Government Reinsurance Programs and Consumer-Driven Care

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Creating sound and equitable health coverage is a goal that has bedeviled Americans for decades. We spend more than any other nation on health, but provide strikingly uneven coverage for tens of millions. People without adequate insurance live shorter and sicker lives. Providers, particularly those in the "safety net" such as public and nonprofit hospitals in poor neighborhoods, strain to maintain services in communities that are home to a high percentage of uninsured and underinsured residents. Proposals for significant reform were few in the years following the failure of the Clinton reform proposal, but in recent years proposals for reform ranging from adoption of universal coverage models to more targeted incremental measures have been advanced. These proposals are disparate, and some challenge our historic notions of health insurance and the role of government in health finance.

Part I of this article will describe two of the casualties of our decades-long failure to create a secure system of national health coverage: uninsured and underinsured people, and safety net providers that are often left to plug the gaps left by our public policy irresponsibility. Part II will describe the renewed interest in systemic reform, and focus on two proposals: the "ownership society" inspired attempts to devolve responsibility and control over much health spending to consumers and the movement to reduce the risk premium (and thereby the price) of private coverage through government reinsurance. It will also argue that these methods are unlikely to cure the illnesses

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they were designed to address. Part III will suggest a synthesis of these two reform proposals, taking the good from both, and consider how this synthesis responds to the needs of consumers and safety net providers.

The proposal credits a central insight of the consumer driven health care movement. American health insurance serves several functions, one of which is the catastrophic coverage protecting people who experience very high costs from impaired access to care and from personal bankruptcy. Although few people experience these very high costs, those that do need expensive acute or chronic care account for a high percentage of health costs. It is a central insight of the consumer driven health care movement that pieces of health insurance can be addressed separately, and in particular, that the catastrophic coverage can be provided by one entity, while the more routine and preventive services can be covered by another. The proposal also credits an insight derived from reinsurance programs active in several states. Through these reinsurance programs, states assume the risk for much of the very high costs of those few members of private insurance pools whose care exceeds a set threshold. In this way, states are able to lessen insurers' incentives to deny coverage to risky persons, and to lessen the "risk premium" that adds to the cost of small group and individual coverage.

Combining these two insights, this article proposes a program by which government assumes a substantial portion of the catastrophic costs of private coverage through broad reinsurance programs. This method of shoring up private coverage both recognizes the social responsibility for truly catastrophic health expenses, while permitting the continuation of politically popular and personally comfortable relationships of coverage in the private sector. The reinsurance program would increase government responsibility for the aspects of health care most clearly beyond individuals' control and therefore most clearly within the realm of broad societal responsibility without embarking on a new or expanded venture by government into direct coverage of the population historically served by private sector coverage.
I. Two Victims of America’s Failing Health Insurance System.

The un-insurance figures in America, though familiar, are truly shocking. A recent survey found that almost 44 million were uninsured for an entire year, and over 53 million were uninsured for at least six months during 2002 and 2003,¹ and that number has been growing.² Institutions that provide care for the uninsured and underinsured are “safety net” institutions—those that provide “health care and other health-related services to the uninsured, Medicaid [recipients], and other vulnerable patients.”³ Increasing numbers of those uninsured and reduced support from strained Medicaid programs and other sources of public funding have presented significant challenges to these essential providers.⁴ This Part reviews the effects of the deterioration of the American health finance system on these two groups.

A. The Uninsured

American health insurance is in transition. It has been a private, largely employer-based system with public supplements. In recent years, however, two evolutionary changes have come to the fore. First, the public component of the system has become more substantial. Medicare’s percentage of coverage grows with the aging of the

¹. Families USA Foundation, One in Three: Non-Elderly Americans Without Health Insurance, 2002-2003, at 3 (June 2004).
population. Medicaid is growing even faster, and now covers fifty million Americans and accounts for $300 billion in health care spending. Meanwhile, the private employment-based component of the system continues to shrink, in large part because of the increasing cost of coverage. In addition, the percentage of uninsured persons is growing alarmingly. Second, insured people are finding that their coverage is shrinking, leaving them more responsibility for coinsurance and co-payments. As coverage becomes less comprehensive, many people with insurance are finding that the gaps in their coverage can drive them to bankruptcy if they suffer an expensive period of illness.

The uninsured have far less certain access to health care services than do people with insurance. They tend not to have a usual source of care, and the care they receive is uncoordinated. They tend to receive less physician care, and to put off physician visits for preventive or curative care longer than do people with insurance. The delays in seeking routine care cause uninsured people to be hospitalized at a high rate for conditions ordinarily treated on an outpatient basis. Chronic conditions that can be

8. See Lambrew et al., supra note 7, at 119.
12. See id. at 37.
treated and managed by a physician, such as diabetes, hypertension, and infectious diseases, then, result in twice the rate of hospitalizations for the uninsured as for the insured.\textsuperscript{13} The treatment of even relatively simple conditions like appendicitis is affected by insurance status, as people without insurance are 50\% more likely to suffer a ruptured appendix than are privately insured patients.\textsuperscript{14} In sum, those without insurance receive less care—preventive and otherwise—and tend to receive care at times of crisis and not at early stages of an illness.\textsuperscript{15}

The Institute of Medicine undertook an investigation of health insurance in America that examined, among other things, the health effects of un-insurance. The several reports publishing the results of the investigation\textsuperscript{16} demonstrated the factual chain by which lack of insurance reduces utilization of health care services, and reduced utilization of health care services leads to reduced health status and early death.\textsuperscript{17} The lack of insurance affects health status as measured by general health and also incidence of mortality from acute conditions.\textsuperscript{18} Significantly

\begin{itemize}
\item \textsuperscript{13} Id.
\item \textsuperscript{14} See id. at 37-38.
\item \textsuperscript{15} See Dianne Miller Wolman & Wilhelmine Miller, \textit{The Consequences of Un-insurance for Individuals, Families, Communities, and the Nation}, 32 J.L. MED. & ETHICS 397, 398 (2004).
\item \textsuperscript{17} See \textit{Care Without Coverage}, supra note 16, at 86-87.
\item \textsuperscript{18} See id. at 6.
\end{itemize}
for purposes of this Article's discussion of health reform, the health effects are particularly pronounced for people with chronic illness. People with hypertension who are uninsured are more likely to have uncontrolled blood pressure than people who are insured; those with end-stage renal disease tend to have more severe renal failure when they begin dialysis than those with insurance; and uninsured people with mental illness are likely to experience more uncontrolled psychiatric symptoms than those with insurance.

The uninsured, then, face both health-related and financial injuries as a result of their insurance status. They have less access to health care, and as a consequence, have measurably diminished health status and increased rates of early death. The absence of the financial protection offered by health insurance also threatens their financial well-being, as uncovered bills for increasingly expensive health care swamp the ability for most low and moderate income families to remain fiscally afloat.

B. Safety Net Hospitals

The uninsured, as the ones who suffer the most direct physical and financial harms from the gaps in our insurance system, surely have first claim to moral and public policy concerns over the shape of our health finance system. There are many other social effects, however. Those whose health is harmed by un-insurance diminish productivity in the workplace and the nation. Their inability to access appropriate primary care can increase public health threats to society at large as communicable diseases go undiagnosed and untreated. Health insurance costs for those with coverage rise as providers attempt to recoup for the cost of care provided to the uninsured by shifting the costs to others. And the quality of life for family members and other loved ones of the uninsured suffers as

19. See infra text accompanying notes 135-38, 154-55 (discussion of the importance of chronic illness in designing health insurance system).

20. See CARE WITHOUT COVERAGE, supra note 16, at 6. See also Wolman & Miller, supra note 15, at 399-400 (summarizing IOM findings on chronic illness).

the effects of foregone care manifest themselves in diminished health, higher stress, and early death.22

This section focuses on one segment of the provider community particularly affected by un-insurance: safety net providers, and in particular nonprofit and public hospitals in low-income areas. The health care safety net comprises those providers of health care available to those who are uninsured or underinsured—those who fall through the cracks in America's health finance system. Indeed, it can be argued powerfully that the health care safety net has provided the opportunity for America to dither over reforming the health insurance system over the last several decades. But for the presence of these last-gasp, unheralded, and under-funded institutions, the pressure to respond to the crisis of un-insurance would certainly be more intense.

America's institutional health safety net has been accomplishing the task of meeting at least the basic needs of the uninsured and underinsured in many areas. In fact, it can be argued that this success is the main reason that American politicians have had the luxury of endlessly (and fruitlessly) debating, rather than enacting, universal coverage for the past 50 years.23

There is no organization of safety net providers. Instead, they are the local governmental and nonprofit providers of care that fill the gaps in a system otherwise geared for patients who enter a facility with an insurance card. They provide services to the uninsured, and also to underinsured people, including beneficiaries of our troubled Medicaid system24 and other vulnerable populations.25 Some are required by law to provide for the poor and underserved, while others do so as a matter of social

22. See HIDDEN COSTS, supra note 16, at 69; Wolman & Miller, supra note 15, at 400-03.


24. See Mann & Westmoreland, supra note 5, at 419 (describing the tension evident in Medicaid expansion over the last decade, as states simultaneously expand the categories of formal Medicaid eligibility while maintaining "complicated and sometimes stigmatizing application and renewal procedures" and suppressing provider reimbursement rates—a move that controls costs but frustrates the goal of patient access).

25. See Siegel et al., supra note 4, at 426.
mission. Safety net providers include “public or nonprofit hospitals, community health centers, public health department clinics, rural health clinics, free clinics and sometimes individual physician practices.” Hospitals serve as anchors to this array of safety net providers, and for understandable reasons. Hospitals are large, permanent, visible institutions that offer the capacity to provide the spectrum of inpatient and outpatient services. They are required by federal and state law to provide at least some medically necessary services regardless of insurance status. These safety net hospitals include public hospitals, academic medical centers, and nonprofit hospitals located in poor and underserved communities.

Safety net hospitals provide a large proportion of the health care provided to the uninsured. Members of the National Association of Public Hospitals—an organization largely comprising government-sponsored public facilities in underserved areas—reported that about 21% of their costs are devoted to care for the uninsured, with just eighty-one of the members hospitals providing “almost a quarter of the uncompensated hospital care in the country.”

Academic medical centers—all but two of which are located in urban areas—also provide a disproportionate share of care to the poor. As a percentage of gross patient revenue, academic medical centers provide twice the care to both uninsured patients and Medicaid patients as to non-teaching hospitals.

Safety net hospitals, like all hospitals,
increasingly provide care in outpatient settings. Their provision of expensive and complex inpatient services is essential to the well being of their poor and uninsured patients. This is an unsurprising concomitant of the fact that uninsured patients tend to forego routine and preventive care (in part because it is difficult for them to access) until a crisis arises, often calling for much more intensive treatment than would be needed by an insured person with coverage for the full range of services. The "last resort" nature of safety net hospitals creates a small but growing phenomenon: the "patient who can't leave." These patients arrive at a hospital with an acute condition requiring inpatient care—and no insurance. After the acute episode is successfully addressed, the patient is ready for discharge from the hospital for treatment and follow-up therapy in a less intense setting such as a nursing home. But, because the other settings have no obligation to treat uninsured persons, the patient is stuck in the hospital, and hospital with the patient.

Safety net hospitals historically survived on direct government support and charitable contributions. The passage of Medicare and Medicaid provided additional support for care for the poor, although services for the poor—whether uninsured or covered by Medicaid—continued to be concentrated in safety net hospitals. The support added by the passage of Medicaid and Medicare was partially offset, however, by the reduction in direct government subsidy, which is now about 14–16% of costs even for public hospitals. To supplement shortfalls in revenue from direct subsidies and government payers, safety net hospitals have relied on cost-shifting, a mechanism by which they shift excess revenue received on

33. See Gage, supra note 23, at 128-33; Siegel et al., supra note 4, at 427.
34. See Rowland, supra note 11, at 36.
35. See Angela Stewart, Hospitals' new problem: Patients who can't leave, NEWARK STAR-LEDGER, March 6, 2005, at 1.
36. Id. at 16.
37. Id.
38. See Gage, supra note 23, at 126.
39. Id.
40. See Singer et al., supra note 4, at 2.
behalf of insured patients to pay for care for the poor.\textsuperscript{41} This informal cross-subsidy was always difficult for safety net hospitals, given their lower percentage of privately insured patients.\textsuperscript{42} The arrival of the managed care revolution added further challenges to funding for these facilities.

The sweeping adoption of managed care principles in commercial and public insurance injected an emphasis on market methods of financing into the funding for safety net hospitals. The hospitals’ response to managed care has included initiatives ranging from increasing quality and patient satisfaction, reorganizing facilities to prune those deemed redundant or most difficult to finance, and even entering the managed care business for themselves.\textsuperscript{43} One negative effect of managed care on safety net hospitals has been a reduction in the ability to cross-subsidize charity patients with revenue for commercial payers.

As managed care organizations created closed networks of hospitals or fashioned incentives for their members to favor in-network hospitals, prices charged by hospitals came under particular scrutiny. The high intensity of care for the poor and uninsured, and the unsponsored cost of that care, drove up the average cost of safety net hospitals in comparison to other available providers of hospital care. This effect was particularly pronounced for academic medical centers, which had both the cost of medical education and the excess of diagnostic services ordered by doctors in training to add to their bills.\textsuperscript{44} The expansion of Medicaid managed care has been a particular concern, as hospitals now have to bargain for price with an array of managed care organizations focused on the bottom line rather than state governments with more nuanced motives in price negotiations. As is true with commercial managed care, Medicaid managed care threatens to shift paying patients (in this case, those insured by Medicaid) from historical safety net providers to those offering lower per-patient charges.\textsuperscript{45}

\textsuperscript{41} See Gage, \textit{supra} note 23, at 136; Reuter & Gaskin, \textit{supra} note 29, at 152.
\textsuperscript{42} See Gage, \textit{supra} note 23, at 136.
\textsuperscript{43} See Siegel et al., \textit{supra} note 4, at 429-30.
\textsuperscript{44} See Reuter & Gaskin, \textit{supra} note 29, at 155-56.
\textsuperscript{45} See Gage, \textit{supra} note 23, at 139-40.
Safety net hospitals have felt the pinch of these new market conditions. They have adjusted, however. They have seen a rebound in their share of Medicaid patients in recent years, in part through their own efforts, in part due perhaps to the erosion in the power of managed care firms to direct their patients to particular hospitals. They continue to provide a significant percentage of the services received by the uninsured, particularly expensive inpatient services.

How will future reform efforts affect safety net hospitals? There is a bit of a paradox here. As Bruce Siegel has noted:

> Viewed simplistically, any initiatives that increase insurance coverage should have a positive impact on the viability of the safety net, as the uninsured are converted to covered lives. Truly universal health care with meaningful benefits and portability, without onerous cost-sharing, would dramatically reduce the uncompensated care burden of all health care providers. It should most dramatically improve the viability of those with the greatest load, namely those in the safety net.

But, as Dr. Siegel notes, “the devil may be in the details for the safety net.” The caveats he embeds in the above analysis are telling; it is unlikely that we will see the “truly universal” in its complete form in the near future. In the absence of truly universal coverage, there will remain a population of uninsured persons who will seek care, as the

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46. See Singer et al., supra note 4, at 1 (reporting that public hospitals experienced negative operating margins, and margins almost 5% below those of all hospitals nationally).

47. See Siegel et al., supra note 4, at 429-30 (describing business strategies undertaken by safety net hospitals in reaction to market changes).

48. See Singer et al., supra note 4, at 3-4 (describing improved screening efforts and enhanced services for labor, delivery, and recovery services).

49. See James C. Robinson, The End of Managed Care, 285 JAMA 2622, 2623 (2001) Managed care organizations are evolving, and reducing their emphasis on restricting members to narrow networks. Id.

50. See Singer et al., supra note 4, at 5-6 (stating that 32% of NAPH member hospitals' services were provided to Medicaid recipients; 25% were provided to "self-pay" uninsured patients).

51. Siegel et al., supra note 4, at 428.

52. Id.
uninsured always do, with safety net providers, and in particular with safety net hospitals. As Siegel points out, however, incremental reform in the past has both reduced the ability of safety net hospitals to cross-subsidize, and has lessened the political will to support safety net providers (perhaps on the mistaken assumption that such support was no longer needed).\footnote{53} Those who remain uninsured—undocumented aliens, those between opportunities for coverage, and other groups likely to be omitted from incremental reform—will seek help from providers that may be less able to provide it. We are likely to see further incremental attempts to modestly reform the health finance system. The following Part examines two such incremental reforms.

II. REFORM EFFORTS: THE MOVEMENT FROM UNIVERSAL COVERAGE — AND BACK AGAIN.

A. Continued Unease, Renewed Creativity, and Little Traction

In the late eighties and early nineties, many states responded to the growing crisis of un-insurance by advancing broadly systemic reform of various descriptions.\footnote{54} Those efforts uniformly,\footnote{55} leading to increased interest in a federal effort at systemic reform. The Clinton reform plan of 1993-94 was premised on sweeping principles. It began with the “bedrock assumption that all Americans must be guaranteed health coverage.”\footnote{56} It promised more: savings, choice, quality, simplicity, and

\footnote{53. See id.}


\footnote{55. See id. at 61.}

responsibility. The defeat of the Clinton initiative has been attributed to many factors, including a level of support for reform in the electorate insufficient to overcome the interests of those fearful of losing favored positions in the current system, and confusion of the reform message by an excessive effort to compromise. Whatever the cause of this defeat, the order of the day that followed was incrementalism at the federal and state levels, by which modest (but important) changes such as insurance portability guarantees and expansions of public insurance programs have been the focus of reform efforts.

More recently, interest in systemic reform has resumed. In a thoughtful recent book, Timothy Jost has argued that in the long run, American incrementalists' substantial reliance on market mechanisms "will not do the job—they cannot expand access and are unlikely to restrain costs." After describing the history of America's failure to achieve universal health coverage and comprehensively describing universal coverage plans in several countries, Jost declines to set out a "blueprint for the reconstruction of the healthcare system." Instead, he emphasizes that any plan effective at constraining costs and assuring access must take as fundamental individuals' legal rights, or entitlements, to coverage.

57. Zelman, supra note 56, at 11.
62. Id. at 277.
The important point is that in designing or evaluating health-care systems it is vital to consider the role of legal rights. Legal rights obviously play a central role in assuring patients (or insureds or consumers) access to health-care goods and services. But if resources for providing health care are not unbounded, rights also cannot be unbounded; rather, they must be rights to a process that determines in some equitable and reasonable way where the boundaries should be. Finally, in fact, rights must be rights to health care, not merely rights to purchase health insurance if one is wealthy—or healthy—enough.63

Another recent call for a return to reforms directed at universal coverage came from the Institute of Medicine project described above.64 After several years of study, and after the publication of several interim reports, the Institute of Medicine’s Committee on the Consequences of Un-insurance found that the un-insurance problem is growing despite incremental efforts to reverse the trend; the absence of insurance renders people sicker and more likely to suffer premature death; and that families, communities and society at large is harmed by the gaps in our current health finance system.65 It concluded:

The evidence of the Committee’s reports on the problems related to un-insurance leads to a logical conclusion—that the interests of our nation and its residents are best served by adopting policies that result in everyone having coverage . . . . Incremental approaches that are geographically limited, narrowly targeted to a subgroup of the uninsured, temporary, and commit too few new dollars are inadequate to address the problem at hand.66

What do the approaches of Professor Jost and the Institute of Medicine have in common? Both advance as their principal thesis that universal coverage is necessary and appropriate in a just and equitable health finance system.67 But neither advances a specific program of

63. Id.
64. See supra text accompanying notes 16-22.
66. Id. at 153-54.
67. See id. at 154 (“[T]he interests of our nation and its residents are best served by adopting policies that result in everyone having coverage.”); JOST, supra note 61, at 6 (describing a goal of health reform as “secur[ing] for all Americans an entitlement to health care and to all of its benefits.”); id. at 270
reforms to reach the goal of universal coverage. After canvassing the interaction of private and public actors in the United States, Great Britain, and Germany, Professor Jost chooses to focus on the importance of establishing enforceable entitlements to care and coverage, and not exclusively on the vehicle through which coverage is provided. Although he clearly favors a single-payer model as the most efficient and most protective of individuals' entitlement to care, he recognizes that other nations—the Netherlands and Germany, for example—have achieved near-universal coverage with a mixed public and private system. He also acknowledges that the culture and political history in the United States may counsel a larger role for internal competition than is present in other systems.

The Institute of Medicine similarly emphasized the overarching goal of assured universal coverage rather than the nature of the system that would provide such assured coverage. The Institute's report instead sets our four "prototypes" that could serve as vehicles for achieving universal coverage: a single payer system in which a federal agency would centrally administer a single, comprehensive benefits package financed through general tax dollars; a combination of our current mixed public-private insurance system with expanded public programs, a mandate on non-poor individuals to purchase coverage, and a tax credit to aid in financing that purchase; a combination of our current mixed public-private insurance system with expanded public programs, a mandate that employers cover employees, a mandate for individuals not covered at their place of employment to purchase coverage, and subsidies to assist both employers and individuals; and an expansion of public insurance, and federal financial support for

(\text{"[W]e should aim for an entitlement program that covers the entire population."}.)

68. See JOST, supra note 61, at 270.
69. Id. at 273-75.
70. See PRINCIPLES AND RECOMMENDATIONS, supra note 16, at 155.
71. See id. at 131.
72. See id. at 129-30.
73. See id. at 128-29.
employers and individuals who purchase coverage, which purchase would not, however, be mandated.\(^4\)

Professor Jost’s and the Institute of Medicine’s proposals can be seen as an evolutionary stage in the American struggle between systemic and incremental reform. Both advance universal reform in the sense that they focus on the importance of assuring that every resident of the United States be assured of coverage and access to care. They are less focused on describing precisely the means by which universal coverage may be achieved; Professor Jost allows room for substantial America-specific tinkering with basic single payer systems, and the Institute of Medicine goes no further than describing a varied menu of program designs that could, if coupled with legal rights and adequate funding, achieve the goal of universal access. The two, then, represent a melding of universal reformers’ insistence on coverage for all with incrementalists’ openness to pragmatic design experimentation.

This melding of the conceptual branches of health finance reform has great promise. Key to its success as a vehicle for achieving successful reform is the continuing development of mechanisms for coverage that can be plugged into a program of universal coverage. Both Professor Jost and the Institute of Medicine incorporate many design choices into their analysis. The next two parts of this Article examine two emerging mechanisms for adjusting health finance to achieve the goal of health coverage more efficiently and effectively. The two mechanisms—consumer-directed health care and government reinsurance of market coverage—have been the subject of substantial attention by health finance policymakers.

B. Consumer-Directed Health Care

Consumer-driven health care rejects the notion (central to managed care) that consumers need expert help to make health purchasing decisions. It directs itself to “getting [health plans] out from between the consumer and the services the consumer wants to consume.”\(^5\) Plans that

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74. See id. at 126-27.

75. James C. Robinson, Renewed Emphasis on Consumer Cost Sharing in
manage care are criticized for assuming "patient ignorance," and patient directed plans are advanced as means to further consumer autonomy and contain costs. Employers see patient directed plans as a means to reduce their own financial exposure for increasing health costs by shifting part of the responsibility to their employees. The spectrum of consumer-driven arrangements runs from the mild version, in which consumers are given incentives in the form of tiered pricing to internalize some of the marginal cost of expensive providers, to the stronger version in which consumers are given the power and responsibility to choose their care and their provider, at least for a portion of the services they receive.

Consumer-driven plans' cost-containment rests on the assertion that raising the amount of health costs directly borne by consumers will reduce consumption of health care services. The simplest way for health plans to couple this

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Health Insurance Benefit Design, W139, W145 (Mar. 20, 2002), at http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.139v1 ("[H]ealth plans increasingly interpret their role as one of packaging health care services, pricing them at actuarially sustainable rates, gathering and disseminating information, promoting electronic conductivity among all participants, and otherwise getting out from between the consumer and the services the consumer wants to consume.").

76. See John C. Goodman, Designing Health Insurance for the Information Age, in CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICYMAKERS 224, 224-26 (Regina E. Herzlinger ed., 2004) (criticizing managed care methods as basing a strategy on "patient ignorance" thereby denying consumers choice in selecting medical treatment). Portions of this section of this Article draws from Part I(C) of John V. Jacobi, Consumer-Driven Health Care and the Chronically Ill, 38 MICH. J. LAW REF._ (forthcoming 2005) (manuscript on file with author).

77. Goodman, supra note 76, at 235-39 (arguing for the value of informed consumer choice and direct consumer power to select care). See also John V. Jacobi, After Managed Care: Gray Boxes, Tiers, and Consumerism, 47 ST. LOUIS U. L.J. 397, 406 (2003) ("The promise of most consumer-driven plans is that consumers themselves can act as prudent purchasers if given the chance, obviating the need for managed care plans to act as expert intermediaries between consumers and providers . . . .").


79. See MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS 26 (1997) ("Empirical studies verify that patients subject to increased cost sharing spend dramatically
basic cost-containment device with a means for consumers to exercise greater autonomy in health care choices is to relate cost-sharing to the price of the service, so that a provider charging the plan a high price could be accessed only with the payment of a high co-payment, while a lower-price (to the plan) provider could be used with the payment of a lower co-payment. This use of tiers permits members to choose from a broad range of providers, but forces them to bear a part of the excess cost, thereby presumably damping their enthusiasm for the most expensive providers.

The practice is most common in pharmaceutical benefits, where most plans now separate available drugs into three tiers—generic drugs, lower-cost name brand drugs, and higher-cost name brand drugs—with co-payments rising from tier to tier. The practice has spread to other services, including physicians and hospitals. This practice serves the plan’s interests in extricating itself somewhat from its mediating role, while maintaining some level of incentive for employees to use lower-cost providers:

An emerging set of health insurance benefit designs seeks to retain some of the advantages of provider coordination while broadening consumer choice. Rather than arm-wrestling with doctors and medical groups under the implicit threat of network exclusion, these insurance products include any willing physician and provider organization but pass the differences in fee levels on to the consumer through higher premiums or co-payments. At the extreme, these insurance product designs do not negotiate fees at all, creating a market that permits providers to charge whatever they think their patients are willing to pay and that permits consumers to choose among all providers rather than be limited to a contracted subset. The premium charged to the employer covers

80. See Jacobi, supra note 77, at 403-04.
most or all of the fees charged by low-cost providers, while the employee pays the full incremental cost of the fees charged by more expensive providers.\textsuperscript{82}

The move to pricing tiers allows a half-step between more traditional forms of managed care and fuller forms of consumer-driven care. But even the quite aggressive use of tiers fails to address some central concerns of the consumer-driven health care movement. To the extent plans are screening some providers out before creating tiers, they are still mediating between consumers and their choice of health care at some autonomy cost to members. To the extent the graduated co-payments only signal, rather than pass on, the marginal cost of expensive providers, plans are merely using proxies for markets instead of employing them directly. The starker break with traditional health plans comes with the consumer-driven plan that combines a spending account with a high-deductible plan, a consumer-driven option that is much discussed, much supported by recent changes in law,\textsuperscript{83} and slowly finding a place in the market.\textsuperscript{84}

The central form of CDHP has three parts—or maybe two parts and a gap.\textsuperscript{85} One version of CDHP provides, first, for payment of an amount into a Health Savings Account

\begin{itemize}
  \item 82. Robinson, \textit{supra} note 75, at W147 to W148.
  
  \item 83. \textit{See infra} text accompanying notes 103-06.
  
  \item 84. \textit{See James C. Robinson, Reinvention of Health Insurance in the Consumer Era, 291 JAMA 1880, 1882 (2004)} ("The most discussed, if least-purchased, contemporary innovation in benefit design is a product that combines a high-deductible PPO with an employer-financed but employee-managed and tax exempt health savings account . . ."); \textit{Jon Christianson et al., Defined- Contribution Health Insurance Products: Development and Prospects, 21:1 HEALTH AFF. 49, 50 (2002)} (describing high visibility but low market penetration of these arrangements), available at \textit{http://content.healthaffairs.org/cgi/reprint/21/1/49} (last visited May 19, 2005).
  
  \item 85. \textit{See Jon B. Christianson, et al., Consumer Experiences in a Consumer-Driven Health Plan, 39 HEALTH SERVS. RESEARCH 1123, 1123-24 (2004)} ("Consumer-driven health plans" has been applied to various structures, but "[r]ecently . . . the most common use of the term has been in reference to benefit plans with three core features: a personal care account; insurance coverage designed to create a 'gap' between the dollars in the account and the level at which a deductible is reached; and various Internet support tools" to assist consumers.).
\end{itemize}
that the consumer and her dependents may use for payment of health expenses. Second, it provides that the consumer has a deductible that the consumer must pay out of her own funds after the HSA is exhausted. Third, it provides insurance that attaches after the HSA contribution plus the deductible have been expended. The residual insurance may have co-payments, subject to out-of-pocket limits, as does more traditional insurance. Consumers, then, would have substantial control over and responsibility for their health spending. This, of course, is the raison d’être for CDHPs: to reverse or blunt the effect of moral hazard, the artificial willingness to overspend that may follow from traditional third-party insurance, and that is often described as the basis for high American health care costs. At one end, the plan first provides a tax-favored spending account for the employee—called a “health savings account” by the Medicare Modernization Act, from which the employee can purchase health care services. At the other end, the plan provides a high-deductible health insurance plan—a traditional PPO, but with coverage that does not attach until the employee has incurred a large deductible. The plan then ordinarily requires the employee to pay an additional unfunded deductible, although this additional deductible is not


87. See § 1201(c)(2) (defining “high deductible health plan” for purposes of the Act).


89. See Medicare Prescription Drug, Improvement, and Modernization Act § 1201(a) (amending IRC § 223 and defining “Health Savings Account”).

90. See § 1201(a) (defining “High Deductible Health Plan”).

91. See Jon R. Gabel et al., Consumer-Driven Health Plans: Are They More Than Talk Now?, W395, W396 (Nov. 20, 2002), at http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.395v1 (“When the account is exhausted, enrollees must typically pay out of pocket until the annual deductible is met, after which the plan becomes a traditional major medical plan.”).
required for the savings account to maintain favored tax status.92

HSAs, health savings accounts, are the heart of CDHPs. Through this mechanism, the plans give members a sense of ownership over the funds and encourage them to be careful purchasers of health services.93 Through this mechanism, consumers are encouraged to participate in a genuine market for health care services, making judgments, as with any consumer purchase, as to the utility of spending as opposed to saving "their" money. Several conditions encourage this sense of ownership. A consumer is likely to feel greater ownership of funds, and therefore use greater care in spending them, if his ownership rights do not disappear on an arbitrary date such as the end of the tax year. In 2002, the IRS facilitated the expansion of CDHPs when it ruled that unspent funds in a spending account could roll over from tax year to tax year, maintaining the funds tax-favored status.94 The Medicare Modernization Act codified that result in statute.95 The sense of ownership is also enhanced if the fund both rolls over and can be converted to other uses if not used for health care.96 Prior to the passage of the Medicare Modernization Act, funds in spending accounts could only be used for medical services. The Act, however, permits the funds to be withdrawn after the beneficiary reaches retirement age with no penalty, and is subject to tax only as ordinary income; the spending account, under those

92. See § 1201(a) (permitting the amount of contribution to the health savings account to equal the amount of the deductible of the high-deductible health plan).

93. See Mark V. Pauly & John C. Goodman, Tax Credits for Health Insurance and Medical Savings Accounts, 14:1 Health Aff., 125, 130 (1995) (arguing that if consumers are assigned specific funds in a spending account devoted to their own benefit, that they will treat them as their own).


96. See Pauly & Goodman, supra note 93, at 130 (stating that incentives to overspend on medical care are reduced if funds in the spending account "can eventually be used for purposes other than medical services . . . ").
circumstances, converts to the functional equivalent of an individual retirement account.  

This mechanism is obviously aimed at blunting the effect of moral hazard. Employees "own" a fund available to cover a portion of health expenditures. When faced with a spending decision, then, they will tend to balance the cost of a proposed service more carefully against the benefits, as they have a much more direct stake in the expenditure than in a system in which they are wholly or partially covered by third party insurance for their care. If, as many acerbic critics of current third-party insurance insist, the single greatest cause of health inflation is the absence of a true consumer-driven market for health care, then HSAs are central to changes in health insurance. In a simple package, they address the frustration consumers express about interference with medical judgments, and address plan sponsors' concerns about health cost increases. The Medicare Modernization Act permits HSA funds to roll over without limit, permitting accumulated funds to serve primarily as a source for medical spending, but ultimately as a source of retirement funds. The President's Council of Economic Advisors has singled out this strong consumer ownership provision of the Medicare Modernization Act as a particularly important aspect of the cost-containment value of consumer-driven health care:

Once [an HSA is] established, this money belongs to the individual and can accumulate over time. The account remains with the individual if he or she changes employers . . . . With less reliance on insurance for routine health expenses, consumers would place a greater value on information about health care options and


98. See CONSUMER-DRIVEN HEALTH CARE, supra note 76, at 58 (identifying the cause of “massive expenditures on health care: "To me, the reason is obvious: health care systems worldwide are guided by someone other than the consumer." (italics in original)); JOHN C. GOODMAN & GERALD L. MUSGRAVE, PATIENT POWER: SOLVING AMERICA'S HEALTH CARE CRISIS 12 (1992) (“In most other sectors of our economy, individuals who make decisions realize most of the benefit from good ones and bear most of the cost of bad ones . . . . The market for health care could be organized in a similar way.”).

99. See Medicare Prescription Drug, Improvement, and Modernization Act § 1201(a) (amending IRC § 223(d)).
More prudent use of insurance would also reduce "middle-man" costs involving an insurance company in what could otherwise be a simple transaction between the patient and the caregiver.\(^\text{100}\)

HSAs, then, provide a fund, considerably under the control of consumers, from which a broad range of health services may be purchased.

The second element of these consumer-driven plans is a gap in coverage between the limits of an HSA and the attachment point of the high-deductible health plan. This deductible, along with the sense of ownership of HAS funds, is intended to minimize the distortions attributed to the moral hazard associated with third-party insurance.\(^\text{101}\) The arguments for the cost-containing effects of HSAs based on a member's sense of ownership for the funds apply even more directly to an additional deductible, as the out of pocket funds are literally owned by the member. Members' dislike of large deductibles can be addressed to a certain extent by permitting the unspent HSA funds to roll over, permitting members at least the possibility that they could avoid all or part of the deductible in future years. The deductible, then, would not pose a barrier to PPO coverage for members who had been able to build up funds in their HSA because they had few health care needs in previous years (although the roll-over feature is a double-edged sword, as it lessens CDHPs' ability to blunt the effect of moral hazard). After the first year of coverage, the deductible would serve as an additional check on spending (and an additional direct savings of funds for the plan sponsor) only for those members who had reason to use the funds in their HSA in previous years.

The third element of CDHPs is high-deductible insurance that attaches after the exhaustion of the HSA and the deductible. Advocates of consumer-driven health care readily acknowledge that there is a place for health insurance in its traditional sense, in which insureds or their sponsors pool funds against the possibility of large


\(^{101}\) See Pauly & Goodman, supra note 93, at 129 (suggesting that moral hazard can be combated by setting up system by which plan members pay at least some expenses out of pocket).
unexpected health costs. They object to "insurance" coverage of predictable, routine, relatively minor expenses. Other than the fact that it has an unusually high deductible, the coverage that attaches at the back end of consumer-driven coverage creates few novel concerns. It can incorporate routine cost-sharing requirements and in- and out-of-network price differentials as do most traditional health coverage, subject to annual out-of-pocket maximums.

C. Government as Reinsurer

Private, employer-based health insurance can be relatively cost-effective, even when compared with public health insurance programs. With smaller groups, the administrative costs—including those attributable to sales commission, underwriting costs, advertising costs, and profits can rise dramatically. This is particularly true in the individual insurance market, in which insurance is purchased by individual consumers for themselves or themselves and their families only. In the individual insurance market, the "load," the cost of coverage above that needed to pay for patient care, can rise to 30% to 40% of premiums.

102. See Pauly & Goodman, supra note 93, at 129 (advocating the coupling of individual spending accounts with "catastrophic" (high deductible) health insurance); GOODMAN & MUSGRAVE, supra note 98, at 44 (advocating high-deductible insurance).

103. See CONSUMER-DRIVEN HEALTH CARE, supra note 76, at 61-64 ( likening low-deductible health insurance to "breakfast insurance," in which one purchases coverage for the cost of breakfast); Phil Gramm, Why We Need Medical Savings Accounts, 330 NEW ENG. J. MED. 1752, 1752 (1994) ( likening low-deductible health coverage to "grocery insurance"); GOODMAN & MUSGRAVE, supra note 98, at 58 (criticizing traditional Medicare for paying for minor expenses that beneficiaries could budget for on a routine basis, while failing to cover truly catastrophic costs such as custodial nursing home care).

104. See David A. Hyman & Mark Hall, Two Cheers for Employment-Based Health Insurance, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 31 (2001) (administrative costs for large group private insurance can be as low as 5% of premium).


106. See Jost, supra note 105, at 427 (stating that loads in the individual insurance market can account for 35% - 40% of premium); Hyman & Hall, supra note 104, at 31 (stating loads can "go above 30% for individual purchasers").
Some of the extra administrative cost of small group and individual insurance is attributable to diseconomies of scale. It simply costs more per member to administer a plan covering a few people than it costs per member to administer a very large group. But a significant part of the extra cost of small group and individual insurance is attributable to the "risk premium"—the additional premium charged by insurers in anticipation that individuals purchasing insurance, or some members of a small group, will be at high risk for significant health costs, rendering the premium bargain a losing proposition for the insurer.\textsuperscript{107} The risk of adverse selection—that is, the self-selection for coverage of a disproportionate number of high-risk persons—is perceived to be high in the individual and small group markets. In part this is because the high administrative costs of small group and individual insurance renders those forms of insurance too expensive for persons who do not anticipate that they will be at risk for high health care costs in during the coverage period; in part it is because insurers believe that people who are not employed by large firms, particularly those who are self-employed or unemployed, tend to be less healthy.

Individual and small group insurance comprise a relatively small but important part of the American health insurance market. The high administrative costs for these forms of coverage, and particularly the attempts by insurers to avoid high-risk customers when selling this form of coverage, create a form of market failure crying out for a regulatory response.\textsuperscript{108} The governmental response to this problem over the last two decades has included programs of reinsurance, by which government provides (or finances) coverage for claims by members of small group insurance and/or purchasers of individual insurance when their claims exceed a threshold amount during the coverage period.\textsuperscript{109}

\textsuperscript{107} See Jost, \textit{supra} note 105, at 428.


The most familiar form of government reinsurance is the high-risk pool, in which people uninsurable in the open market find insurance through specially-constructed pools for people who have been and are predicted to be high cost consumers of health care. Individuals with underwriting indications of high risk, who would otherwise be denied coverage, are offered membership in a high-risk pool. The premiums are sometimes capped at a multiple of the average premium of a similarly situated well person, and benefits levels limits may be less rich than in standard policies. In Idaho, for example, all carriers are required to guarantee issue of a high-risk product, and may charge a premium that is capped at 200% of the average premium for a standard-risk member. Even with this higher premium, reinsurance is necessary. The allocation of responsibility between the carrier and the reinsuring state is allocated as follows:

Each carrier is responsible for the initial $5,000 of benefits paid per calendar year for each enrollee in a high-risk pool plan, as well as 10 percent of the next $25,000. Above these amounts, the High-Risk Reinsurance Pool fully reinsures the enrollee.

The funding for the reinsurance pool comes to the state from an assessment on health carriers; the carriers, therefore, are spreading the risk among themselves, and eventually to all of their insureds.

High-risk pools are well-established, and almost uniformly quite small. Recently, however, states have expanded the concept of reinsurance of private insurance to

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111. See Kaiser Family Foundation, supra note 110 (gathering state plan descriptions).

112. Chollet, supra note 109, at 2.

113. See Kaiser Family Foundation, supra note 110.

114. See Chollet, supra note 109, at 2-4.
serve a broader social goal: the stabilization and support of the general individual and small group insurance markets.115 Through reinsurance, states attempt to “improve the predictability of claims, and reduce the mark-up of premiums that insurers charge as a buffer against unanticipated claims.”116 As is stated above, small group and individual insurance is more expensive than large group insurance, resulting in higher rates of insurance for people who are self-employed, unemployed, or working for a small employer. While part of the higher cost is the diseconomy of scale caused by individual and small group sales and servicing, a significant portion of the higher cost is attributable to the risk premium caused by fears of adverse selection in these markets.117 Through this form of reinsurance, government permits the private carriers to operate as market participants, competing with each other on the basis of quality, service, and price, while moderating the cost effects of the risk exposure inherent in these markets:

If the government becomes the reinsurer in nongroup [and small group] markets, these markets can operate more efficiently. The costs of producing health insurance will be lower, which will reduce premiums and ought to induce more uninsured people to purchase coverage.

Having the government assume the role of reinsurer also spreads the burden of the costs of very-high-cost people from the relatively small number of people insured by any particular carrier to the broader population base of all taxpayers.118

These reinsurance programs are designed so as to moderate the risk premium while leaving an incentive with the insurance company to manage the cost of care:

For example, government reinsurance might be initiated when a person spends more than $30,000 in a given year. The reinsurance might be responsible for 90 percent of costs between $30,000 and $75,000; then 85 percent for costs between $75,000 and $125,000; and then again 90 percent of costs between $125,000 and

115. See Chollet, supra note 109, at 1; Swartz, supra note 110, at W380.
117. See Jost, supra note 105, at 427; Chollet, supra note 109, at 1.
118. Swartz, supra note 110, at W381.
$200,000, before finally assuming 100 percent of the costs above $200,000.119

The initial coverage is treated as coverage for a low-risk person—as the responsibility of the carrier. When a member crosses a threshold to become a high-cost member, the state takes over primary responsibility for cost, but the carrier continues to be responsible for providing coverage and coordinating the care of the member as required under the insurance contract’s terms. To ensure that the carrier does so efficiently, it remains responsible for a portion of the cost (10-15% of the total in the example above) to remain vigilant over expenditures, until the member reaches a very high threshold.

New York's version of reinsurance for small group and individual insurance is called Healthy New York. It was established in 2001, and already has established itself—it had 67,000 active enrollees as of August 2004, and was enrolling about 5500 new members per month.120 It is open to small employers who have a significant number of low-income workers, and to individuals with family incomes below 250% of the federal poverty level.121 Barriers to participation are intended to prevent the crowding out of unsubsidized insurance coverage; for example, enrollees must have been uninsured the previous year.122

New York’s level of reinsurance is somewhat less generous than the example given above—it provides 90% of the costs between $5000 and $75,000 for any calendar year.123 Even at that level, however, it is estimated that Healthy New York will finance about 13.5% of costs for insureds in the program, and more significantly, reduce the need for carriers to build risk premiums into their rates.124

119. Id.
120. Chollet, supra note 109, at 5.
121. Id. at 4.
122. Id.
123. Id. at 5.
124. Id. at 5. It is interesting to note insurers' response to changes in the reinsurance design. Prior to 2003, the reinsurance corridor was between $30,000 and $100,000. In 2003, it was changed to $5,000 to $75,000. Insurers reduced their premiums by approximately 17% in 2003, largely in response to the change in reinsurance design.
Healthy New York demonstrates that it is possible to design a reinsurance program that makes a modest, although not inconsequential, dent in the problems of insuring people in the small group and individual markets.

The next Part returns to the discussion of systemic reform, the stake the uninsured and safety net providers have in systemic reform, and the relationship between the goal of systemic reform and the incremental strategies of consumer-driven health care and government reinsurance of private health coverage. It considers the weaknesses of both incremental strategies as they stand alone, and proposes a method for drawing aspects of both into a synthetic reform proposal.

III. SYNTHESIS FOR A “NEW BALANCE.”

The above discussions suggest the following points. First, health coverage promotes regular access to necessary care; the absence of health coverage is closely associated with impaired health status and the likelihood of death at an early age. Universal coverage for necessary health care is therefore a public policy goal of significant moral import. Second, the lack of universal coverage and the proliferation of market-based “reform” measures have placed strains on safety net providers, as they remain the provider of last resort for the uninsured but face diminishing opportunities for funding. Third, recent history suggests that the movement to universal health coverage in the United States is a difficult one, and that consideration of the particular political and social concerns that have stymied past reform efforts is important. In particular, as both Professor Jost and the Institute of Medicine counsel, a pragmatic implementation strategy should accompany pursuit of the fundamental goal of universal coverage.

This Part first briefly reviews the barriers to implementation of universal coverage and the clear political preference for incremental steps toward addressing the problem of un-insurance. It then examines the weaknesses of the two incremental reforms described above: consumer-driven health care and government reinsurance of private coverage. Finally, it suggests a synthesis of these two incremental reforms as a platform for broader reform. This synthesis takes from the theory of consumer-driven health care the breaking apart of insurance coverage into its
constituent parts: one covering routine care and treatment of non-catastrophic illness, and another portion covering catastrophic coverage of high-cost treatment for expensive acute and chronic conditions. It applies this insight to the limited success achieved by state governments in providing reinsurance for the small group and individual markets, allowing private insurers to cover routine costs and design provider networks, leaving government the task of spreading catastrophic costs more broadly.

A. The Limits to the Separate Pieces

The failure of repeated efforts to produce a politically viable program of universal coverage can be discouraging. Much of the current resistance to new initiatives originates in financial concerns; budgets are bad at all levels of government, and America’s anti-tax period continues. New ideas are essential; they might not be right, and they might not work, but new ideas are needed to breathe new life into the debate. The costs are real, and there is no question that extending coverage to the 45 million uninsured Americans will require new spending at the federal level. The Institute of Medicine’s Committee on the Consequences of Un-insurance estimated the cost the new medical services universal coverage would bring:


Should one be optimistic about rational reforms for our health care system in 2004 and beyond? Given the state of the U.S. economy, and a depressing world situation characterized by unending and escalating conflicts, there is little to be optimistic about in regard to health care. Resources, financial and human, which could be directed to improving the human situation generally will instead, for the foreseeable future, go to the unanticipated additional expenditures related to international terrorism. Consequently, there is not much hope for the 44 million Americans who do not have health insurance, the millions of people throughout the world who not only lack access to even modest health care but face the onslaught of HIV/AIDS, tuberculosis, malaria and other infectious diseases with few or no resources.

Id.

126. See James J. Mongan & Thomas H. Lee, Do We Really Want Broad Access to Health Care?, 352 NEW ENG. J. MED. 1260, 1260-61 (2005); Southby, supra note 125, at 442-43.
The costs of the additional health care that would be provided to the uninsured once they become insured will be on the order of $34 to $69 billion a year . . . . This amounts to a 2.8 to 5.6 percent increase in spending for personal health services for 2001. It is equivalent to between one-third and two-thirds of the 8.7 percent growth in national expenditures for personal health services between 2000 and 2001. \(^\text{127}\)

The cost is large but not prohibitive, and is arguably offset to a large degree by the social savings realized by reducing the personal, family, community and societal costs created by the absence of insurance. \(^\text{128}\) I will say nothing more about the funding issue, and lay it aside at this point. What, then, should be done? Judith Feder and Mark Pauly have recently argued in separate articles that what has scuttled previous proposals has been the interference such proposals would work on existing insurance programs—programs with which people are at least moderately satisfied. Feder argues,

Recent debates about coverage expansions have consistently drawn attention to the fiscal "crowd-out" effect—the degree to which the newly available, publicly financed coverage will replace privately financed coverage currently in effect. But a review of the nation's policies and politics indicates that from a political perspective, the problem is exactly the opposite. It is the attachment to existing private coverage that "crowds out" the political potential for proposals that would truly expand coverage to the uninsured. \(^\text{129}\)

Pauly makes a similar argument. He suggests that most Americans favor some form of expansion that would provide coverage to the uninsured. They favor, however, many different methods for addressing un-insurance, and many people's favored plan conflicts with others' favored plans. Further, "for each group, the next best alternative to its preferred solution is to do nothing, and no single group constitutes a majority." \(^\text{130}\)

\(^{127}\) HIDDEN COSTS, supra note 16, at 104 (citation omitted).

\(^{128}\) Id. at 105-19.


Professor Jost recommends flexibility in constructing a program for achieving universal coverage. The Institute of Medicine's Committee on the Consequences of Uninsurance recommends pragmatism in melding public and private, mandatory and optional strategies for reaching universal coverage. Professor Feder counsels sensitivity to the comfort many people feel in their current health finance state. And Professor Pauly suggests that progress can be made if public program supports bend to allow for public financing of a variety of plans (some private), and if market advocates were to agree to methods of controlling administrative costs in private plans and to the use of public, as well as private, insurance as vehicles for expansion. This simple summary takes great liberties with quite subtle arguments. What is clear from past setbacks, however, is that efforts to expand coverage must, at least for the foreseeable future, hew a path between universal plans that install coverage for all while sweeping away many existing institutions, and incremental plans that tinker at the edges of the existing system but leave the structure of private insurance unchanged. The former goal feels unreachable across a chasm of special interests, risk aversion, distrust of government, and tight budgets. The latter is simply not enough. In the face of diminishing private coverage, small-scale adjustments are shifting deck chairs on the Titanic.

Consumer-driven health care, as I have argued at length elsewhere, takes our notions of health insurance apart in an interesting way—separating the catastrophic coverage from more routine and preventive coverage. However, the implementation of consumer-driven health care then focuses on the wrong disaggregated aspect when addressing cost control—the initial expenditures of the many and not the extremely expensive costs of the few very sick. Seventy percent of health costs each year go to the

Stuart Altman for originating this insight.

131. See supra text accompanying notes 62-64, 67-70.
132. See supra text accompanying notes 65-67, 71-75.
133. See supra text accompanying note 130.
134. See Pauly, supra note 130, at 467-69.
135. See Jacobi, supra note 76 (manuscript at 39-51).
136. See id. (manuscript at 79-80).
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sickest ten percent of the population, and forty percent go to the sickest two percent.\textsuperscript{137} The disaggregation of the health insurance structure may be helpful; the focus on the marginal spending of the well fails to address the greatest opportunity for economies, and avoids the truly critical social concerns of assuring appropriate care for those most in need—those with serious chronic illness.\textsuperscript{138}

B. Synthesis – A Pragmatic Melding of CDHC and Government Reinsurance

This section attempts to suggest a strategy for addressing un-insurance that pays heed to the wisdom discussed in the previous section. It attempts to borrow insights and structures from consumer-driven health care and from government reinsurance programs. It attempts to do so in a way that can be extended to the entire population, that is respectful of the interests of people to maintain connections, where possible, with their private coverage, that attempts to contain administrative costs, and that might work.

The core model of consumer-driven health care, which combines a personal spending account with high-deductible insurance,\textsuperscript{139} highlights an important aspect of health insurance. Modern health insurance is really two things. First, it is protection from catastrophic expenses incurred when a person suffers an expensive acute or chronic spell of illness. Second, it is payment for more modest, and more predictable costs of preventive care and relatively routine care. All agree that first set of costs is the proper subject of insurance. Advocates of consumer-driven care argue that the second set of costs is not the proper subject of insurance;\textsuperscript{140} for the reasons described above, that argument is contestable.\textsuperscript{141} But coverage for catastrophic losses and more routine expenditures are sufficiently

\textsuperscript{137} See id. (manuscript at 65-66).

\textsuperscript{138} See id. (manuscript at 72-79).

\textsuperscript{139} See supra text accompanying notes 83-104.


\textsuperscript{141} See supra text accompanying notes 135-37.
different to permit them to be treated quite differently by the health finance system.

Government reinsurance programs have been little more than a curiosity, given their size and the extent to which states guard against the possibility of crowding out unsubsidized insurance, and programs catering to individuals and groups priced out of the traditional insurance market are vulnerable to adverse selection concerns. But reinsurance has several very attractive attributes. First, it permits employers and individuals to choose and maintain their own insurance. Second, it serves double-duty by both subsidizing the cost of coverage and moderating (at least for small group and individual coverage) the effect of the risk premium—thereby cutting a dead-weight loss from the system. Third, it permits variation in richness to add or subtract government subsidy as appropriate through the modification of the attachment levels for reinsurance.

A program that places government frankly and broadly in the role of reinsurer for private health insurance synthesizes the most valuable aspects of CDHC and programs like Healthy New York. The program, operated either as a federal or joint state/federal venture, could operate as a reinsurer of all small group and individual coverage or all private coverage. The program could provide coverage of high-cost claims as described above. This move would add substantial government support for health coverage without increasing government’s role as primary insurer. It would leave intact the existing infrastructure of both the employment-based insurance market and the individual insurance market, and even accommodate experimentation with new consumer-driven health care models. The virtues of this program would be several.

142. See Chollet, supra note 109, at 4-5.
143. See supra text accompanying notes 107-13, 117-19.
144. See supra text accompanying notes 119-24.
145. These are the areas in which reinsurance has been used by states, in large part because most employees of large firms are insured. See Chollet, supra note 109 and Swartz, supra note 110.
1. A comprehensive reinsurance program moderates adverse selection concerns. One of the concerns with more modest reinsurance programs (and with many small-scale attempts to intervene in small group and individual insurance markets) is that the reform efforts will lead to a skewing of the market. Adverse selection arises when an insurance product is attractive to high-risk consumers, leading to an unexpectedly expensive risk pool. In the reinsurance context, the concern is that "[i]f the primary insurance program attracts an unusual volume of high-cost groups or individuals, the cost of reinsurance, and, therefore, the cost of the whole insurance package, will be higher." If the reinsurance program, however, is available to all insurers in the market, for all of their business, then the risk of a distorting effect arising from adverse selection is reduced or eliminated.

2. A comprehensive reinsurance program reduces the risk of the crowding out of existing insurance. Crowd-out of existing insurance arises when a new government program or a new subsidy provided in a targeted way leads people to drop purely private coverage to gain the advantages attendant on membership in the new program. Crowd-out can occur in reinsurance programs when a small segment of the market gains the price advantage of reinsurance. Again, however, providing reinsurance to all the participants in the market reduces or eliminates the possibility of crowd out.

3. Reinsurance programs leave current coverage arrangements intact, and may staunch the flow out of employer-sponsored coverage. The employment-based private insurance system, so long the core of American

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146. See Chollet, supra note 109, at 4.
150. Chollet, supra note 109, at 4.
health coverage, is shrinking. Continuing health care inflation strains employers' ability to maintain coverage, particularly in small workplaces employing low and moderate income workers. Incremental reform programs based on the creation of new public insurance programs directed at low and moderate income workers face the problem of "crowd out." Crowd-out occurs in this context when employers marginally able to provide coverage to their employees drop that coverage in favor of their employees’ enrolling in the new government program. The new public insurance program thereby experiences larger than projected costs as it is accessed not only by those who were previously uninsured, but also by some portion of the previously-insured population.

In an attempt to respond to the deterioration of the employment-based insurance system, then, incremental reforms may accelerate that deterioration, and lead to an increase in the cost of such reform programs.

To a certain extent, any publicly funded response to the deterioration and increasingly apparent inadequacies of the private insurance market will suffer from the crowd-out phenomenon. Reinsurance programs can, however, if thoughtfully constructed, minimize this risk. First, if reinsurance is offered to all private plans, the government subsidy is comprehensively spread and no hot pockets of public subsidy will exist to drain the marginally insured from their current coverage. Second, even if a program were more targeted—e.g., to only small group and individual coverage, or to such coverage when the members are below a threshold income level—the targeting could minimize crowd-out. For example, if all individual and small group coverage were eligible for a public reinsurance program, then current insurance would benefit as well as new plans, and members would likely stay put, enjoying the benefits of the subsidy in the context of their existing coverage.

151. See Glied & Borzi, supra note 2, at 406.


4. The subsidy applied to reinsurance programs could be metered, allowing a gradual increase in public funding as budgets allowed. The logic of health reform through government reinsurance holds for all forms of private insurance. Large employers, like small employers and individuals, are facing the problems arising from inflation in health costs. Offering government reinsurance to all privately groups and individuals would stabilize and subsidize our private insurance system, and perhaps serve as a recognition that some health costs—perhaps the catastrophic costs of care for those with serious acute or chronic conditions—are social responsibilities. But the subsidy could be applied in steps, as budgets permitted. The progression might be from small, targeted programs like Healthy New York, to the care of all persons below a set income level, to all small group and individual coverage, to all insured coverage, to all insured and self-funded private coverage. In this way, the subsidy could be rolled out without substantial risk of crowd-out, at a pace consistent with the ability of government to absorb its share of the cost.

5. Reinsurance programs could facilitate the development of disease management programs. Reinsurance programs are designed to share the burden of high-cost cases between government and private insurers. A substantial percentage of the high-cost cases are chronic cases or acute cases requiring coordinated care over a substantial period of time.\textsuperscript{154} It has long been recognized that coordination of care in such cases benefits both the patient and the funder of services.\textsuperscript{155} Truly coordinated and effective disease management programs, however, have been slow in coming. Giving government a direct stake in the cases in which disease management may allow for more coordination of research in this area; the residual stake of private insurers may permit a wide range of experimentation while such programs develop.

\textsuperscript{154} See supra text accompanying notes 109-25.

C. Concerns: Efficiency and Safety Net Providers

The benefit of government's acceptance of the obligation to cover much of the catastrophic costs of the most expensive privately insured people is substantial. The reform must be acknowledged to be yet another incremental reform, although one that could easily (if not inexpensively) be applied to all privately insured Americans. Two major concerns should be noted here.

1. The reform would lock in much of the excess costs of private insurance. The reinsurance program described above would build government responsibility for coverage on a system of private insurance. The virtue of this move is that it avoids the dislocations that arguably doomed prior, more intrusive attempts to expand access to health coverage. The vice is that it builds upon a flawed structure—a private insurance system that adds substantial costs for marketing, administration, and profits, particularly in the small group and individual markets. The reinsurance proposal therefore builds in significant inefficiencies that divert health care funding from patient care. It may be that this cost is necessary and appropriate, at least in the short term. It is clear that there is significant support for a continuing substantial role for private insurance companies in the American health coverage system. It is even clearer that these private insurers have substantial political power, and that any reform that does not leave them substantially intact will face stiff political opposition. A reinsurance-based reform does not sweep away most of the costs inherent in the fragmented private system, particularly those for small group and individual coverage. Instead, it removes the incentive for insurers to add a high “risk premium” to their costs and provides a mechanism for government to assume responsibility for that aspect of coverage most naturally falling into the category of social obligation.

156. See generally Feder, supra note 58.
157. See supra text accompanying notes 105-07.
158. See SKOCPOL, supra note 59.
159. See supra text accompanying notes 115-19.
2. **Exposure of safety net providers.** Incremental reforms have been a mixed blessing for safety net providers, as is described above. The synthesis of consumer-driven care and government reinsurance programs builds incrementally on the private insurance system by consigning to government much of the cost of catastrophic care for insured persons. As is also described above, the reinsurance reform could be and should be coupled with an expansion of public programs to expand public coverage to those not uninsured. But reforms in the past have been pursued piecemeal, and if the reinsurance of private coverage is pursued without a substantial effort to provide coverage to those now uninsured, safety net hospitals could remain in the position of responsibility for providing care to the residual population of uninsured persons, perhaps with less public funding to support their efforts.

**CONCLUSION**

Reform efforts are more pressing than ever. Rates of coverage, particularly in the private sector are dropping, and recent studies make it crystal clear that losing health coverage has dramatic consequences for the life, health, and financial well-being of Americans. Unfortunately, universal reform efforts are politically and socially infeasible, while incremental reforms seem ineffective at staunching the flow of coverage from the private sector. A possible solution is to borrow from the consumer driven health care movement and the programs of reinsurance operating in small-scale efforts in several states. Under this synthesis, government would undertake to reinsure private coverage—that is, assume responsibility for much of the cost of the sickest of the private members of private plans. In this way, government could take substantial responsibility for the catastrophic aspect of health coverage in the private sector, leaving to private experimentation, bargaining, and private arrangements the means by which employers cover the costs of non-catastrophic care. In this way, government could assume a portion of private insurance costs—that aspect of the costs most clearly implicating social duties of

160. See supra text accompanying notes 51-53.
161. See supra text accompanying notes 145-53.
care and coverage—while leaving to private arrangements less intense aspects of coverage. That coverage left to private arrangements would involve routine physician and occasional hospital care for the vast majority of Americans who are not high utilizers of care, and who have a significant attachment to the networks and arrangements for care present in their current private insurance. The catastrophic coverage, on the other hand, involves the bulk of health costs, but only a few very sick persons. For that care, the public-private partnership that will arise from the reinsurance arrangements will allow for intense, coordinated attention to using appropriate disease management programs and other means to provide care to those who need it most.

This proposal attempts to walk the path between politically blocked universal care reforms and ineffective incremental reforms. It will help to shore up the private insurance system to which so many Americans are so attached by sharing between private sponsors and government the costs of the most expensive cases, thereby reducing the number of uninsured. This proposal holds out hope to low and moderate income workers who are most at risk of losing their coverage. Left out, however, are those unattached to the private insurance system—the unemployed without sufficient income to purchase (even subsidized) individual coverage, undocumented aliens, and other marginalized groups. These groups must be addressed by expansions in public systems such as Medicaid in order to knit together a more seamless blanket of coverage. This public program expansion may be more palatable if pursued in conjunction with the shoring up of the private system in a way that will discourage the crowd-out effects previously attending expansions of public programs. If this public program expansion does not accompany the implementation of a reinsurance program, safety net providers will be imperiled by shrinking budgets and unrelieved need for care from those without alternatives.