be diluted in a mandates plus subsidies approach, but only if the perception of the universality of the program is stronger than any stigmatization from line drawing.

²⁰² Blendon et al., *supra* note 19, at w560.

²⁰³ *Id.*

²⁰⁴ This comfort could, of course, grow out of a belief that the reform doesn’t affect them or that even if it does, it’s worth it. Either way, it signals a growing comfort with a redistributive program.

²⁰⁵ See, e.g., Glied, *supra* note 4; Gruber, *supra* note 4.

²⁰⁶ See, e.g., Glied, *supra* note 4, at 1619-20; Gruber, *supra* note 4, at 601. A study by the Lewin Group assessed ten proposals to expand coverage. The four that included an individual mandate appear likely to achieve significantly higher levels of coverage. See JOHN SHIELS & RANDALL HAUGHT, THE LEWIN GROUP, COST AND COVERAGE OF TEN PROPOSALS TO EXPAND HEALTH INSURANCE COVERAGE 2-3 (2003).

²⁰⁷ SHARON K. LONG & KAREN STOCKLEY, URBAN INST., HEALTH INSURANCE COVERAGE AND ACCESS TO CARE IN MASSACHUSETTS: DETAILED TABULATIONS BASED ON THE 2008 MASSACHUSETTS HEALTH INSURANCE SURVEY 3 (2009), *available at* http://www.mass.gov/Eeohhs2/docs/dhcfp/r/survey/08his_detailed_tabulations.pdf. Based on 2008 tax filings, only 97,000 people had access to affordable coverage and remained uninsured, a number expected to decrease as penalties increase. JOHN HOLOHAN & LINDA

While compliance is an important measure of success, it is an insufficient measure of the mandate's ability to achieve the three different potential objectives, explored in this proceeding Part.²⁰⁸ Compliance primarily measures the mandate's impact on uninsured as consumers (or non-consumers) of health insurance. Thus, it can at best reflect success on objectives that rely primarily upon the mandate's ability to convert the uninsured into consumers of health insurance.

Paternalism and efficiency objectives depend largely on the mandate's ability to convert the uninsured into consumers of insurance. This is not to say that the mandate's influence over financiers and ability to promote health redistribution has no bearing on these objectives, because it certainly does. It is only to say that if the mandate were to lead to universal coverage, paternalism and efficiency objectives would be met with some reasonable level of success.

High compliance serves as a reasonable proxy for paternalistic goals, so long as insurance coverage provides sufficient health and financial protection to make purchasing it of value to the insured. With a significant and growing problem of underinsurance, as the cost of insurance increases, it will be more difficult for insurance to provide such protection as some would hope. For example, if a low-income purchaser buys a high deductible policy, where he must pay the first \$5000 in expenses out-of-pocket, it is possible he won't be able to afford to access medical care or will face financial problems if he does obtain necessary care and is billed for the \$5000 deductible. Likewise, if a policy carves out certain conditions or caps coverage at low limits, the same may occur. To the extent these problems are exacerbated by fragmentation and not just by problems inherent in the high cost of medical care translated into insurance premiums, paternalistic objectives might also face problems due to the fragmentation discussed below.²⁰⁹

Compliance also provides some (albeit imperfect) measure of the ability of the individual mandate to increase efficiency. The link between compliance and increased efficiency is more tenuous because efficiency first relies upon individuals becoming consumers of insurance but also relies in part on behavioral shifts by insureds and insurers. For example, to reduce inefficiencies from inappropriate use of ER care, the newly insured must use

BLUMBERG, URBAN INST., MASSACHUSETTS HEALTH REFORM: SOLVING THE LONG-RUN COST PROBLEM 2-3 (2009).

²⁰⁸ Low compliance may also be a sign that a mandate was not well-implemented, not necessarily of fundamental mandate failure, as discussed in a recent article by Professor Sherry Glied and colleagues. Glied et al., *supra* note 4. Compliance is a function of at least four factors: (1) knowledge of a mandate's requirements, (2) penalties for noncompliance, (3) levels of enforcement of penalties, and (4) costs of compliance. *Cf. id.* at 1618-19 (identifying only three of these four factors in their analysis of the effectiveness of mandates on participation in programs).

²⁰⁹ The interconnection between paternalist goals and fragmentation is complicated. For some, a fragmented market works to their benefit if they can obtain inexpensive coverage based on their own risk profile. If they are charged more for premiums when risk pools more broadly, at some point the purchase of insurance might not be in their own interest but rather to serve distributive goals, at least in the short term. It is difficult to identify the level of trade off between paternalist and redistributive objectives across individuals and over time, but there is clearly some trade off.

clinical care when more efficient.²¹⁰ Similarly, perfect compliance eliminates the possibility of adverse selection into health insurance markets and thus should eliminate the standard lemons pricing effect, so long as insurers respond to the lower average risk of insureds by lowering the price of the average premium accordingly.

Compliance, on the other hand, is a necessary yet entirely insufficient measure of the mandate's ability to promote health redistribution. Compliance is a precondition; at the most basic level, everyone must participate so that insurance can be used as the mechanism to pool risk for everyone. Yet compliance entirely fails to gauge the impact of the mandate on the uninsured as financiers of care. Understanding whether the mandate's influence over potential financiers does in fact result in effective health redistribution relies upon understanding how well the financiers pool risk and fund medical costs for those sicker than themselves.

Thus, reliance so far in the literature on compliance to measure the individual mandate's success has particularly obscured the mandate's potential, and I argue certain failure, to promote redistributive objectives and capture the anticipated benefits from doing so. In Part III of this paper, I will show that the fragmentation of insurance markets makes it structurally impossible for the mandate to promote health redistribution, even in the case of perfect compliance. Unless fragmentation is understood and addressed, the best a mandate could do would be to serve paternalist objectives and to capture some part of the efficiencies possible.

IV. THE PROBLEM OF MARKET FRAGMENTATION AND FAILED HEALTH REDISTRIBUTION

Fragmentation of health insurance markets on the basis of risk is a well-documented phenomenon of the American health insurance system.²¹¹ This section does not reveal a novel story of fragmentation but rather augments the stories that have been told in the literature to date in two ways. First, it provides a summary retelling to reveal the full extent of both market-based and regulatory fragmentation of the health insurance market. Second, it analyzes how fragmentation will cause the individual mandate to fail to achieve health redistribution (and to some extent limit its ability to fully achieve paternalistic and efficiency objectives) because fragmentation limits mechanisms for pooling risk and broadly distributing medical costs.

To the extent the mandate fails to achieve health redistribution, it will clearly be unable to seize upon the benefits described above that may result from it, including creating a more solidaristic model of health insurance. Furthermore, a mandate without health redistribution will draw more people

²¹⁰ So far in Massachusetts, emergency department (ED) use for non-emergencies has not decreased. Sharon K. Long & Paul B. Masi, *Access and Affordability: An Update on Health Reform in Massachusetts, Fall 2008*, 28 HEALTH AFF. (WEB EXCLUSIVE) w578, w583 (2009). The shortage of primary care providers may have contributed to this problem. It is also possible that consumers are in a habit of using the ER for non-emergency care.

²¹¹ See, e.g., Austin, *supra* note 16; Hunter, *supra* note 9 (showing that health law as a field is in fact structured around principles of risk allocation); Light, *supra* note 16; Stone, *supra* note 12.

into a system where some (likely those who are poorer or less healthy) face a disproportionately high cost to comply with the mandate.²¹²

Below, I describe how insurance market competition has caused fragmentation and how regulation has both exacerbated and entrenched fragmentation. Finally, I summarize the bottom-line impact of this fragmentation on the mandate's ability to promote health redistribution, drawing evidence from reform in Massachusetts.²¹³

A. MARKET-DRIVEN FRAGMENTATION AND THE RISE OF ACTUARIAL RISK RATING

Fragmentation of the insurance markets grew first and foremost out of a shift from a model of insurance built upon ideals of solidarity to one where competition between commercial insurers is based upon actuarial risk rating and risk selection.²¹⁴ In the early twentieth century, Blue Cross (hospital) and Blue Shield (medical) plans offered open enrollment and community rating, where each group's insurance premium is based upon average expected costs in their broader community, enabling the risks and costs of poor health to be shared among all members of the community.²¹⁵ Blue Cross organizations began to lose market share when commercial for-profit insurers offered premiums based upon a group's actual use of medical expenses.²¹⁶ This practice allowed groups with healthier-than-average employees to buy insurance less expensively.²¹⁷ The commercial insurers selected out (i.e., cherry-picked) low-risk groups and left the Blues with higher-risk groups. As a result, the Blues' average expected costs per subscriber increased, forcing them to increase premiums and causing a business model based on community rating to struggle.²¹⁸

And thus began the ascendance of actuarial risk rating, where insurers price premiums for an individual or group so that if risk-rating formulas accurately predicted experienced costs (which is debated²¹⁹), each enrollee or group would finance its own medical expenses – a concept of insurance antithetical to solidarity because each individual (or group) is presumed

²¹² See Alan Weil, *Increments Toward What?*, 20 HEALTH AFF. 68, 72 (2001). See also sources cited *supra* note 211 (discussing social stratification effects of risk classification practices); see Jost, *supra* note 4 (discussing how differential costs played into a stratified system in Massachusetts); Mariner, *supra* note 12.

²¹³ Many think an individual mandate will face much greater challenges nationally than it did in Massachusetts. Prior to reform, the uninsurance rate in Massachusetts (8-10%) was much lower than the national rate of 16%. Massachusetts also had ready funding ready for reform – a large Uncompensated Care Pool and federal funding of \$385 million from a Medicaid § 1115 waiver. Mary Ann Chirba-Martin & Andres Torres, *Universal Health Care in Massachusetts: Setting the Standard for National Reform*, 35 FORDHAM URB. L.J. 409, 412 (2008); Christie L. Hager, *Massachusetts Health Reform: A Social Compact and a Bold Experiment*, 55 U. KAN. L. REV. 1313, 1315-16 (2007); Elizabeth A. Weeks, *Failure to Connect: The Massachusetts Plan for Individual Health Insurance*, 55 U. KAN. L. REV. 1283, 1297-98 (2007).

²¹⁴ See Stone, *supra* note 39, at 654.

²¹⁵ See Nichols, *supra* note 146, at 180.

²¹⁶ *Id.*; see also Stone, *supra* note 12, at 301.

²¹⁷ See Nichols, *supra* note 146, at 180; Stone, *supra* note 12, at 301.

²¹⁸ See Nichols, *supra* note 146, at 180; Stone, *supra* note 12, at 301.

²¹⁹ See e.g., Simon *supra* note 16, at 784.

responsible for only his (or its) own expected risk. Professor Baker characterizes it as a model with an “individualistic conception of self-interest . . . as the foundation of health insurance.”²²⁰ In this model, insurers’ profit is based on their ability to predict risk accurately and to avoid high-risk (i.e., “uninsurable”) beneficiaries.²²¹ To maximize profit, an insurer seeks to avoid the subscriber who will cost \$50,000 and attract as many as possible who will cost little to nothing.

This section describes the two major ways competition between commercial insurers has driven fragmentation. First, insurers have divided the market into three primary sub-markets – large group, small group, and individual. With this structural fragmentation, risk does not pool among the different markets. Second, in the individual (and less so the small group market), insurers profit based upon their ability to actuarially rate and design policies to individualize risk. This means that higher-risk individuals (or groups) bear higher costs, and the highest-risk individuals (or groups) may be excluded from coverage altogether and thus absorb out-of-pocket the full cost of any health problems they might encounter, as explained below.

1. Structural Fragmentation into Three Sub-Markets

The method for risk selection differs among large groups, small groups, and individual customers. Insurance carriers thus created three different submarkets along these lines, and each insurer generally only operates within one of these three sub-markets.²²² As discussed above, selecting out the healthy members is not important for large groups, where insurers are better able to price premiums accurately in accordance with a group’s overall risk. Within group insurance, each member generally pays the same premium for a plan based upon average group member risk, as required by federal law, so that the cost of medical care for the group is pooled and shared equally among all members.²²³ Healthy members counterbalance the \$50,000 beneficiary so the insurer is less concerned that there are likely to be expensive members within a group. Insurers can fairly accurately determine the expected costs for the group and thus the premium to charge; they then adjust that premium over time based upon the group’s actual expenses.

In contrast, in the individual market, where applicants seek insurance on their own, premiums are based upon an individual’s (or family’s) own expected risk. If an insurer presumes an individual to be high-risk, it will subject him to high premiums, limited coverage (e.g., carve outs for pre-existing conditions or low coverage limits), or may even deny him coverage, to the extent allowed by a state’s laws on insurance issuance and pricing.²²⁴

²²⁰ Baker, *supra* note 12, at 47.

²²¹ See Nichols, *supra* note 146, at 178; Stone, *supra* note 12, at 292-94.

²²² Swartz, *supra* note 44, at 95.

²²³ 26 U.S.C. § 105 (2008); 26 U.S.C. § 125 (2007).

²²⁴ See, e.g., Melinda Beeuwkes Buntin et al., *The Role of the Individual Health Insurance Market and Prospects for Change*, 23 HEALTH AFF. 79, 81 (2004); COLLINS ET AL., *supra* note 57, at 3-4; Michelle M. Doty et al., *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*, COMMONWEALTH FUND PUB. 1300, Feb. 2009, at 1-3.

The small group market is a hybrid between the large group and individual markets. All members in a small group are subject to the same premium, which means that a small group pools risk among its members the same way a large group does. However, insurers often treat a small group more like an individual applicant, underwriting the risk of individual members and designing or pricing policies in line with individual members' risk. This is because in a small group, one or two very high-risk individuals might make it difficult for an insurer to write insurance profitably.

Thus, at the most basic level of fragmentation, insurers created three sub-markets in order to manage the different nature of risk in each. As noted above, with the creation of these three sub-markets, risk is no longer pooled at all across the large group, small group, and individual markets. This means that people in the large group market do not share in the risk of poor health of those in the individual market, causing a problem for health redistribution that I will tease out in subsection 3 below.²²⁵

2. Fragmentation of the Individual Market on the Basis of Individual Risk

Fragmentation also occurs within each of these three markets in a way that limits or defines who will share risk with whom, and to what degree, within each sub-market. In particular, as described above, the nature of actuarial risk rating in the individual (and less so the small group) market is the epitome of fragmentation and is a frequent subject of study by economics, public health, and health law scholars.²²⁶ A perfectly risk-rated system would charge each individual the exact price of her own expected medical care, plus administrative costs and profit. Thus, the more precisely actuarial formulas attempt to predict and divide up medical expenditures, the less risk will pool among individual enrollees. The entire structure of an actuarially-rated individual market attempts to minimize health redistribution among enrollees. This way, insurers can attract those who are perceived as low-risk with the lowest premiums possible because they are only charged for their own expected costs, which are by definition low.²²⁷

As noted above, insurers limit risk pooling (i.e., charge individuals premiums based upon their own risk) through a number of risk selection and pricing mechanisms to the extent allowed by state insurance regulation.²²⁸ For a high-risk applicant, an insurer might quote a premium higher than the standard rate for a particular product, limit the scope of coverage by carving out certain conditions or capping benefits, or deny coverage altogether. All of these practices cause beneficiaries who are deemed higher-risk to pay higher

²²⁵ See HOW PRIVATE HEALTH COVERAGE WORKS, *supra* note 102, at 7.

²²⁶ See, e.g., Austin, *supra* note 16; Hunter, *supra* note 9 (showing that health law as a field is in fact structured around principles of risk allocation); Light, *supra* note 16; Stone, *supra* note 12.

²²⁷ Of course, this expectation does not necessarily translate into low costs.

²²⁸ While it is difficult to generalize about risk selection practices because different practices are permitted or prohibited state-by-state, no state prohibits all risk selection. For an overview of state laws on risk-selection practices, see the Henry J. Kaiser Family Foundation Website, <http://www.statehealthfacts.org/comparecat.jsp?cat=7> (last visited Mar. 5, 2010) (data on regulation in states' small group and individual markets) [hereinafter Statehealthfacts.org].

prices and limit the extent that their risk is pooled with healthier applicants in the individual market, who pay lower prices for the same or better coverage.²²⁹

This is not to say that there is no risk pooling of premiums in the individual market. Some states force risk pooling through laws, such as community rating laws, that require everyone within a community be charged the same or similar premiums, rate bands that restrict the variance in premium prices, pre-existing condition laws that prohibit insurers from excluding certain conditions when issuing insurance, and guaranteed issue laws that require insurers to take all comers.²³⁰ Even without such laws, Economists Mark Pauly and Bradley Herring have identified some pooling occurs across members within the individual market. Their research revealed that while individual market premium prices increase with risk, they increase less than proportionately.²³¹ They hypothesize this pooling occurs because of insurers' diminishing returns from actuarial rating and from assumption of the ability to smooth premiums across an individual's lifetime following enactment of required guaranteed renewal of policies under HIPAA.²³² Finally, even if premiums are charged based upon expected risk, actual expenditures may deviate in a way that leads naturally to ex-post pooling of realized medical costs. Yet, even with some pooling in the individual market, scholars generally agree it is significantly less than in group markets.²³³

Any such limitations to risk pooling result in a situation where higher-risk applicants in the individual market are more vulnerable to not being able to access care when in need than similarly situated applicants in group markets. As discussed above, the process of risk selection results in high overhead costs that make the individual market coverage relatively more expensive, as compared to group market coverage. The small group and individual markets often have higher load factors and less generous policies.²³⁴ These overhead costs and higher premiums for some result in more people priced out of the individual market and other people, who obtain insurance, paying relatively more for coverage.

In 2005, nearly 3 in 5 adults who applied for coverage in the individual market failed to find a plan they could afford because they were denied coverage, charged higher prices, or had a health problem excluded from coverage.²³⁵ One study found that in states with little individual market

²²⁹ Without mandated benefits as part of coverage, fragmentation could also result in a less obvious way by limiting risk pooling for a particular condition. If a condition is included in one policy but not another, risk does not pool among the policy holders for such a condition. See *supra* Part B.

²³⁰ See Statehealthfacts.org, *supra* note 228.

²³¹ MARK V. PAULY & BRADLEY HERRING, POOLING HEALTH INSURANCE RISKS 21, 33-38 (1999); Mark V. Pauly & Bradley Herring, *Risk Pooling and Regulation: Policy and Reality in Today's Individual Health Insurance Market*, 26 HEALTH AFF. 770, 770 (2007). See also Vip Patel & Mark V. Pauly, *Guaranteed Renewability and the Problem of Risk Variation in Individual Health Insurance Markets*, HEALTH AFF. (WEB EXCLUSIVE) w280 (2002) <http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.280v1/DC1> (arguing guaranteed renewability increases pooling in the individual market).

²³² See Pauly & Herring, *supra* note 231.

²³³ See, e.g., Beeuwkes Buntin et al., *supra* note 224 (contending that poor pooling is a significant problem in the individual market).

²³⁴ See Gruber, *supra* note 4, at 574-75.

²³⁵ COLLINS ET AL., *supra* note 57, at 4.

regulation, as many as 30-40 percent of applicants are rejected for coverage.²³⁶ Finally, while half of adults with employer-sponsored coverage rate their coverage as excellent or good, only one-third of those with individual market coverage do so.²³⁷ Thus, this fragmentation creates a market where some people will pay more for the same or less access to medical care than others, and those who are most in need of care might be shut out of insurance markets.

B. REGULATORY-BASED FRAGMENTATION AND INEQUITIES

At the same time, regulation has exacerbated fragmentation within both public and private insurance. As explained in this section, regulatory fragmentation has occurred intentionally through the creation of partial social insurance and, perhaps less intentionally, with passage of the Employee Retirement Income Security Act of 1974 (ERISA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and through tax subsidies for group insurance.

1. Regulatory Exacerbation of Fragmentation

First, Medicare and Medicaid offered an incremental approach to social health insurance, creating an initial divide between public and private insurance as a compromise position following an unsuccessful effort to create national health care in the mid-twentieth century.²³⁸ With the creation of Medicare and Medicaid, Congress, in one fell swoop, lifted the most expensive populations (the elderly and poor disabled) out of private insurance risk pools, making a decision to fund their health insurance through tax revenues. Elderly and disabled populations are now isolated into pools where the average cost per beneficiary is high.

Although taking high-risk populations and providing them with care regardless of ability to pay is desirable for many reasons, doing so has nonetheless largely limited their ability to pool risk with lower-risk individuals.²³⁹ This means that the health costs of the highest-risk populations are not shared society-wide through health redistribution but rather are funded by wealthier taxpayers or through payroll contributions. Such an approach to providing access to medical care, regardless of ability to pay, singles out high-risk groups for differential treatment, maintains a high

²³⁶ *Id.* at 21.

²³⁷ *Id.* at 4.

²³⁸ See DASCHLE ET AL., *supra* note 2, at 47-50, 61-64. For a rich discussion of the politics that led to the creation of Medicare, see THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* (2d ed. 2000). The compromise reached by Presidents Kennedy and Johnson and Ways and Means Chairman, Wilbur Mills became law in 1965 as Medicare Parts A and B and Medicaid. *Id.* at 31-56. In 1997, Congress authorized the State Children's Health Insurance Program (SCHIP) to extend coverage to children in families with income too high to qualify for Medicaid but unable to obtain or afford private health insurance coverage. The Balanced Budget Act of 1997, Title XXI State Children's Health Insurance Program (SCHIP), Pub. L. 105-33, H.R. 2015, 105th Congress (1997).

²³⁹ Medicaid does pool the expensive disabled beneficiaries with some healthy beneficiaries, including poor children and their parents, who are inexpensive. Yet, even with the presence of children in the risk pools, the average cost remains high because Medicaid covers expensive benefits for the disabled, including long term care.

average cost per person, and creates a system, particularly in Medicaid, where high costs are borne more narrowly by wealthier taxpayers.

In the private insurance market, the McCarran-Ferguson Act resulted in two main types of fragmentation. The first is geographical fragmentation. McCarran-Ferguson protected state insurance regulation from unintended intrusion of the federal government.²⁴⁰ With insurance regulation the realm of the states, each state has developed its own health insurance rules and market. Different carriers compete in each state, different rules apply to each market in each state, and risk doesn't effectively pool across state lines for the most part.²⁴¹

Second, fragmentation has also resulted from an interplay between the McCarran-Ferguson Act and ERISA that motivated many large employers to self-fund their health insurance plans and, in so doing, extract their employees into their own risk pool. McCarran-Ferguson prompted an increase in insurance regulation by states freed from concerns of preemption.²⁴² One form such state-level regulation has taken is mandated benefit laws, which require all insurance plans to include particular (typically expensive) medical conditions as a standard benefit.²⁴³ The intended result of such a law is to spread the cost of treating that mandated condition among all insured in a state – essentially risk pooling at the level of a particular condition.²⁴⁴

However, such state insurance regulation also laid the groundwork for fragmentation of the large group market into self-funded plans following the passage of ERISA in 1974, which created uniform requirements for large, multi-state companies in administering their employee benefit plans.²⁴⁵ Through a series of complex judicial interpretations expanding and contracting the bounds of its preemption rule, which Professor Nan Hunter calls the “ERISA accordion,” ERISA has been interpreted to allow large employers to avoid state insurance regulation, including mandated benefit laws, by creating self-funded employee benefit health plans.²⁴⁶ As discussed

²⁴⁰ 15 U.S.C. § 1011 (2006).

²⁴¹ An insurer's highest risks might in effect pool across state lines through some carriers' reinsurance policies.

²⁴² Amy Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361, 1365 (2007).

²⁴³ Every state currently has such mandated benefits laws, which might require insurers to cover certain providers (e.g., chiropractors), benefits (e.g., pediatric care), or patient populations (e.g., students up to the age of 30 on their parents' plans). See VICTORIA CRAIG BUNCH & J.P. WIESKE, COUNCIL FOR AFFORDABLE HEALTH INSURANCE, HEALTH INSURANCE MANDATES IN THE STATES 2008 (2008).

²⁴⁴ One study suggests mandated benefits increase the cost of basic health coverage from 20-50%. *Id.* at 1; Amy B. Monahan, *The Case for Federalizing Mandated Health Benefits*, 32 ADMIN. & REG. L. NEWS 2, 2 (2007).

²⁴⁵ 29 U.S.C. § 1144 (2006).

²⁴⁶ Hunter, *supra* note 9, at 35 (describing ERISA preemption law). ERISA sets standards for employer-sponsored benefit plans, including group health plans, and preempts any state law that “relates to” an employer-sponsored benefit plan. 29 U.S.C. § 1144 (2006). Under *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 651-52 (1995), a state law that has a “connection with” an ERISA plan might also be preempted. Yet, ERISA “saves” from preemption those laws that regulate the business of insurance. 29 U.S.C. § 1144(b)(2)(a) (2006). Nonetheless, the “deemer clause” excludes employee benefits plans from the savings clause, by providing that ERISA plans, such as self-

above, in a self-funded (i.e., self-insured) plan, the employer assumes risk for its employees instead of buying a “fully-funded” plan from an insurer. In return, the employer can design its plan, including choosing covered benefits, so long as it’s in compliance with ERISA.²⁴⁷

Not surprisingly, following ERISA, there was an upsurge of self-funded plans, so that 55 percent of all workers and 77 percent of workers in large companies are now in self-funded plans,²⁴⁸ as compared to just 7 percent 1977, and thereby segregated out of the broader insurance market.²⁴⁹ That is, in a self-funded plan those employees pool their risk only with their co-workers, not directly with any other private purchasers. Furthermore, employers who have healthier-than-average employee populations have greater incentive to self insure to avoid a situation in which their employees pool risk with and subsidize costs for less healthy individuals outside of the company. Although employers with self-funded plans carry reinsurance, which can be seen as a mechanism that pools some self-funded plans’ losses, this coverage only pools a slice of such losses above the attachment point for the policy.

With fewer healthy people in the large group insurance pools, the goals of regulation, such as mandated benefits laws and health redistribution through the individual mandate, which rely upon broad risk pooling, are impeded.

2. Regulatory Exacerbation of Inequities

While federal insurance regulation, through HIPAA and tax law, augments risk pooling for group plans, it simultaneously exacerbates inequities between individual and group markets by not equally facilitating risk pooling in the individual market.

First, Congress passed HIPAA in part to enable people to maintain meaningful coverage when moving between jobs (i.e., portability).²⁵⁰ While HIPAA has largely achieved this goal for enrollees in group markets, because of legislative compromise that limited its scope, it has largely failed to do so in the individual market.²⁵¹ Prior to HIPAA, many states had already begun to implement portability requirements for group markets but not for the individual market.²⁵² Congress was persuaded to design the federal legislation to mirror early state efforts to enable meshing of state and federal standards.²⁵³

HIPAA imposes several requirements on health insurers that in essence promote risk pooling within group markets. HIPAA requires that insurers “guarantee issue” coverage to any applicant and “guarantee renewability” of

insured health insurance, “shall [not] be deemed to be an insurance company or any other insurer” *Id.* § 1144(b)(2)(b).

²⁴⁷ For a discussion of ERISA and mandated benefits, see Amy Monahan, *supra* note 242, at 1371.

²⁴⁸ KFF EMPLOYER HEALTH BENEFITS: 2007, *supra* note 45, at 148, ex. 10.3.

²⁴⁹ Phyllis C. Borzi, *There’s “Private” and Then There’s “Private”: ERISA, Its Impact, and Options for Reform*, 36 J.L. MED. & ETHICS 660, 661 (2008).

²⁵⁰ Pub. L. No. 104-191 § 101, 110 Stat. 1936 (1996) (note description of the Act on the first page).

²⁵¹ See Robert Kuttner, *The Kassebaum-Kennedy Bill – The Limits of Incrementalism*, 337 NEW ENG. J. MED. 64, 64 (1997).

²⁵² *Id.* at 65.

²⁵³ *Id.*

policies from year-to-year.²⁵⁴ It limits the scope and duration of pre-existing condition exclusions to those conditions where “advice, diagnosis, care, or treatment” was provided within six month before enrollment in a new plan.²⁵⁵ It also prohibits discrimination in group plans on the basis of health status.²⁵⁶ These rules together require that insurers cover all members of a group for all conditions, preventing limits to pooling that would otherwise result from denying, dropping, or carving out coverage of conditions for higher-risk applicants within a group.

While these requirements apply broadly to group insurance, in the individual market, the guaranteed issue and pre-existing condition requirements apply narrowly to “HIPAA eligible” subscribers, which in reality has meant that most people who must rely on individual market coverage do not benefit.²⁵⁷ Thus, HIPAA bolsters enrollee risk pooling in the group markets by requiring insurers cover all members equitably while doing little for those seeking insurance on their own, driving a wider wedge between the quality of coverage available to group insured and most individually insured. Last, but certainly not least, a critical force that exacerbates inequities among group and individual markets is the federal tax subsidy for group policies. Federal tax law excludes all dollars spent by employers on group health plans from federal income and payroll taxes (including employer and employee Social Security and Medicare taxes).²⁵⁸ Tax subsidies on group plans equal a 35-cent discount on every dollar spent on group health insurance.²⁵⁹ In addition, employees’ own contributions toward premiums and cost shares (copayments and deductibles) are excludable if paid out of “cafeteria plans.”²⁶⁰

This subsidy in effect pools part of the risk of members in group insurance among all taxpayers, who fund this subsidy. It has been fodder for heated health reform debate because of its size – more than \$200 billion per year – and its regressive nature.²⁶¹ Note that this exclusion works regressively in two ways. First, it applies to those with employer-sponsored insurance, who tend to be higher earners.²⁶² Second, higher earners are in higher tax brackets and thus benefit more from excluded income.

In most cases, the only federal tax assistance for purchasing an individual health insurance policy is the ability for those who itemize expenses to deduct medical expenses that exceed 7.5 percent of adjusted gross income.²⁶³ This

²⁵⁴ Pub. L. No. 104-191 § 101, 110 Stat. 1939 (1996).

²⁵⁵ *Id.* Further, any exclusion is shorted by the length of creditable coverage prior to enrollment so long as there was no break in coverage of 63 days or longer. *Id.*

²⁵⁶ *Id.*

²⁵⁷ Kuttner, *supra* note 251, at 64-66. HIPAA eligible individuals are those who have had 18 months of creditable coverage in a group plan without a significant break of 63 days or more and have exhausted available COBRA benefits. Pub. L. No. 104-191 § 101, 110 Stat. 1939 (1996).

²⁵⁸ 26 U.S.C. § 106 (2007).

²⁵⁹ Gruber, *supra* note 4, at 574.

²⁶⁰ 26 U.S.C. § 125 (2007). Section 125 allows an employee to pay for certain expenses out of pre-tax income, excluding such amounts from income and payroll taxes.

²⁶¹ CONGRESSIONAL BUDGET OFFICE, U.S. CONGRESS, CBO’S HEALTH INSURANCE STIMULATION MODEL: A TECHNICAL DESCRIPTION 1 (2007).

²⁶² COLLINS ET AL., *supra* note 57, at 2.

²⁶³ 26 U.S.C. § 213 (2007). Self-employed workers benefit from the same exclusion rules that apply to groups. Gruber, *supra* note 4, at 575. For some individuals, Health Savings Accounts provide some tax benefits. Pub. L. No. 108-173, § 1201, 117 Stat. 2066 (2003). For

assistance is structured as a deduction, not an exclusion, so while it reduces income tax liability, it does not reduce payroll (FICA) tax liability.²⁶⁴

Thus, through HIPAA and tax law, the federal government has exacerbated inequities that run along lines of market fragmentation. These inequities undermine an individual mandate's ability to facilitate health redistribution and access to care equally in both markets because higher-risk enrollees in the individual market will find it relatively harder than similarly situated individuals in group markets to obtain and finance coverage that provides them with meaningful access to care.

C. FRAGMENTATION'S IMPEDIMENTS TO HEALTH REDISTRIBUTION WITH THE INDIVIDUAL MANDATE

Mandating people join fragmented markets where they will differentially bear risk based upon factors such as type of employer or past or anticipated future health status is antithetical to the objective of health redistribution, whereby costs of medical care are pooled more equitably among all healthy and sick insureds.

For example, at the most basic, structural level, the lack of risk pooling between private and public markets and among self-funded plans, large group, small group, and individual markets poses a problem for equitable health redistribution, unless each of the sub-markets contains a similar distribution of healthy and sick insureds. Without pooling among markets, the benefit from the financiers, who have costs lower than premiums, may help enrollees in some markets more than others. If, under the mandate, one market were to attract more financiers on average, that market would benefit from lower average per enrollee costs and eventually lower premiums.²⁶⁵ For example, imagine that following the mandate a large self-funded employer enrolls 100 new, healthy members. Its employees will benefit from the ability to pool risk with these new financiers, who will help to subsidize insurance premiums for their sicker or less lucky coworkers.²⁶⁶ Their acquisition of insurance will do nothing to help enrollees in other pools. Conversely, public programs, for example, are likely to gain additional high-cost enrollees. The cost of these enrollees will not be cushioned by any premium dollars paid by newly-insured financiers.

While it is difficult to be certain how an individual mandate will affect distribution of the healthy and sick among each sub-market nationally, it is

discussion of HSAs and solidarity, see Amy Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 *TULANE L. REV.* 777 (2006).

²⁶⁴ 26 U.S.C. § 213 (2007). This assistance is further limited. It is only available to those who itemize deductions, which generally means itemized deductions exceed the standard deduction and it is only of value to those with federal tax liabilities. THE HENRY J. KAISER FAMILY FOUND., *TAX SUBSIDIES FOR HEALTH INSURANCE: AN ISSUE BRIEF 10-11* (2008).

²⁶⁵ If the markets are competitive, subscribers in these groups will benefit from lower or moderated premiums over time. If not, as some suggest may be the case, insurers might extract the surplus revenue from financiers longer term as increased profits. See James C. Robinson, *Consolidation and the Transformation of Competition in Health Insurance*, 23 *HEALTH AFF.* 11 (2004) (describing a lack of competition in the insurance industry, leading to inefficiency and increased profits for insurers).

²⁶⁶ We can assume these financiers will pay a significant share of premiums or else the employee would not have opted out in the first place.

reasonable to believe the mandate might cause more healthy to enroll in the large group market and self-funded plans and sick to enroll individually. On one hand, consider the almost certainly healthier-than-average population whom a mandate would compel to enroll in group coverage. This population is comprised of two types of opt-outs. Some previously declined available group coverage. Anyone who had access to subsidized group coverage and who is less healthy than average would have had a strong incentive to enroll since their premiums, based upon the average risk of the group, would be lower than their own expected risk. Thus, those who opted-out are likely to be healthier than average. In addition, others may gain access to group coverage that is newly sponsored and offered by an employer post-mandate if an employer mandate is simultaneously enacted. Any employer who decides to offer new group coverage, rather than opting to meet any contribution requirements by subsidizing employees' purchase in the individual market, presumably has an employee group with above-average health. The employer can get more value for its healthy employees by creating their own group plan, where they can benefit from low average costs per person. Thus, the group market will likely benefit from an influx of new, healthier-than-average enrollees.

On the other hand, the mandate could simultaneously result in a residual population with individual coverage that is less healthy than average. Some part of the population that will join the individual market under a mandate has previously been declined coverage or priced out of coverage offered at higher than standard premiums. This population is probably less healthy than average and will likely buy into the individual market to comply with a mandate. Thus, as the group market benefits from new financiers, the individual market will not feel their benefit and may simultaneously suffer from an influx of high-risk enrollees.

Not surprisingly, early results in Massachusetts demonstrate that the mandate has caused uneven distribution of healthy and sick among different markets.²⁶⁷ Massachusetts has seen some adverse selection into government-subsidized plans, and an infusion of healthy into already strong employer markets.²⁶⁸ Nearly 60 percent of the newly insured are now enrolled in government-subsidized insurance through MassHealth, Massachusetts' Medicaid program, (76,000 new enrollees) or through Commonwealth Care ("CommCare"), a new program offering sliding scale subsidies to residents who earn below 300 percent of FPL and who do not have access to employer-sponsored insurance (169,000 new enrollees).²⁶⁹ Contrary to concerns that the reform might "crowd out" employer-sponsored insurance, Massachusetts has seen the opposite, possibly due to employer mandates, as discussed below.²⁷⁰ One hundred and thirty-eight thousand people (35 percent of the newly insured) enrolled in private group insurance.²⁷¹

²⁶⁷ HOLOHAN & BLUMBERG, *supra* note 207, at 4.

²⁶⁸ *Id.*; MASS. DIV. OF HEALTH CARE FIN. AND POL'Y, HEALTH CARE IN MASSACHUSETTS: KEY INDICATORS 3 (2009), available at http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/key_indicators_02-09.pdf [hereinafter KEY INDICATORS].

²⁶⁹ KEY INDICATORS, *supra* note 268, at 3.

²⁷⁰ *Id.*

²⁷¹ *Id.*

An Urban Institute study shows that healthier insureds in Massachusetts are disproportionately enrolled in employer-sponsored plans.²⁷² Of Massachusetts non-elderly adults who self-identify as in “good, very good, or excellent health,” 84 percent have employer-sponsored insurance.²⁷³ Those who self-identify as in “fair or poor health” are enrolled disproportionately in public or individual coverage (53 percent), rather than in employer-sponsored insurance (47 percent).²⁷⁴ Regardless of whether the mandate created this reality or if it was already present before reform, if these polls accurately reflect health status, they show that the mandate can only go so far to enable risk pooling among the healthy and sick to the extent they belong to different risk pools.

Even if we put the above discussion aside and assume that healthy financiers will buy coverage at the same proportion in each market, the health redistributive benefits of their doing so will be limited in the individual market. To the extent insurers can still engage in risk selection and differential pricing, when healthier people buy insurance in the individual market, they will pay lower premiums more in line with their own low expected risk, providing few premium dollars to subsidize medical care of others. The converse is that sicker individuals will pay higher premiums (or get less valuable coverage) because of their high individual risk. Furthermore, when the voluntary opt-outs buy into the individual market, as much as 30-40 percent of their premium dollars go toward overhead, leaving less of a surplus to fund care for the sick.²⁷⁵ This means that those whom the mandate compels to buy insurance in the individual market are less engaged in a system of health redistribution – either as financiers or receivers of subsidy – than those who belong to a group health plan, where everyone pays the same premium for the same plan.

With such barriers to health redistribution, it is not surprising that an individual mandate will fall short of creating a system that enables distribution of medical care equitably on the basis of medical need and that submarkets with greater fragmentation will be farthest from achieving this goal. Fragmentation has led to a system where some are charged more for less coverage – if able to obtain coverage at all – simply because they buy insurance in the individual and small group markets, in particular if they show any likelihood to need care. Those insured through their employer pay less to access medical care and benefit from beneficial tax treatment and employer contributions to premiums.²⁷⁶ Those insured in the individual insurance market are likely to receive less access to care while paying relatively more. Forty-three percent of adults in individual plans spend over

²⁷² SHARON K. LONG ET AL., URBAN INST., HEALTH INSURANCE COVERAGE IN MASSACHUSETTS: ESTIMATES FROM THE 2008 MASSACHUSETTS HEALTH INSURANCE SURVEY 26 (2008).

²⁷³ *Id.*

²⁷⁴ *Id.*

²⁷⁵ Pauly & Nichols, *supra* note 100, at w326.

²⁷⁶ Recent estimates show that covered workers on average contribute 16% of the premium for single coverage and 28% for family coverage. KFF EMPLOYER HEALTH BENEFITS: 2007, *supra* note 45, at 68. Covered workers in small firms are more likely to have 100% of premiums paid by their employer than workers in large firms, but when they are responsible for a part of the premium, they are more likely to have to pay over 50% of it. *Id.*

10 percent of income on health expenses as compared to twenty-four percent of those in employer plans.²⁷⁷ Scholars believe that the individual market has primarily served as a safety net between periods of employment-based insurance.²⁷⁸ Those whom a mandate compels into this market may be forced to convert this safety net into more permanent, expensive coverage.

Fragmentation not only leads to highly variable premium costs, it also tends to disadvantage those with lower incomes or who are already sick and more likely to be consumers in the more fragmented individual market. Enrollees in employer-sponsored group insurance are higher earners on average. Eight of ten higher-wage workers have insurance through their employer, as compared to three in ten poor workers.²⁷⁹ And those earning under \$40,000 a year are more likely to have insurance in the individual market.²⁸⁰ In addition, those who are already sick and without employer coverage are likely to suffer most from actuarial rating in the individual market and may be unable to access insurance in absence of guaranteed issue laws.

A mandate that bolsters the group markets with new low-risk enrollees and demands more from the sick and the poor in the individual market to comply is counterproductive to the goals of health redistribution. The mandate would, in essence, compel everyone into insurance markets in the name of making medical care more accessible to those in need, but because of fragmentation, it would not only fail to achieve this goal but also disproportionately burden more vulnerable populations.

V. THE INDIVIDUAL MANDATE IN LIGHT OF FRAGMENTATION

The solution to the impediments fragmentation presents for the mandate is, not surprisingly, defragmentation. Eliminating fragmentation can reshape insurance institutions in a way that accommodates risk pooling and enables greater health redistribution, rather than letting the institution, as is, limit the way Americans share and distribute risk post-mandate.

Because of the incentives commercial insurers have to fragment, there are three primary ways to eliminate insurance market fragmentation: change insurers' incentives so they profit on a basis other than fragmentation; regulate insurers to prohibit fragmentation; or restructure insurance markets in a way that eliminates fragmentation, including by expanding the bounds of public insurance to replace private insurance for some beneficiaries.

To be clear, it is certainly possible to eliminate fragmentation in one fell swoop by instituting a single payer system like that in Canada or the UK. However because this approach is considered politically infeasible in the current American political climate, I focus instead on solutions that are more compatible with the preservation of private insurance, and, in particular, included in or consistent with the approach taken in the Health Reform Law.

²⁷⁷ *Id.*

²⁷⁸ MICHAEL J. NEW, THE CENTER FOR DATA ANALYSIS, THE EFFECT OF STATE REGULATIONS ON HEALTH INSURANCE PREMIUMS: A PRELIMINARY ANALYSIS 2 (2005).

²⁷⁹ Diane Rowland & Adele Shartzter, *America's Uninsured: The Statistics and Back Story*, 36 J.L. MED. & ETHICS 618, 621-22 (2008).

²⁸⁰ COLLINS ET AL., *supra* note 57, at 2.

European countries like Germany, Switzerland, and the Netherlands show the potential to create less fragmented health insurance systems with multiple, private payers, so long as insurers are highly regulated and programs are carefully designed.²⁸¹ By saying the solutions discussed below may be more feasible than a single payer system is not to suggest they would go uncontested; the contentiousness of reform debates over the past year illustrate that many of these ideas will generate significant controversy in their own right, especially in the charged political climate that appears to have taken hold of Congress.

This article does not intend to describe comprehensively every policy solution that could address fragmentation, but rather offers a framework for thinking about how a range of policies might work to ameliorate fragmentation. It highlights three categories of solutions that could increase the scope and breadth of risk pooling among more heterogeneous populations – both healthy and sick – without dismantling private insurance. The solutions are discussed in the order from those that are less politically charged to those that are more contested, in large part because of increasing disruptiveness to the private markets. Part A describes the use of incentives to discourage private insurers from engaging in risk selection and thus causing fragmentation, particularly in the individual market. Part B outlines regulatory solutions that prohibit or reverse fragmentation of markets, such as requiring insurers to issue policies to all applicants and charge insureds premiums that fall within a certain range of price variation. The Health Reform Law relies on versions of policies from both of these categories of solutions. Finally, Part C examines ways we might restructure insurance markets more fundamentally going forward, such as through merging private markets, creation and careful design of exchanges, or expanding public insurance in ways that might cover those most harmed by fragmentation. At the end of this section, I suggest that undertaking such policies of defragmentation might in fact help shape the legitimacy of health redistribution over time. In other words, I probe whether blurring the lines of fragmentation that currently define American limits to risk pooling might help reshape American norms regarding, and perhaps preferences for, broader distribution of the costs of poor health.

A. REDUCING INSURERS' INCENTIVES TO FRAGMENT MARKETS

Some policy solutions improve the individual market by reducing incentives for risk selection, either through attempts to make insurers less sensitive to enrolling high-risk applicants or through ex-post solutions that lessen insurers' exposure if they do enroll a high-cost member.²⁸² The theory of such approaches is that they can cause commercial insurers to be less concerned about the need to select out good risks and, if effective in doing so, can eliminate some expenses associated with such risk selection practices.

²⁸¹ Jost, *supra* note 32, at 1; ROBERT E. LEU ET AL., THE COMMONWEALTH FUND, THE SWISS AND DUTCH HEALTH INSURANCE SYSTEMS: UNIVERSAL COVERAGE AND REGULATED COMPETITIVE INSURANCE MARKETS I (2009).

²⁸² For a comprehensive discussion of approaches to limiting risk selection and risk adjustment, see Katherine Baicker & William H. Dow, *Risk Selection and Risk Adjustment: Improving Insurance in the Individual and Small Group Markets*, 46 INQUIRY 215 (2009).

The Health Reform Law incorporates some of these solutions, mostly in ways that will lubricate insurance markets in the short term before more comprehensive insurance market regulation becomes effective.²⁸³

One way to reduce risk selection is to lessen the profit possible from attracting a healthier mix of enrollees through a practice known as risk adjustment of premiums. The idea is to create a system where insurers are compensated more for higher-risk enrollees and less for lower-risk ones so that they do not benefit, in theory, from cherry-picking out healthier enrollees. While the enrollees still contribute equally (or on the basis of income or wealth) through premiums or taxes, a central administrative body pools the contributions and then pays insurers based upon the risk profile of their enrollees. Such risk adjustment is used, for example, in Medicare Advantage plans, in some states' Medicaid managed care plans (including in Massachusetts), and in many European countries, including in the Netherlands, whose social insurance system uses fairly sophisticated risk-adjustment formulas.²⁸⁴ Risk adjustment of premiums is included in the Health Reform Law for plans that will be sold through state insurance exchanges created under the Law.²⁸⁵ However, such efforts at risk adjustment can be incomplete if they are not based upon comprehensive information and are difficult to administer, particularly if they are comprehensive.²⁸⁶

Another way states have attempted to limit insurers' exposure in the individual market is through the use of high-risk pools, where the states offer plans, typically subsidized, for high-risk enrollees to draw them out of the standard private insurance market.²⁸⁷ In theory, if the highest-risk people were isolated within high-risk pools, insurers might worry less about enrolling outliers. In practice, these pools may not achieve the desired effect. Although a majority of states have high-risk pools, these pools have only enrolled about 200,000 people nationally and are chronically underfunded.²⁸⁸ Low enrollment has been attributed to long waiting periods for pre-existing conditions, limited benefits, and expensive coverage.²⁸⁹

Further, despite the potential high-risk pools may offer to increase efficiency and coverage in the individual market, they might do so at a trade-off to health redistribution. Even if effective, such solutions remove the cost of the sickest enrollees from insurance pools, lessening the ability of the healthy to share in the risk of and to finance care for the sickest in their communities within insurance risk pools. Taxes (either on insurers or the public at large) must be used to subsidize high-risk pool coverage, which states have found can be difficult pragmatically and politically.²⁹⁰

²⁸³ H.R. 3590, *supra* note 2.

²⁸⁴ Baicker & Dow, *supra* note 282 at 224.

²⁸⁵ H.R. 3590, *supra* note 2.

²⁸⁶ Baicker & Dow, *supra* note 282 at 224.

²⁸⁷ The Health Reform Law uses this approach to provide a bridge for high-risk enrollees in the individual market before requirements for state exchanges and insurance market regulations are in effect. H.R. 3590, *supra* note 2.

²⁸⁸ Baicker & Dow, *supra* note 282, at 220.

²⁸⁹ Deborah Cholett, *Expanding Individual Health Insurance Coverage: Are High-Risk Pools The Answer?*, HEALTH AFFAIRS (WEB EXCLUSIVE) w349, w349 (Oct. 23, 2002), <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.349v1>; Jost, *supra* note 107, at 5.

²⁹⁰ Baicker & Dow, *supra* note 282, at 220. Time will tell if the appropriations set aside in the Health Reform Law for high-risk pools will prove sufficient.

Finally, there are also ex-post solutions that could limit insurers' exposure even if they enroll high-risk insured. Professor Katherine Swartz has championed an expansion of public reinsurance as an alternative way to reduce risk selection by limiting the exposure insurers face from exorbitantly high costs if they write coverage for a particularly expensive beneficiary.²⁹¹ She proposes the government provide excess-of-loss relief, assuming some percentage of losses above a certain dollar threshold for a policy.²⁹² This type of government reinsurance is incorporated in several ways in the Health Reform Law, including as a means to cushion the costs of 55-65-year-olds in group plans to incent employers to continue to insure retirees in their group plans.²⁹³

Although public reinsurance may reduce the behaviors insurers engage in to avoid expensive beneficiaries, it also raises concerns. Professor Timothy Stolfus Jost argues that such an approach of "backstopping private insurers" is not the most efficient way to invest tax dollars in insurance because it decreases insurers' incentives to control health care utilization and cost if such costs can be externalized onto the government.²⁹⁴ Swartz believes it is possible to preserve incentives for cost control, by requiring insurers retain some percentage of the risks above the attachment point for the policy.²⁹⁵ However, the two goals of reducing insurers' incentives to risk select by limiting exposure and maintaining their incentives to control utilization are in tension with one another. The greater insurers' exposure, the more they will both want to avoid high-risk individuals and also manage expenditures. Conversely, the lower their exposure, the more they will welcome high-risk individuals and also have less incentive to manage costs.

Furthermore, such programs may trigger a Russian doll problem, where removing a layer of outliers may not eliminate insurers' desire to differentiate among remaining beneficiaries. Once the first Russian doll is removed, another lies beneath – slightly smaller but remarkably similar. Likewise, even if the costs of the top two percent of most expensive beneficiaries are covered by government-funded reinsurance, insurers might then be concerned with those in the 95-98 percentiles of spending and continue underwriting and marketing to manage these new "highest" risks. Finally, once the government guarantees insurers protection from high risks, it is questionable what value insurers add beyond simple administration of policies.

B. REGULATORY DEFRAGMENTATION OF MARKETS: LESSONS FROM MASSACHUSETTS

Insurance market regulation has been used to require insurers to reduce fragmentation within the individual market. While such regulation is a critical element of defragmentation and is an important and significant focus

²⁹¹ Swartz, *supra* note 44, at 90-91; see KATHERINE SWARTZ, REINSURING HEALTH: WHY MORE MIDDLE-CLASS PEOPLE ARE UNINSURED AND WHAT GOVERNMENT CAN DO 101-02 (2006); see also John Jacobi, *Health Law Symposium: The Present and Future of Government-Funded Reinsurance*, 51 ST. LOUIS U. L.J. 369, 369 (2007).

²⁹² Swartz, *supra* note 44, at 90-91.

²⁹³ H.R. 3590, *supra* note 2.

²⁹⁴ Jost, *supra* note 107, at 5.

²⁹⁵ SWARTZ, *supra* note 291, at 101-02, 114-15.

of the Health Reform Law, it might nonetheless prove to be a partial solution and a difficult to design and imprecise tool, as evidenced by challenges in Massachusetts, highlighted below.²⁹⁶

1. Insurance Market Regulation and the Connector

One might consider regulation of private insurers as a counterbalance to the benefit insurers enjoy from the individual mandate. With an individual mandate, the government creates a requirement that all Americans obtain insurance. Yet it leaves implementation for the most part in the hands of private insurers, who, to whatever degree permitted, design, price, and issue the plans that Americans must buy. This power over design, in essence, imbues insurers with a tremendous amount of delegated state power to determine the contours of how the mandate is put in place and effects Americans.²⁹⁷ Regulations, thus, may be seen as a way to ensure insurers implement the mandate consistent with intended legislative objectives, including health redistribution.

Private markets can be regulated to prohibit the risk selection practices that fragmented markets in the first place. Such regulation, which has been a part of all federal proposals for reform and is central to the Health Reform Law,²⁹⁸ is like navigating a u-turn back toward a Blue Cross, community-rated model of health insurance by limiting insurers' freedom to differentiate among applicants based upon risk rating.

At a minimum, regulation could limit the risk selection practices that drive fragmentation in the individual market. It could do so by requiring that insurers in the individual market issue policies to all applicants (guaranteed issue), that plans meet minimum benefits standards so that insurers don't use policy design to segment customers by risk, that pre-existing condition exclusions are limited, and that applicants pay community-rated premiums. All of these types of requirements are included in the Health Reform Law,²⁹⁹ and many of these changes have been implemented in Massachusetts, whose reform effort evinces the ability of regulation to lessen, although not eliminate fragmentation.

Massachusetts implemented several coordinated policies, some regulatory and some structural, to increase health redistribution within the individual

²⁹⁶ Jost, *supra* note 107. For discussion of the difficulty of achieving intended results by regulating insurance markets, see Deborah Chollet, *What Have We Learned from Research on Individual Market Reform?*, in STATE HEALTH INSURANCE MARKET REFORM 46, 53-58 (Alan C. Monheit & Joel C. Cantor eds., 2004); Deborah J. Chollet et al., *The Impact of Access Regulation on Health Insurance Market Structure* (2000) <http://aspe.hhs.gov/health/Reports/impact/index.html> (unpublished research submitted to ASPE, HHS) (showing impact of regulation depends on relative strength of intermediate effects on number of insurers in the market and market concentration).

²⁹⁷ See Baker & Simon, *supra* note 12, at 13.

²⁹⁸ H.R. 3590, *supra* note 2. See, e.g., Sara R. Collins et al., *Issue Brief: How Health Care Reform Can Lower the Costs of Insurance Administration*, 61 COMMONWEALTH FUND PUB. 1299 (2009) (outlining common elements of leading health reform proposals) [hereinafter COMMONWEALTH FUND PUB. 1299]; SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, A ROADMAP TO HEALTH INSURANCE FOR ALL: PRINCIPLES FOR REFORM (2007), available at http://www.commonwealthfund.org/usr_doc/Collins_roadmaphtinsforall_1066.pdf [hereinafter ROADMAP].

²⁹⁹ *Id.*

market and between individual and small group markets and to ameliorate inequities in the individual market arising from high overhead and inequitable application of tax subsidies. Even prior to reform, Massachusetts was one of the few states both to require that insurers guarantee issue of insurance to all applicants and charge modified community rates in its individual market.³⁰⁰ Massachusetts's modified community rating requires that the most expensive premium for a plan can be no more than two times the least expensive premium for the same plan.³⁰¹ Further, premiums may only vary based upon a limited number of factors, including age, geography, and group size.³⁰² Such modified community rating promotes greater, although not completely equitable, distribution of medical costs among insureds in the individual market.³⁰³ The reform further limits differentiation through plan design by requiring all plans offered meet certain actuarial values.³⁰⁴

Massachusetts also addressed inconsistencies in tax law between group and individual market insurance by enabling purchase of individual market plans with pre-tax dollars for more people.³⁰⁵ Massachusetts created the Connector, an independent, quasi-governmental agency, which acts as a clearinghouse for the purchase of health insurance by small businesses and individuals without access to employer-sponsored coverage.³⁰⁶ The legislation increased individual purchasers' access to insurance on a pre-tax basis, by requiring that employers with over ten employees sponsor a premium-only cafeteria plan, which its employees can use to fund purchase of individual insurance with pre-tax dollars through the Connector.³⁰⁷ The benefit of this requirement does not extend to those who work for companies with fewer than 10 employees, those whose employers don't comply, or the unemployed.³⁰⁸

2. Limitations of Regulatory Solutions

While Massachusetts's reform shows that a more heavily regulated insurance industry can provide a stronger foundation for an individual mandate to promote health redistribution, particularly in the individual market, it also suggests the limits of a regulatory solution.

³⁰⁰ Hager, *supra* note 213, at 1323; *see also* Statehealthfacts.org, *supra* note 228 (providing information on risk-pooling techniques employed by various states).

³⁰¹ *See* MASS. GEN. LAWS ch. 176J, § 8; MASS. GEN. LAWS ch. 176M, § 2. *See also* Statehealthfacts.org, *supra* note 228.

³⁰² *See* Statehealthfacts.org, *supra* note 228.

³⁰³ *See* Hager, *supra* note 213, at 1316.

³⁰⁴ *See* Holohan & Blumberg, *supra* note 4, at 2.

³⁰⁵ *See* CONFERENCE COMMITTEE REPORT, *supra* note 69, at 4; *see also* Chapter 58, *supra* note 3.

³⁰⁶ *See* CONFERENCE COMMITTEE REPORT, *supra* note 69, at 1; *see also* Chapter 58, *supra* note 3, § 111M (establishing MGL 176Q).

³⁰⁷ An employer who fails to set up a cafeteria plan could be subject to pay for uninsured employee's hospital care. *See* Hager, *supra* note 213, at 1325; *see also* CHAPTER 58, *supra* note 3. Participants in a cafeteria plan must be permitted to choose among at least one taxable benefit (such as cash) and one qualified benefit. Qualified benefits include accident and health benefits. 26 U.S.C. § 125 (2007).

³⁰⁸ *See* 26 U.S.C. § 125 (2007).

Massachusetts's insurance market regulation – while more aggressive than most states' insurance regulations at eliminating risk selection – did not close the door on such practices, and certain populations still bear more of the cost of reform. Two percent of the population was exempted from the mandate on “affordability” grounds because the costs of available coverage equaled more than ~7.5-10.5% of their take-home income.³⁰⁹ One population particularly vulnerable to exemption is middle-income 55-65 year olds, who don't qualify for subsidies and could be subject to relatively high premiums under the modified community rating rules, which allow older insureds to be charged twice as much as younger insureds for a policy.³¹⁰ One study reported that in December, 2008 the least expensive plan for a middle-income 56-year-old could cost as much as \$9,872 in total annual costs, including premium, deductible and co-insurance costs.³¹¹ By exempting this population from the mandate, the Commonwealth yielded to the reality that reform didn't distribute costs in a way that made insurance affordable for its aging, yet not yet Medicare eligible, residents. This type of problem for older uninsured might be even worse under the Health Reform Law, which allows older insured to be charged 3 times as much as younger insured.³¹²

In an attempt to make insurance affordable as broadly as possible, the Connector Board authorized deeper subsidies to more individual market enrollees than initially projected.³¹³ Doing so increased the overall cost of reform in early years and has threatened its stability in light of budgetary pressure more recently.³¹⁴ In response to recent budget cuts, Massachusetts limited the scope of subsidized coverage available to 31,000 legal immigrants by eliminating dental, hospice, and skilled nursing care and by limiting choice of insurer to one managed care company.³¹⁵ Finally, it has also eliminated automatic enrollment into subsidized plans to control costs through natural attrition and failure of some residents to enroll.³¹⁶

In addition, Massachusetts's individual market still enables insurers to engage in risk selection through product design that steers enrollees to self-segregate into different products in part of the basis of their own anticipated future health.³¹⁷ Experts are concerned that in this system, low-income individual market purchasers of insurance may buy plans with low premiums in return for high cost-sharing obligations, which might deter use of medical

³⁰⁹ Robert Steinbrook, M.D., *Health Care Reform in Massachusetts – Expanding Coverage, Escalating Costs*, 358 N. ENG. J. MED. 2757, 2759 (2008).

³¹⁰ See RACHEL NARDIN ET AL., MASSACHUSETTS' PLAN: A FAILED MODEL FOR HEALTH CARE REFORM 8 (2009), http://www.pnhp.org/mass_report/mass_report_Final.pdf.

³¹¹ *Id.*

³¹² H.R. 3590, *supra* note 2.

³¹³ See Holohan & Blumberg, *supra* note 207, at 4.

³¹⁴ See *id.* Original estimated costs for subsidies for CommCare's subsidies were \$400M for FY08; actual costs are estimated to be \$647M. *Id.* at 3. For FY09, original estimates were \$725M; the amount requested for budget was \$869M and actual costs may be even greater. *Id.*

³¹⁵ Abby Goodnough, *Massachusetts Cuts Back Immigrants' Health Care*, N.Y. TIMES, Sept. 1, 2009, at A17.

³¹⁶ *MA Health Care Hit by Budget Cuts*, MASS. ASS'N HEALTHCARE ACCESS MGMT., June 25, 2009, http://www.mahamweb.org/june_2009_news.html.

³¹⁷ See Jost, *supra* note 4 (discussing coverage stratification in Massachusetts).

care or threaten income security if medical care is needed.³¹⁸ For example, plans that meet Massachusetts's "minimum creditable coverage" requirements could have deductibles as high as \$2000 for an individual or \$4000 for a family and out-of-pocket maximums as high as \$5000 for individuals and \$10,000 for families.³¹⁹ These levels of out-of-pocket spending, similar to those allowed in the Health Reform Law,³²⁰ could serve as a significant deterrent of use of care for many of the families and undercut the mandate's effectiveness toward its goals.

These limitations of regulatory solutions to address problems of fragmentation are perhaps not surprising.³²¹ Because insurers' profit depends on risk selection and segmentation, they have developed numerous practices to achieve such ends.³²² Historically, insurers have been innovative in finding alternative factors to use for risk selection – both legal and illegal – when some practices are prohibited.³²³ For example, insurers can design provider networks to attract healthy or sick applicants.³²⁴ Insurers have also been known to disenroll high-risk insureds ("lemon dropping") through rigorous utilization review, poor service, or even discontinuing a particular policy.³²⁵ It would be nearly impossible to regulate private markets in all the ways necessary to prevent insurers from treating people with different risks differentially, as well as to enforce all such regulations.³²⁶ Thus, while private insurance regulation is a critical element of defragmentation, and one well-represented in the Health Reform Law, it may be insufficient to maximize the mandate's ability to promote health redistribution.

C. RESTRUCTURING MARKETS

While regulatory solutions offer the potential to address some problems of defragmentation, particularly within the individual market, solutions that dismantle structural barriers to risk pooling – among private markets, among public programs, and between public and private markets – could begin to melt the boundaries of fragmentation more comprehensively. There are numerous ways to restructure markets towards the goal of reducing fragmentation. This paper does not attempt to examine them all. Rather, this section intends to select out and describe several policies that might result in significant structural defragmentation to explore the potential benefit of a structural approach. While the Health Reform Act ventures to a small extent

³¹⁸ See Melissa B. Jacoby, *Individual Health Insurance Mandates and Financial Distress: A Few Notes from the Debtor-Creditor Research and Debates*, 55 U. KAN. L. REV. 1247, 1250-51 (2007); Jost, *supra* note 4. Experts contend the state could have improved the quality of plans in the individual market by doing more to negotiate rates on behalf of all plans sold through the Connector and, further, by opening enrollment in Connector plans to employers of all sizes (rather than just those with under fifty employees), growing the number of enrollees, negotiating power, and ability to pool risks. Holohan & Blumberg, *supra* note 207, at 5-8.

³¹⁹ Steinbrook, *supra* note 309, at 2759.

³²⁰ H.R. 3590, *supra* note 2.

³²¹ See Jost, *supra* note 107, at 1.

³²² See, e.g., Light, *supra* note 16, at 2504-06.

³²³ Baker, *supra* note 12, at 38; Jost, *supra* note 107.

³²⁴ Jost, *supra* note 107, at 3.

³²⁵ Jost, *supra* note 107, at 4.

³²⁶ See *id.*

into this space with Medicaid expansions and the creation of state-based exchanges for the sale of insurance, these types of solutions are largely beyond the scope of the current reform. These structural solutions could, however, provide a roadmap for future policies aimed at the next layer of defragmentation.

1. Restructuring Private Markets

The current boundaries to risk pooling in private markets could be softened or broken down in a number of ways over time. For example, individual and small group markets can be combined to provide better risk pooling opportunities for the individual market. Massachusetts' merger of its individual and small group markets in 2006 was credited with lowering premium prices for individual market policies about 15 percent, which was counterbalanced by a 1-1.5 percent increase in premiums for small group plans.³²⁷ The Health Reform Law similarly allows states to merge their individual and small group markets, beginning in 2014.³²⁸

In conjunction, a health insurance exchange, depending on how designed, could both administratively and symbolically blur lines currently drawn by insurers between markets. At the most basic level, exchanges can serve as a marketplace to make the purchase of insurance more transparent within the bounds of current plans and markets. Yet, an exchange might serve a larger risk pooling and defragmentation role if explicitly and carefully designed to do so. An exchange could be designed to enable risk to distribute among all exchange enrollees, who might include individuals previously divided among individual and group and public and private plans. In addition, the exchange could act as a purchasing pool, where an administrator negotiates lower reimbursement rates with providers on the behalf of all enrollees in exchange plans (even if these plans are administered by different private insurers).³²⁹ Thus, as more people enroll through an exchange, all members might benefit from the increase in scale and bargaining power. Finally, an exchange could also create a symbolic shared identity among all enrollees, who might credit the exchange, rather than individual private insurance companies administering the policies, with insuring their health.

Massachusetts's Connector hosts such a website exchange where consumers can compare and enroll in plans, and a similar model of state-based exchanges is included in the federal Health Reform Law.³³⁰ While the

³²⁷ See GORMAN ACTUARIAL LLC ET AL., IMPACT OF MERGING THE MASSACHUSETTS NON-GROUP AND SMALL GROUP HEALTH INSURANCE MARKETS 10 (December 26, 2006), *available at* http://www.mass.gov/Eoca/docs/doi/Legal_Hearings/NonGrp_SmallGrp/FinalReport_12_26.pdf.

³²⁸ H.R. 3590, *supra* note 2.

³²⁹ The Health Reform Law provides and opportunity for greater pooling over time at the option of each state. Each state can choose to merge its individual and small group markets or if expand the population of people eligible to purchase insurance through the exchange to enrollees in large group plans as well (groups with over 100 employees). H.R. 3590, *supra* note 2.

³³⁰ See Amy M. Lischko et al., *Issue Brief: The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions*, 55 THE COMMONWEALTH FUND PUB. 1268 1, 11 (May 2009), *available at*

Connector has created a more transparent marketplace for individual market and small group policies where customers can compare plans side-by-side on relevant criteria, many believe it has not seized upon its full potential to reduce fragmentation.³³¹ Some argue it has not leveraged its market power to negotiate better rates for enrollees; rather, it relies on individual insurers to each do so separately.³³² This is an issue of particular concern in Massachusetts because of the pressure large academic medical centers have put on insurers to keep reimbursement rates high, contributing to higher than average medical costs in the state.³³³ Furthermore, the Connector has done little to streamline administration or marketing of the different categories of plans sold through it. The subsidized CommCare and nonsubsidized CommChoice plans are marketed, sold, designed, administered, and priced differently. And MassHealth, while similar in many ways to the subsidized CommCare plans, remains a separate program. Thus, while exchanges have potential to serve goals of defragmentation, they must be intended, and carefully designed and implemented, in a way that seizes upon this potential.

Finally, to break down the barrier between the small group, individual, and large group market, a final and bold step would be to begin to dismantle the current system of employer-sponsored insurance (“ESI”). Erosion of ESI is typically framed as a concern or potential negative consequence of reform.³³⁴ In the short term, such concerns may be valid to the extent erosion would undercut what is currently the market that best pools risk and offers the least expensive, highest value policies.

Such fear of crowding out ESI leads to reform elements, such as employer mandates and the above mentioned reinsurance of policies for 55-65-year-olds in employer plans, that aim to stabilize ESI. In Massachusetts’s reform, the employer mandate has been largely credited with preventing crowd-out.³³⁵ Massachusetts’s employer mandate is structured as a “pay or play” law, requiring employers with more than ten employees to contribute to their employees’ health coverage or, alternately, to pay a fine of \$295 annually per eligible employee.³³⁶ This type of law attempts to avoid triggering ERISA preemption of state regulation of employee benefits by *creating incentives for*, rather than directly *requiring*, employer contribution to their employees’ health insurance.³³⁷ This distinction may be a legal splitting of hairs. In

<http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2009/May/Issue%20Brief.pdf>. H.R. 3590, *supra* note 2.

³³¹ HOLOHAN & BLUMBERG, *supra* note 207, at 6-7.

³³² *Id.*

³³³ See Allen et al., *supra* note 186, at A1.

³³⁴ E.g., Gruber, *supra* note 4, at 587 (explaining the idea of crowd-out); Sharon K. Long, *On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year*, 27 HEALTH AFFAIRS (WEB EXCLUSIVE) w270, w276 (2008).

³³⁵ Many were concerned that employers might drop ESI if their employees could get less expensive coverage and public subsidies through the Connector.

³³⁶ CHAPTER 58, *supra* note 3; MASS. GEN. LAWS ch. 149, § 188 (2008); 430 MASS. CODE REGS. 15.05-15.06 (2008); 114.5 MASS. CODE REGS. 16.03 (2008). Revenue from the “pay or play” fair share contribution was initially projected to be \$50 million per year but is estimated to have raised only \$6.7 million in 2007. Robert Steinbrook, *supra* note 309, at 2759-60.

³³⁷ As discussed in Part III above, ERISA preempts all state laws that relate to an employee benefit plan (with certain exceptions). Despite several state-level attempts to enact employer mandates and wide public support of them, they have had mixed results in preemption challenges. Massachusetts (1998), Oregon (1989), and Washington (1994) all

reality, most rational employers would choose to comply by establishing, maintaining, and contributing to an ESI plan, rather than paying the fine. By contributing to ESI, their dollars go further because every dollar is tax subsidized and results in a direct benefit for employees. Employers can thus offer employees more value from every dollar spent, which will presumably translate into benefits in terms of recruiting and retention. While employers could theoretically choose to spend the same dollars paying a fine, most rational businesses would put the dollars toward additional employee compensation in the form of an ESI plan.

While such preservation of ESI through a mandate might be beneficial in the short-run, in term of maximizing health redistribution, such preservation may be a short-term gain and long-term loss. Erosion of ESI might in fact be beneficial to defragmentation and could in fact be hastened through elimination of the tax subsidies for these plans (although such an approach would be a significant political feat). If dollars employers spent on health insurance were no longer less expensive than dollars spent on salary, offering health insurance – which requires significant administrative investment for American firms – might no longer be an appealing way for them to compensate their employees. We might thus see the prevalence of ESI drop off significantly.

In the long-term, such erosion of ESI, including both self-funded and fully-funded plans, could eliminate current barriers between individual and group insurance. We could imagine that erosion of plans in the group insurance market might result in a system where all Americans would be insured in the individual market.³³⁸ If everyone were in the individual market,

enacted but did not implement such mandates (Massachusetts returned to and eventually enacted one in 2006, as discussed above). Shelley K. Hubner, *State "Pay or Play" Employer Mandates: Prescribed or Preempted?*, 20 THE HEALTH L. 15, 17-18 (2008); Peter D. Jacobson & Rebecca L. Braun, *Let 100 Flowers Wilt: The Futility of State-Level Health Care Reform*, 55 U. KAN. L. REV. 1173, 1175-97 (2007) (describing failed employer mandates). Hawaii, Massachusetts, and San Francisco have the only active employer mandates. See Hubner, *supra*, at 18-21. Hawaii's was exempted from preemption because it was passed before ERISA. Jacobson, *supra*, at 1175-76. Currently, the circuits are split on whether this type of plan design will survive a preemption challenge, an issue that will possibly be decided by the U.S. Supreme Court this session. See generally Borzi, *supra* note 249 (discussing ERISA preemption as an obstacle to health reform). The Fourth Circuit held that the Maryland's "Fair Share Health Care Fund Act" was preempted. *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180 (4th Cir. 2007). This act required employers with more than 10,000 employees in the state (i.e., Wal-Mart) to either (1) spend eight percent of payroll on employee health care or (2) pay the same to the state. *Id.* at 183. But see *Golden Gate Rest. Ass'n v. City and County of San Francisco*, 546 F.3d 639 (9th Cir. 2008) (upholding city pay or play ordinance). Opinions are mixed on whether Massachusetts's fair share contribution would survive a challenge. It has not been challenged yet and might not be challenged because of the seeming disinterest by potential challengers in doing so. Some believe the small fee imposed for failure to contribute (\$295 per employee) may be considered to create a valid opt-out, which may be sufficient to avoid ERISA preemption. Amy Monahan, *Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55 U. KAN. L. REV. 1203, 1217-20 (2007). Preemption would, of course, not be a concern with an employer mandate in federal legislation.

³³⁸ A number of policy proposals have advocated elimination of ESI. See, e.g., RESEARCH AND POLICY COMM., COMM. FOR ECON. DEV., QUALITY, AFFORDABLE HEALTH CARE FOR ALL: MOVING BEYOND THE EMPLOYER-BASED HEALTH-INSURANCE SYSTEM (2007) (promoting market-based universal health insurance). Famously, elimination of ESI was at the heart of John McCain's health policy platform in the 2008 election.

and the individual market were regulated in a way that reduced internal fragmentation, fairly broad health redistribution would be possible among all privately insureds. Such a system might begin to look structurally more like the Dutch or Swiss systems, which experience significant health redistribution within a system reliant on private insurers.

2. Expansion of Existing Public Insurance and the Public Option

Finally, an alternate route might entail expansion of existing public programs or creation of a public plan option to draw a greater proportion of Americans, particularly those currently left to the individual market, into public health insurance plans. Such plans, organized around larger social goals, could better promote risk pooling and provide higher-value coverage more equitably.

These approaches have received the most resistance when proposed as part of reform, in large part because they more aggressively disrupt the current private market and public programs. Some are particularly concerned that expansion of public insurance is simply a slippery slope toward a single payer system.³³⁹ While it would arguably take more than a slippery slope to move from our current fragmented public and private insurance markets all the way to a single payer system, these types of proposals could significantly increase the number of publically insured Americans. If eligibility for public programs is broadened and these programs offer high-quality, high-value insurance, it is in fact likely that more people will enroll in them, even if they must buy in at “full price.” If, for example, more people were allowed to buy into Medicare, and if Medicare were a more appealing option than private insurance, we would expect to see crowd out of private insurance by Medicare. Currently, public insurance programs – federal and state – finance 46 percent of all health care delivered in the United States.³⁴⁰ If a new public plan were added and/or current public programs were expanded, well over half of the health costs of our population might be publically financed. That being said, the patchwork of publicly financed insurance would still be far from a single payer system.

There are a number of ways policymakers and scholars have considered expanding enrollment in public insurance plans. The one approach that made its way into the federal Health Reform Law is Medicaid expansion, by extending eligibility to 133 percent of the FPL and removing categorical eligibility restrictions, which currently limit Medicaid eligibility to pregnant women, children up to age 19, their parents and caretakers, the disabled, and the elderly.³⁴¹ This approach will not only grow the numbers of beneficiaries in Medicaid but will also diversify risk pools by allowing more low-income healthy beneficiaries into the program. Doing so would promote greater health redistribution among a somewhat more diverse group of insureds and bring down the cost of the program per insured.

³³⁹ See, e.g., TANNER, *supra* note 4, at 1, 7-9 (expressing particular concern with individual mandates).

³⁴⁰ HEALTH POLICY BRIEF: A PUBLIC HEALTH INSURANCE PLAN, *supra* note 41, at 2.

³⁴¹ H.R. 3590, *supra* note 2, § 2001. See, e.g., Alan R. Weil, *Expanding Access Through Public Coverage: Permitting Families to Use Tax Credits to Buy into Medicaid or SCHIP*, 38 INQUIRY 146 (2001).

Over time, we could even imagine consolidating programs like Medicaid and SCHIP as the eligibility criterion began to overlap. The earlier House Bill had envisioned such a phasing out of SCHIP over time, where SCHIP beneficiaries would have been transitioned either into Medicaid or a new public plan option.³⁴² Such streamlining could lead to administrative simplification, better risk pooling, and perhaps greater public acceptance of the programs. Enrollment, reimbursement rate negotiation with providers, and billing could be consolidated. Such streamlining would also prevent variable access to care for someone having to switch programs and perhaps providers as earnings increase, as is now the case for some states that have different Medicaid and SCHIP provider networks.

Consolidation of such programs to encompass a broader range of incomes might also positively shift the public perception of these programs as they cover not just the stigmatized poor.³⁴³ Consider the food stamp program. As recipients of the food stamp program have begun to include not just the poor but also the middle class (and in fact currently 1/8 of Americans), the perceived value of the program and public support for it have grown.³⁴⁴

Another approach would be to expand Medicare eligibility to younger beneficiaries, who might pay a premium to join early.³⁴⁵ The idea of allowing 55-65-year-olds to buy in was briefly on the table as part of discussions in the Senate towards the end of 2009.³⁴⁶ Since this age group is particularly disadvantaged in the individual market, a Medicare buy-in option, even if expensive, might be an attractive option for them. A buy-in would bring paying, younger, and presumably healthier-on-average beneficiaries into the Medicare program, increasing the program's ability to promote greater health redistribution. It would also allow the newly enrolled to maintain their same coverage as they aged into subsidized Medicare coverage.

Finally, the public insurance expansion proposal that garnered the most attention (and opposition) in reform debates was the creation of a new national public plan option to compete with private insurance plans.³⁴⁷ If well implemented, a public insurance option could be a platform for greater health

³⁴² H.R. 3962, *supra* note 2, § 1703.

³⁴³ See generally WILLIAM JULIUS WILSON, *THE TRULY DISADVANTAGED: THE INNER CITY, THE UNDERCLASS, AND PUBLIC POLICY* (1987) (analyzing the flaws of race-specific and class-specific policies).

³⁴⁴ Jason Deparle & Robert Gebeloff, *Once Stigmatized, Food Stamps Find Acceptance*, N.Y. TIMES, Feb. 10, 2010, at A22.

³⁴⁵ See, e.g., Pamela Farley Short et al., *A Workable Solution for the Pre-Medicare Population*, 38 INQUIRY 214, 217-18 (2001).

³⁴⁶ See Janet Adamy, *For Some Ages 55 to 64, Medicare Will Cost Too Much*, WALL ST. J., Dec. 10, 2009, at A8; Jane M. Von Bergen & Stacey Burling, *Medicare Buy-in Could Benefit Involuntary Retirees*, PHILA. INQUIRER, Dec. 10, 2009, at A1.

³⁴⁷ See JACOB S. HACKER, *THE CASE FOR PUBLIC PLAN CHOICE IN NATIONAL HEALTH REFORM* (2008), http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf [hereinafter HACKER, *THE CASE FOR PUBLIC PLAN CHOICE*]; JACOB S. HACKER, *HEALTHY COMPETITION: HOW TO STRUCTURE PUBLIC HEALTH INSURANCE PLAN CHOICE TO ENSURE RISK-SHARING, COST CONTROL, AND QUALITY IMPROVEMENT* (2009), http://www.ourfuture.org/files/Hacker_Healthy_Competition_FINAL.pdf [hereinafter HACKER, *HEALTHY COMPETITION*]; HEALTH POLICY BRIEF: *A PUBLIC HEALTH INSURANCE PLAN*, *supra* note 41; JOHN HOLAHAN & LINDA BLUMBERG, *URBAN INST., CAN A PUBLIC INSURANCE PLAN INCREASE COMPETITION AND LOWER THE COSTS OF HEALTH REFORM?* (2008), http://www.urban.org/UploadedPDF/411762_public_insurance.pdf.

redistribution across a diverse population and across state lines if it were able to attract a large number of both high and low risk beneficiaries to join. The ability of a public plan to attract both healthy and sick enrollees would rely, in particular on at least two factors. The first is that regulatory requirements imposed on private plans must sufficiently prevent them from selecting out the healthiest beneficiaries and leaving the highest risk beneficiaries to the public plan. Professor Jacob Hacker, a champion of the public plan option, contends that successful implementation of a public plan relies upon applying the same rules to public and private plans (e.g., guaranteed issue, community rating, minimum benefits rules) and risk adjustment of premiums to deter commercial insurers from cherry-picking healthy beneficiaries.³⁴⁸

The second is whether the public plan will be able to sufficiently control costs so that even if it were to enroll higher risk insureds on average, it could still offer insurance inexpensively enough to attract healthy enrollees. Because a public plan will inevitably attract many higher-risk enrollees who have had difficulty obtaining quality private insurance, it must be able to counterbalance the higher per person medical costs of such enrollees to remain a compelling alternative to private insurance. There is reason to believe a public plan could do so by operating with lower administrative costs,³⁴⁹ by managing cost growth, and because it does not extract profits for shareholders.³⁵⁰ Studies also suggest a public plan may also be more successful at controlling costs through negotiating lower reimbursement rates for medical care than private insurers have been, as has occurred with Medicare and Medicaid, so long as it is able to insure enough enrollees to accrue sufficient bargaining power.³⁵¹ Finally, a large public plan might provide an opportunity for experimentation with improved methods for health care utilization and costs.³⁵² Despite the perceptions to the contrary, Medicare may be more effective than private insurers at restraining excessive cost growth.³⁵³

³⁴⁸ HACKER, *HEALTHY COMPETITION*, *supra* note 347, at i, 10.

³⁴⁹The overhead costs of public programs are currently lower than that for private insurance, perhaps not surprising considering that public insurance does not incur expenses for risk selection. Experts estimate 2-5% overhead in Medicare and 7% in Medicaid, as compared to an average of 12% for private insurance, including the aforementioned 30-40% for private plans in the individual market in some states. Steffie Woolhandler et al., *Costs of Health Care Administration in the United States and Canada*, 349 *NEW ENG. J. MED.* 768, 771-72 (2003).

³⁵⁰ COLLINS ET AL., *supra* note 298, at 3-4; HACKER, *THE CASE FOR PUBLIC PLAN CHOICE*, *supra* note 347, at 5-6.

³⁵¹ See Robinson, *supra* note 265, at 21-22 (explaining that consolidation within each state reduces competitive behavior among health plans). Cf. Theodore Marmor et al., *The Obama Administration's Options for Health Care Cost Control: Hope Versus Reality*, 150 *ANNALS OF INTERNAL MED.* 485, 487 (2009) (noting that a larger public plan will have greater purchasing power to control prices). This aspect of the public plan is of particular concern to its opponents and to some providers, who are concerned that the public plan's reimbursements to doctors and hospitals will be unacceptably low. See, e.g., Am. Hosp. Ass'n, *Hospitals and Health Reform* 1-2, http://www.haponline.org/downloads/AHA_Health_Reform_Policy_Initiatives_and_Key_Is_sues_for_Hospitals.pdf.

³⁵² Marmor et al., *supra* note 351, at 486-87.

³⁵³ HACKER, *THE CASE FOR A PUBLIC PLAN CHOICE*, *supra* note 347, at 8-11.

Even with these potential means to manage costs, it is possible the public plan may not be able to counterbalance the number of higher-than-average-risk enrollees it attracts and would itself create greater fragmentation. If the public plan enrolls the highest-risk Americans, it would enable private pools to grow healthier on average. The public plan could in essence default into a high-risk pool and exacerbate fragmentation by further limiting risk pooling among healthy and sick, with the healthier Americans in private insurance and sicker Americans in public insurance.

Although the possibility exists that a public option defaults into a high-risk pool, the fact that proposals for a public option ignited strong insurance industry resistance and were eventually defeated suggests its likely ability to compete for both sick and healthy enrollees. To the extent the public plan attracts a large number of both healthy and sick beneficiaries, and especially to the extent it is permitted to draw new enrollees from all of the existing submarkets (individual, small group and large group), it could facilitate considerably broad health redistribution. It could also provide more equitable access to insurance for enrollees who would have otherwise struggled to find the same in the individual market.

Finally, it's possible a national, coherently defined public plan could generate a sense of group salience among a heterogeneous mix of insured.³⁵⁴ Once people belong to a shared public plan, they may develop identification with being a member of the plan. Even if they don't extract in benefits as much as they contribute each year in premiums, enrollees might appreciate having a safety net of high quality coverage that wasn't previously available through the private market. If such a sense of group salience and loyalty to the public plan were to develop, it might increase the likelihood of the political sustainability of the plan.³⁵⁵

D. DEFRAGMENTATION AND BUILDING SOLIDARITY

What is the power of lessening the lines of fragmentation while mandating all Americans carry insurance? Is it simply about short-term health redistribution and who shoulders more of the weight of universal health care reform? Or, as scholars have suggested, is there more at stake? Is it possible that where lines are drawn actually constructs notions of who is willing to share risk with whom? Might broadly redefining the institutional structure of who *will* share risk with whom help to shape American's conceptions about who *should* share risk with whom? While answering these questions is beyond the scope of this paper, asking them highlights what might be at stake with continued efforts at defragmentation as the Health Reform Law is implemented over the next decade.

We have seen acculturation over time in our current health insurance system. The individualization of risk in the private insurance market – a fairly recent phenomenon that developed through the rise of actuarial rating in the mid-twentieth century – has created a deeply embedded notion that private health insurance is all about individual risk. Part of American insurance culture is “fair” pricing, which has been redefined as *actuarially* fair pricing.

³⁵⁴ Lester, *supra* note 150, at 46.

³⁵⁵ *Id.*

The different approaches discussed above to addressing fragmentation will each result in a different degree and type of defragmentation, and different pictures of risk pooling. The regulatory solutions can shift the individual, private market back toward a model of collectivized risks, rather than one that seeks to individualize risk through risk classification and selection. Restructuring private and public markets might more fundamentally redefine and broaden current boundaries of risk pooling among different private insurance markets, including eliminating the distinction between individual and group insurance, and between public and private markets.

The policies for defragmentation that accompany a mandate might define future American conceptions about what degree and types of risk pooling are appropriate and beneficial. By changing the baseline, norms and conceptions of risk pooling might change over time. If both the current Health Reform Law and future efforts broaden risk pools while maintaining, and perhaps expanding, access to quality medical care for Americans, Americans might grow in their support of programs that rest on broad risk pooling, as was the case for both Medicare and Social Security. Americans might learn that programs of broad health redistribution are not only less painful than imagined but perhaps largely beneficial. The twenty-five-year-old who resists buying insurance today might come to see that his participation today is a critical element in creation of a social norm of broad risk pooling and that this norm will make premiums affordable for him when he grows older.

In addition, the structure of the programs themselves might lessen future barriers to health redistribution, by actuating altruism among members of the program, as discussed earlier in the context of Gillian Lester's work.³⁵⁶ For example, by grouping people together into more heterogeneously, cohesively designed insurance markets and programs, it might be possible to shift the notions of who should share risk with whom.³⁵⁷ Americans might begin to understand structures that facilitate mutual security with respect to health risks as valuable reciprocal endeavors and perhaps begin to feel commonality through membership in such a program with a more broadly defined group of enrollees. It is possible this sense of commonality would translate into a willingness to support a program that serves to ensure access to medical care for a broad population.

During the current political debates, the actions of Medicare beneficiaries provide the perfect illustration of the power of how we initially define communities of shared risk.³⁵⁸ The resistance to reform by current Medicare beneficiaries led to ironic cries at town hall meetings of "keep your

³⁵⁶ See Fehr & Gintis, *supra* note 196; Fehr & Schmidt, *supra* note 196; Lester, *supra* note 150, at 22-31, 43-46.

³⁵⁷ Cf. Hunter, *supra* note 9, at 51-56. Nan Hunter contends that the structure of employer sponsor insurance might be ideal for building notions of health solidarity within the workplace if health benefits were allocated through a process of deliberative democracy in the control of the employees themselves. *Id.*

³⁵⁸ Medicare also shows the risks of incremental reform. Medicare was intended to be a stepping stone on the way to universal health care. Clearly, it never got us there and now serves as a barrier. As we engage in incremental defragmentation, we risk redefining lines of risk sharing somewhere on the line to full defragmentation at an intermediary point that will then become calcified itself.

government hands off my Medicare,”³⁵⁹ in protest to expansion of public insurance. This resistance by Medicare beneficiaries to reform is perfectly illustrative of the power of line drawing. Before Medicare, seniors shared little in common with respect to their health risks, apart from a higher likelihood of both needing medical care and finding it difficult to obtain insurance. With Medicare, the government decided to pool risk among all seniors, creating a program where they would contribute while working for the opportunity to draw benefits once retired. Within this program, seniors don’t typically object to the fact that they are pooling risk with other seniors, even through some are considerably sicker than others. But they are fiercely resistant to changes that might begin to soften the boundaries of “Medicare beneficiary” as currently (and somewhat arbitrarily) defined and thus force them to share risk with others. While this fierce loyalty is a bane to current reform, it shows the power of creating a group identity by how we draw the lines around a risk pool or a health insurance program. Medicare might speak to the promise of generating broader notions of solidarity over time if membership lines are drawn more broadly.

Are there limits to how broadly we can draw lines and maintain solidarity among insureds? In her recent work, Nan Hunter has argued that employer groups might actually provide an ideal structure on which to develop collaborative processes for making decisions about risk allocation.³⁶⁰ Coworkers are a group with a previously shared identity and whose wellbeing is tied to each other through the employer’s success. It’s also possible that people with identifiably similar characteristics, such as the elderly or veterans, can more naturally cohere into groups and programs of mutual assistance. However, the solidarity underlying health insurance systems built upon broad, heterogeneous, and typically non-employment-related risk pools in all other industrialized nations suggests that it might be possible to draw the lines of inclusion and participation much more broadly and maintain, and even perhaps grow, an underlying ethic of mutual aid.

Thus, what is at stake in decisions about continued efforts at defragmentation might be both the ability of the individual mandate to affect health redistribution and also the American perception of how much health redistribution and mutual aid is desirable for a society.

VI. CONCLUSION

While often held up as a key to insurance market efficiency, the individual mandate has potential to do more. There are at least three visions of what the mandate might accomplish that have threaded through popular, political, and scholarly discussions of the mandate. In this paper, I have characterized them as paternalist, efficiency, and redistributive objectives.

For many, support for the individual mandate arises in part out of its ability to promote health redistribution in a climate where doing so through a single payer system is politically unlikely. They see the mandate as a tool to

³⁵⁹ See, e.g., William Wong, *Don’t Touch My Medicare Benefits!*, S.F. GATE (Aug. 25, 2009, 07:00 PST), http://www2.sfgate.com/cgi-bin/blogs/wwong/detail?blogid=156&entry_id=45987.

³⁶⁰ Hunter, *supra* note 9, at 51-56.

distribute the costs of medical care more broadly by compelling the healthy or lucky into risk pools with the sick or unlucky. The mandate's ability to promote health redistribution in this way can unlock some of the benefits Americans hope will result from health reform. In particular, many look to reform to create a world where all Americans can see a doctor or go to the hospital when they are in need, regardless of their past health problems or limited means – a vision the mandate can support best if it promotes broad health redistribution.

Yet, fragmentation of American insurance markets aims to individualize risk in a way that will thwart the mandate's effectiveness on this front. This is because health redistribution relies on the mandate's ability not only to increase coverage but also to draw the healthy into risk pools with the sick so that within these risk pools they help finance care for those sicker or less lucky than themselves. Fragmented insurance markets prevent such risk pooling in structural ways – by dividing up insureds into separate public and private markets – and through the use of risk classification and selection processes that distribute risk unevenly and inequitably among insureds within each market.

If an individual mandate is to serve the objective of health redistribution, it must be implemented in conjunction with policy reforms that reduce fragmentation in markets. The Health Reform Law takes important first steps at defragmentation by regulating the private insurance markets to prevent fragmentation within these markets. Additional, more fundamental and structural efforts at defragmentation are left, however, to future reform efforts.

The degree of defragmentation undertaken is important in the short term and the long term. In the short-term, defragmentation will more evenly distribute the costs of health reform among all Americans – healthy and sick. In the long term, the degree of defragmentation (or the level of risk pooling or collectivization) might in fact help shape Americans' views about the appropriate level of risk pooling. If a mandate compels Americans to join a health insurance system that, by spreading risk broadly, is better able to provide everyone with access to care when in need, this redistributive system might over time be seen as serving a socially important role. Americans might grow to tolerate, appreciate, and perhaps even identify deeply with membership in such a program, legitimizing the health redistribution that occurs within. If redrawing the lines of where risk is pooled could serve this legitimizing function, defragmentation may be critical not only for the mandate's short-term success but perhaps also for the long-term sustainability of health reform build upon an individual mandate.