

Unmanaged Care: Towards Moral Fairness in Health Care Coverage

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Health insurers are generally guided by the principle of “actuarial fairness,” according to which they distinguish among various risks on the basis of cost-related factors. Thus, insurers often limit or deny coverage for vision care, hearing aids, mental health care, and even AIDS treatment based on actuarial justifications. Furthermore, approximately forty-two million Americans have no health insurance at all, because most of these individuals cannot afford the cost of insurance. This Article argues that Americans have come to demand more than actuarial fairness from health insurers and are increasingly concerned about what I call “moral fairness.” This is evidenced by the hundreds of laws that have been passed to constrain insurers’ discretion with respect to particular coverage decisions. Legislative mandates are frequent, but seemingly haphazard, following no systematic methodology. This Article suggests an analytical framework that can be utilized to determine which interventions are appropriate and evaluates a variety of means by which moral fairness could be promoted in the arena of health care coverage.

INTRODUCTION

Traditionally, health insurers have enjoyed the freedom to determine their own terms of coverage, to decide to what extent, if any, patients should be reimbursed for different kinds of treatment, and to establish premium prices. Health insurers typically deny coverage for speech therapy, eye glasses, hearing aids, most foot care, and treatment for infertility.¹ Many insurance providers also exclude or severely limit coverage for therapy to treat mental illness, dental problems,² AIDS, diabetes mellitus, severe obesity, epilepsy, and alcoholism or drug abuse.³

Insurance restrictions have generated significant litigation, but have rarely been proscribed by the courts.⁴ For example, Mutual of Omaha Insurance Company

1. 3 BERTRAM HARNETT & IRVING I. LESNICK, *THE LAW OF LIFE AND HEALTH INSURANCE* § 6A.11[1] (2000).

2. Samuel A. Marcossou, *Who Is “Us” and Who Is “Them”—Common Threads and the Discriminatory Cut-off of Health Care Benefits for AIDS Under ERISA and the Americans with Disabilities Act*, 44 AM. U. L. REV. 361, 416 (1994).

3. Donald W. Light, *The Practice and Ethics of Risk-Rated Health Insurance*, 267 JAMA 2503, 2504 (1992).

4. See, e.g., *McNeil v. Time Ins. Co.*, 205 F.3d 179, 186-89 (5th Cir. 2000) (finding that health insurance plan caps for AIDS treatment do not violate the Americans with Disabilities Act (“ADA”)); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 608-14 (3rd Cir. 1998), cert. denied, 525 U.S. 1093 (1999) (finding that a disparity in an employer’s insurance benefits for treatment of mental and physical conditions did not violate the ADA); *Bythway v. Principal Health Care of Delaware, Inc.*, 1999 WL 33220042 (D. Del. 1999) (holding that a health insurance provision that denied coverage of bone marrow transplants to Hodgkin’s disease patients while allowing it for those suffering from aplastic anemia or acute leukemia

offered its customers insurance policies that limited lifetime benefits for AIDS or AIDS-related conditions ("ARC") to either \$25,000 or \$100,000, while therapy for other conditions was covered up to \$1 million over a lifetime.⁵ When this discrepancy was challenged by two plaintiffs who alleged that it violated the Americans with Disabilities Act ("ADA"),⁶ the Seventh Circuit ruled that the AIDS cap was not unlawful and could continue to be utilized by Mutual of Omaha.⁷ Thus, while some Americans enjoy full coverage for all their health needs, other insured individuals with serious or even life-threatening conditions, such as AIDS, must incur the expense of costly treatment or forego it if it is unaffordable.

Of even greater concern is the fact that in the United States approximately 42.6 million people have no health insurance coverage whatsoever.⁸ While the large population of the American uninsured has generated much debate and consternation during the past decade,⁹ little has been done to make health insurance accessible to those who do not have it.¹⁰ The American health insurance system can therefore be characterized as having two different gaps: first, discriminatory insurance terms that adversely affect insureds with particular medical conditions, and second, the complete exclusion of millions of Americans from the system so that they have no coverage at all.

An accepted principle that guides health insurers is "actuarial fairness."¹¹ Health insurers distinguish among various risks on the basis of relevant cost-related factors and base their insurance terms on expected cost differences.¹² Insurance markets drive health insurers to make classifications of health risks based on the costs of those risks.¹³ These classifications are subject to a rule of nondiscrimination, but

was not unlawfully discriminatory under the ADA); *but see* *Boots v. Northwestern Mut. Life Ins. Co.*, 77 F.Supp.2d 211, 215-20 (D.N.H. 1999) (holding that a disability plan's limitations on coverage for mental disabilities were potentially discriminatory under the ADA).

5. *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557, 558 (7th Cir. 1999).

6. 42 U.S.C. §§ 12101-12213 (2000).

7. *Doe*, 179 F.3d at 561.

8. Geri Aston, *Individual Market Tough for Many Insurance Buyers*, AM. MED. NEWS, July 9-16, 2001, at 14; Randall R. Bovbjerg & Frank C. Ullman, *Health Insurance and Health Access*, 22 J. LEGAL MED. 247, 247 (2001). Other estimates range from 42.1 million uninsured (in 1999) to 44 million uninsured (in 2000). See Steven A. Schroeder, *Prospects for Expanding Health Insurance Coverage*, 344 NEW ENG. J. MED. 847, 847 (2001) and Stephen Blakely, *The Economic Costs of the Uninsured*, EBRI NOTES, Aug. 2000, at 1. Over eighty percent of the uninsured are from families in which at least one member is employed, and almost two-thirds are under the age of thirty-five. Schroeder, *supra*, at 847. More than half are in families whose incomes fall below 200% of the federal poverty level, that is, less than \$34,100 for a family of four. *Id.*

9. See e.g., Lawrence O. Gostin, *Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America*, 39 ST. LOUIS U. L.J. 7, 17-26 (1994).

10. See Laurie Zoloth, *Heroic Measures: Just Bioethics in an Unjust World*, HASTINGS CENTER REP., Nov.-Dec. 2001, at 34, 36.

11. See Thomas Murray & Ray Moseley, *Panel on Ethical Issues in Genetic Testing*, 25 J. INS. MED. 252, 254 (1993) ("One approach that the insurance industry has taken has been to stress, through some spokespeople, a particular kind of justice, called actuarial fairness.").

12. Comm. on Risk Classification Am. Acad. of Actuaries, *Risk Classification Statement of Principles*, 6 J. AM. ACAD. ACTUARIES 132, 133 (1980).

13. *Id.*

that rule only prohibits discrimination between people who are in the same actuarially or economically defined class. Classifications that are actuarially justified, but that result in discrimination against people who have conditions for which treatment is not covered or who cannot afford to pay for insurance, are permissible.¹⁴

Actuarial fairness provides a limited amount of protection to consumers because it prohibits insurers from implementing exclusions and limitations that are arbitrary or based purely on prejudice. The American people, however, have come to demand more than actuarial fairness from the health insurance system. This is evidenced by the numerous federal and state laws that govern the insurance industry. Society often chooses to override decisions based purely on actuarial fairness and instead to impose on insurers standards of what can be described as "moral fairness," that is, standards that take into account values of just distribution that cannot be achieved by actuarial fairness alone.¹⁵ "Moral fairness" is a complex concept that evades simple definition. Its meaning will be explored at length below.¹⁶

In the context of health care coverage, just distribution implicates not only the avoidance of unfair discrimination in insurance terms for those who are already beneficiaries of the system, but also a reallocation of resources so that the system does not exclude a large segment of society. A variety of polls and surveys reveal that a majority of the American population believes that all Americans should have a right to adequate health care,¹⁷ though only approximately half state that they are

14. Phillip E. Stano, *Underwriting in the Twentieth Century: Grafting Societal Values to the Regulation of Risk*, 19 J. INS. REG. 273, 275-76 (2000).

15. NORMAN DANIELS, *SEEKING FAIR TREATMENT: FROM THE AIDS EPIDEMIC TO NATIONAL HEALTH CARE REFORM* 84 (1995); Gostin, *supra* note 9, at 26-29.

16. See discussion *infra* Parts III and IV.

17. See e.g., Robert J. Blendon & Karen Donelan, *Public Opinion and Efforts to Reform the U.S. Health Care System: Confronting Issues of Cost-Containment and Access to Care*, STAN. L. & POL'Y REV., Fall 1991, at 146, 147, 151 (stating that as early as 1942, three-fourths of Americans stated that the government should provide medical care to all who need it, and have voiced similar opinions in public opinion surveys that have been conducted throughout the following decades. Americans, however, have not supported universal health care as enthusiastically as their counterparts in other countries); Liz Kowalczyk & Raja Mishra, *Ad Blitz Targets Health Care Initiative*, BOSTON GLOBE, Oct. 7, 2000, at B1 (discussing a survey that indicated that 72% of Massachusetts voters supported an initiative that would guarantee universal health care coverage for all state residents); Barbara Langner, *Kansas Commission on the Future of Health Care, Inc.: Working to Define and Solve Health Care Problems in the State of Kansas*, KAN. J.L. & PUB. POL'Y, Fall 1993, at 51, 52 (reporting that over two-thirds of those responding to a survey conducted in Kansas stated that Americans should have a right to effective health care); Vicente Navarro, *Where Is the Popular Mandate?* 307 NEW ENG. J. MED. 1516-18 (1982) (stating that opinion polls in the U.S. show strong public support for national health insurance even at the cost of higher taxes).

According to the Roper Center of the University of Connecticut, polls conducted in the early 1990s by the Los Angeles Times and the Associated Press revealed that approximately 60% of Americans believed "good health care is something all Americans are entitled to receive from the government." Polls conducted in 1994 by the Princeton Survey Research Associates ("PSRA")/Newsweek, the National Conference of Catholic Bishops, and ABC News revealed that approximately 70% of Americans supported universal healthcare. Two

willing to pay more out-of-pocket for medical services in order to support universal coverage, when asked specifically about cost implications.¹⁸ Although the problems of discriminatory insurance terms and the uninsured constitute two distinct issues, they are both discussed in this paper because both involve an unfair distribution of resources, and each must be addressed in order to remedy the moral shortcomings of contemporary health care policy.

A myriad of legislative mandates indicate that Americans are increasingly choosing to constrain the discretion of health insurers. For example, these statutes prohibit insurers from rejecting clients in particular circumstances, limit insurers' ability to determine their benefit terms, and deem many discriminatory reimbursement restrictions to be unacceptable regardless of their grounding in sound actuarial analysis.¹⁹ Approximately 1000 different state mandates concerning health insurance coverage have been issued by state legislatures.²⁰ Over half the states, for example, have enacted laws prohibiting health insurers from requiring genetic testing as a condition of coverage or from denying insurance or charging higher rates based upon the results of genetic tests.²¹ On the federal level, several laws establish specific coverage mandates, prohibit various forms of discrimination, and intervene in the health insurance market in other ways. The Women's Health and Cancer Rights Act of 1998,²² for example, requires all group health plans and health insurance issuers offering coverage for mastectomies to provide reimbursement for reconstructive surgery that is associated with a mastectomy,²³ and is a striking example of a law that prevents insurers from making their own decisions based on actuarial data.

As this Article shows, government interventions to regulate or change actuarial classifications are frequent, but seemingly haphazard. They follow no known

years later, in 1996, when the Clinton reforms were no longer a current topic of debate, a Kaiser/Harvard Health Policy Survey found that individuals responded as follows to the question of how they felt about universal health care: 18% very positive, 24% somewhat positive, 19% neutral, 14% somewhat negative, 7% very negative, and 16% unfamiliar with the concept. Roper Center for Public Opinion Research, University of Connecticut, *Public Opinion Data Search Prepared for Sharona Hoffman* (January 2002 on file with author).

18. When individuals were asked by PSRA/Newsweek whether they would be willing to pay more for routine health care costs in order to allow for universal coverage, only 51% stated that they would be willing to do so. Roper Center for Public Opinion Research, *supra* note 17.

19. See discussion of legislation *infra* Part II.

20. See U.S. GENERAL ACCOUNTING OFFICE, PUB. NO. GAO/HEHS 96-161, HEALTH INSURANCE REGULATION: VARYING STATE REQUIREMENTS AFFECT COST OF INSURANCE 9 (1996) (noting that "[o]n average, states have enacted laws mandating about 18 specific benefits"); Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 2 (1999) (citing Alain C. Enthoven & Sara J. Singer, *Markets and Collective Action in Regulating Managed Care*, HEALTH AFF. NOV.-DEC. 1997, at 26, 30); *New Study Shows 992 Mandated Benefits in the States*, MED. BENEFITS, Sept. 30, 1991, at 6.

21. Mark A. Rothstein & Sharona Hoffman, *Genetic Testing, Genetic Medicine, and Managed Care*, 34 WAKE FOREST L. REV. 849, 867 (1999).

22. 29 U.S.C. § 1185b (Supp. 2000). The Act was passed by Congress as an amendment to the Employee Retirement Income Security Act, 29 U.S.C. §§ 1001-1461 (2000) ("ERISA").

23. *Id.*

analytical method for determining how to construct socially responsible insurance categorizations. Indeed, many interventions may be political; they may be a response to lobbying by discrete groups that have legislative influence. Thus, while legislative mandates reflect the legislators' sympathy and their desire to provide morally appropriate remedies for those in need, the laws that are passed may favor those with a strong political voice without promoting overall moral fairness.

In this Article, I suggest an analytical framework that can be utilized to determine which interventions are suitable for the health insurance arena. This typology is not intended to determine the outcome of particular coverage issues or controversies. Rather, it is intended to suggest considerations that appropriate social policy ought to take into account in facing specific coverage decisions and in constructing its health care system.

To build this framework, I develop six principles that should guide policymakers. Substantively, I make three recommendations: (1) the health care system should embrace the concept of universality; (2) priority should be given to standard therapies that are medically necessary to cure or alleviate the symptoms of mental or physical impairments that substantially limit major life activities; (3) priority should be given to standard preventive care. Procedurally, I recommend that policymakers craft a system that gives stakeholders in the health care system an opportunity to participate in the decisionmaking process. Finally, I address approaches that policymakers should not utilize. Namely, an absolute antidiscrimination mandate should not be adopted, and the moral culpability of patients should not be considered for purposes of coverage decisions.

Part I of the Article analyzes the structure and values of health insurance in the United States. Part II discusses existing federal and state legislation that addresses issues of just distribution in health insurance. Part III explores the nature of moral fairness, evaluating a large body of scholarship concerning the concept. Part IV develops original principles of moral fairness to provide guidance for those making health coverage decisions. Finally, Part V assesses a variety of alternatives for the implementation of these principles and the enhancement of moral fairness in health insurance. These options include: (1) the passage of additional legislation; (2) deregulation of the health insurance market; (3) the establishment of a new regulatory governmental agency; and (4) the implementation of a universal coverage mandate. The advantages and disadvantages of each are carefully assessed, as is their consistency with the suggested principles.²⁴ The analysis leads

24. This Article focuses only on health insurance and not on other types of insurance, such as life or casualty insurance. Several distinctions can be made between health insurance and other insurance benefits. First, health insurance is generally considered to be a necessity or even a right, while life insurance is generally viewed as far less essential. Mark A. Rothstein, *The Use of Genetic Information for Nonmedical Purposes*, 9 J. L. & HEALTH 109, 114 (1994-95); Dennis S. Karjala, *A Legal Research Agenda for the Human Genome Initiative*, 32 JURIMETRICS J. 121, 173-74 (1991); Roberta B. Meyer, *Justification for Permitting Life Insurers to Continue to Underwrite on the Basis of Genetic Information and Genetic Test Results*, 27 SUFFOLK U. L. REV. 1271, 1293 (1993); Murray & Moseley, *supra* note 11, at 256. Norman Daniels argues that reasonable access to health care is necessary to promote fair equality of opportunity for all members of society because those who are ill or disabled often cannot function without medical attention. DANIELS, *supra* note 15, at 11. Another scholar asserts that reasonably good health is necessary in order to earn a livelihood, to exercise the fundamental rights of liberty and autonomy, and to achieve

to the conclusion that while the first two alternatives are not advisable, the second two hold promise as effective mechanisms for the promotion of moral fairness.

I. THE STRUCTURE AND VALUES OF THE HEALTH INSURANCE SYSTEM

A. How the Health Insurance System Works

Health insurers design their plans to manage health risks by distributing them among a large number of individuals.²⁵ Individuals pay a relatively small sum for insurance coverage, the insurance premium, and receive in return a promise from the insurance company to pay costs for the insured if they suffer illness or injury.²⁶ The insured avoid the risk of suffering a devastating loss by accepting a limited expense, that is, the payment of periodic premiums.²⁷ On the other hand, health insurance providers protect themselves against net losses by covering a large number of individuals.²⁸ Some of the insured will suffer costly health problems and will require the insurer to pay more in expenses than it earned from their premium payments, but others will be healthy and will require little or no reimbursement from the insurer, thus allowing it to profit from their premium payments.²⁹ Consequently, healthy people subsidize treatment of the sick, because their premium payments are used to cover costs for those who need frequent or expensive care.

In order to safeguard the company's economic viability, health insurers also utilize a mechanism known as "risk classification."³⁰ Risk classification can be defined as "[c]ategorization on the basis of established criteria for rating risks, establishing premiums and tabulating statistical experience."³¹ Risk classification typically has three basic components: rating, coverage, and underwriting.³² Rating is the practice of assigning different premiums to individuals or groups in different

personal satisfaction, happiness, and fulfilling personal relationships. Gostin, *supra* note 9, at 12-13. Therefore, health insurance serves the important social function of providing people with access to health care so that they can have a fair opportunity to enjoy and succeed in life. Thomas H. Murray, *Genetics and the Moral Mission of Health Insurance*, HASTINGS CENTER REP., Nov.-Dec. 1992, at 12, 16; Murray & Moseley, *supra* note 11, at 254 ("[I]n some ways . . . reasonably good health is the precondition for the pursuit of all the other things that are good in life."). Life and property insurance do not provide benefits that are of the same magnitude. Furthermore, life insurance and property insurance are utilized in response to isolated, catastrophic events. By contrast, people seek health care throughout their lives for a variety of purposes, including maintaining good health, preventing illness, and treating existing ailments. *Id.* at 255. Health insurance, therefore, has a much more important presence in people's lives than other types of insurance.

25. See KENNETH S. ABRAHAM, *DISTRIBUTING RISK* 1 (1986).

26. *Id.* at 2.

27. *Id.*

28. *Id.*

29. *See id.*

30. See Maria O'Brien Hylton, *Some Preliminary Thoughts on the Deregulation of Insurance to Advantage the Working Poor*, 24 *FORDHAM URB. L.J.* 687, 691 (1997).

31. RICHARD V. RUPP, *RUPP'S INSURANCE & RISK MANAGEMENT GLOSSARY* 76 (1991).

32. Hylton, *supra* note 30, at 691.

risk categories based on general criteria.³³ The term "coverage" refers to the insurer's ability to reduce the amount of coverage offered or the number of events covered for its insured.³⁴ Underwriting relates to an insurer's specific decision concerning whether, and on what basis, to accept a particular customer.³⁵

Health insurance is sold on both an individual and a group basis.³⁶ In some cases, health insurance policies are sold to individuals, and the insurer may assess the applicants' health risks on a case-by-case basis.³⁷ Insurers also sell policies to groups, such as employee groups for whom employers provide insurance benefits. Insurers classifying risks for group health insurance will consider the characteristics of the group as a whole by examining factors such as gender, age, industry of the group's employer, geographic area of residence, family composition, and group size.³⁸ Each member of the group pays the same premium, and low risk members are assumed to subsidize their higher risk counterparts within the group.³⁹

Insurers have broad discretion when engaging in risk classification, and they utilize a variety of tools in making underwriting decisions.⁴⁰ These tools include the application form, reports obtained from the individual's treating physicians, and a medical examination conducted for insurance purposes.⁴¹ Insurance underwriters also consult the company's underwriting manual, which provides a listing of various health and social conditions and specifies the effect they should have on policy issuance.⁴² Finally, underwriters can consult the company's medical director⁴³ and the Medical Information Bureau ("MIB"), which has a vast data bank containing medical and social information concerning a large number of individuals who have previously applied for insurance.⁴⁴

In many states, insurance providers are not required to disclose the criteria they use in making insurance decisions, and state governments often do not analyze the

33. *Id.* An insurer, for example, might charge smokers a higher premium than nonsmokers.

34. *Id.* An insurer might decide to exclude coverage for vision care, dental care, or mental health care.

35. *Id.* See also Karen A. Clifford & Russel P. Iuculano, *AIDS and Insurance: The Rationale for AIDS-Related Testing*, 100 HARV. L. REV. 1806, 1809 (1987); Stano, *supra* note 14, at 275; RUPP, *supra* note 31, at 335.

36. See Clifford & Iuculano, *supra* note 35, at 1809.

37. See *id.*

38. *Id.*; John V. Jacobi, *The Ends of Health Insurance*, 30 U.C. DAVIS L. REV. 311, 374 (1997); Marcossou, *supra* note 2, at 411.

39. See BANKS MCDOWELL, *THE CRISIS IN INSURANCE REGULATION 96-97* (1994).

40. See HARNETT & LESNICK, *supra* note 1, § 3.01[2].

41. *Id.*

42. *Id.* § 3.01[2][c].

43. This is a physician who is employed by the insurance company. *Id.* § 3.01[2][f].

44. *Id.* § 3.01[2][d]. The MIB was established in 1909 as an association of medical directors of several large insurers who wished to pool data about people who applied to their companies for insurance. MIB members can access the data bank's information by submitting the name and birth date of the proposed insured and can add to the data bank any information they have learned concerning the health problems and risks of their applicants. *Id.*

statistical information upon which insurers base their classifications.⁴⁵ Furthermore, state statutes provide only vague guidelines, requiring that classifiers “reasonably reflect differences in loss experience and that the data be credible.”⁴⁶

According to some analysts, the regulatory vacuum has led to significant flaws in contemporary risk classification practices. Classification decisions often are not actuarially sound, and different insurers vary significantly in how much risk they assign to identical disorders.⁴⁷ As one commentator notes, insurers “are free to

45. Sheri A. Mullikin, Note, *A Cost Analysis Approach to Determining the Reasonableness of Using Domestic Violence as an Insurance Classification*, 25 J. LEGIS. 195, 198 (1999); Leah Wortham, *Insurance Classification: Too Important to Be Left to the Actuaries*, 19 U. MICH. J.L. REFORM 349, 373 (1986). However, insurers may be required to file records reflecting their classification of risks, premium rates, and policy forms with their state’s insurance commissioner’s office. See LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INSURANCE 3d § 2:24 (1997). The National Association of Insurance Commissioners (“NAIC”) suggests that states include the following language in their “Guidelines for Filing of Rates for Individual Health Insurance Forms”: “[e]ach rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called ‘anticipated loss ratio,’ of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage.” NAIC MODEL LAWS, REGULATIONS, AND GUIDELINES 134-1 (1989). The states vary widely with respect to their requirements. Maryland, for example, provides that “[a]t the request of the Commissioner, each insurer shall file with the Commissioner a copy of its underwriting standards” and that “[t]he Commissioner may review and examine the underwriting standards to ensure compliance with [the law].” MD. CODE ANN., INS. § 27-501(h)(2), (3) (2002). North Dakota requires small employer carriers to file only their actual benefit plans with the insurance commissioner. N.D. CENT. CODE § 26.1-36.3-06 (2002). Other states require insurers to maintain, at their principal places of business, descriptions of their rating practices and proof that their rating methods are based on sound actuarial principles and to file with the commissioner an annual certification affirming the actuarial soundness of their plans. COLO. REV. STAT. § 10-16-105(6) (1999); FLA. STAT. ch. 627.6699(8) (1996); UTAH CODE ANN. § 31A-30-106(4) (2001).

46. Wortham, *supra* note 45, at 372. Common statutory language pertaining to insurance rate standards prohibits rates from being “excessive, inadequate, or unfairly discriminatory.” See e.g., ALASKA STAT. § 21.39.030(a)(1) (Michie 2000); ARIZ. REV. STAT. § 20-356(1) (West 2002); ARK. CODE ANN. § 23-67-208(a) (Michie 2001); DEL. CODE ANN. tit. 18, § 2503(a)(2) (1999); FLA. STAT. ch. § 627.062(I) (1996 & Supp. 2002); GA. CODE ANN. § 33-9-4(1) (1996 & Supp. 2002); IND. CODE ANN. § 27-4-1-4(7)(C)(iii) (West 1993 & Supp. 2002); MO. ANN. STAT. § 379.318(4) (West 2002); MONT. CODE ANN. § 33-16-201(1)(a) (2001); N.M. STAT. ANN. § 59A-17-6(A) (Michie 1978 & Supp. 2002); TENN. CODE ANN. § 56-5-303(1) (2000 and Supp. 2002); WIS. STAT. ANN. § 625.11(1) (West 1995 and Supp. 2002). Many statutes pertaining to insurance rates allow insurers to “measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses.” See ALASKA STAT. § 21.39.030(a)(4) (Michie 2000); ARIZ. REV. STAT. § 20-356(4) (West 2002); ARK. CODE ANN. § 23-67-210(a) (Michie 2001); DEL. CODE ANN. tit. 18, § 2503(a)(5) (1999); GA. CODE ANN. § 33-9-4(7) (1996 & Supp. 2002); MO. ANN. STAT. § 379.318(2) (West 2002); MONT. CODE ANN. § 33-16-201(4) (2001).

47. Light, *supra* note 3, at 2505. See also 28 C.F.R. App. B § 36.212 (2001) (noting that “[s]everal commenters reported that, even when statistics are available, they are often outdated and do not reflect current medical technology and treatment methods” and that according to one insurer, “hard data and actuarial statistics are not available to provide

choose among the infinite number of marginally valid relationships between applicants' circumstances and possible health risks, choosing, combining, and rejecting them with or without plan or rationale."⁴⁸ While some errors that are made in the marketplace can be benign and affect only the competitive advantage of the seller, mistakes in risk classification might be of much greater concern because they can result in denial of coverage for life-saving therapy such as AIDS treatment.

The health insurance industry is characterized by a number of market failures,⁴⁹ one of which is inconsistent risk classification methodology.⁵⁰ Other market imperfections include information imbalance and disparity of bargaining power between insurers and consumers, as well as externalities that are imposed on third parties.⁵¹ These market failures will be discussed at length below,⁵² as they explain why government intervention in the health insurance industry is justifiable and why so many attempts have been made to change market outcomes through regulation. At this point, however, it is useful to explore the general values that underlie the industry.

B. The Recognized Values of the Health Insurance System

The health insurance system in the United States embodies competing goals and therefore is characterized by a number of tensions. The contrasting objectives of the health insurance system are: efficiency, social pooling, individual advantage, actuarially justified discrimination, and fairness.

precise numerical justifications for every underwriting determination.")

48. Jacobi, *supra* note 38, at 329.

49. A market failure can be defined as occurring in the absence of one or more of the conditions for perfect competition. According to one source, there are five basic conditions for perfect competition:

- (i) there are a huge number of buyers and sellers; (ii) the products traded in the market are homogenous; (iii) each market participant has perfect knowledge of the offers made by each side; (iv) there are no barriers to entry into or exit out of a market; and (v) transaction costs are zero.

Mathias Strasser, *A New Paradigm in Intellectual Property Law? The Case Against Open Sources*, 2001 STAN. TECH. L. REV. 4, 97 n.288 (2001). Another source asserts that there are four conditions for perfect competition: "product homogeneity, relatively small buyers and sellers, mobile resources, and perfect information." Robert H. Lande, *Consumer Choice As the Ultimate Goal of Antitrust*, 62 U. PITT. L. REV. 503, 505 n.9 (2001) (citing EDWIN MANSFIELD, *MICROECONOMICS: THEORY AND APPLICATIONS* 232-33 (5th ed. 1985)). An alternative definition of market failure is the following: "'market failure' means that unless something is done to fix things, people will produce either too much or too little of some good or service, where 'too much or too little' are defined in relation to what would be the optimal use of society's resources." I. Trotter Hardy, *Not So Different: Tangible, Intangible, Digital, and Analog Works and Their Comparison for Copyright Purposes*, 26 U. DAYTON L. REV. 211, 218 (2001).

50. Jacobi, *supra* note 38, at 329.

51. ABRAHAM, *supra* note 25, at 32-33; U.S. GENERAL ACCOUNTING OFFICE, *ISSUES AND NEEDED IMPROVEMENTS IN STATE REGULATION OF THE INSURANCE BUSINESS* 10-13 (1979) [hereinafter GAO REPORT].

52. See *infra* Part V.B.

1. Efficiency

Inherent in the competitive insurance market is the value of efficiency.⁵³ Insurers seek to compete for customers with low health risks by setting prices that reflect expected loss and thus are attractive to individuals or groups with good health.⁵⁴ Similarly, insureds may want choices so that they can shop for the policies that are most attractive to them.⁵⁵

Health insurers are particularly concerned about two phenomena identified by economic theory: adverse selection and moral hazard. "Adverse selection" refers to a potential shift in the health insurance customer population. If insurers raise premium prices too high, those who perceive themselves as being low-risk will consider the product's price to be higher than its value and will therefore buy little, if any, health insurance coverage.⁵⁶ Those who believe they are high-risk will purchase extensive coverage, unless premium prices rise to the point that it is cheaper for consumers to pay for the full cost of health care out-of-pocket.⁵⁷ If all individuals who have insurance coverage incur high medical costs because of health problems, insurance prices will rise higher and higher, creating a "death spiral" of premiums and leading ever-decreasing numbers of healthy people to buy insurance. As prices continue to rise, even high-risk individuals will become unable to afford insurance coverage. Ultimately, adverse selection could destabilize or even bankrupt the insurance industry.⁵⁸ Insurers therefore try to keep premium prices low by attracting as many low risk insureds as possible.

The term "moral hazard" refers to the concern that the acquisition of insurance itself leads to a change in individuals' behavior.⁵⁹ Those who have health insurance are more likely to use medical facilities than those who are uninsured, because their use of medical services is subsidized.⁶⁰ Thus, health insurance can increase the cost of health care through unnecessary doctor visits.⁶¹ In addition, insured individuals

53. See ABRAHAM, *supra* note 25, at 10-11.

54. *See id.*

55. *See id.*

56. Jacobi, *supra* note 38, at 387.

57. *Id.*

58. *Id.* at 387-388; Mark A. Hall, *Insurers' Use of Genetic Information*, 37 JURIMETRICS J. 13, 17-18 (1996).

59. Kenneth Vogel, *Discrimination on the Basis of HIV Infection: An Economic Analysis*, 49 OHIO ST. L.J. 965, 990 (1989). Moral hazard can be defined more specifically as follows:

A moral hazard problem is encountered when payment of medical expenses is borne by a third party, either an insurance company or the government, affecting the individual's own behaviour. It may lead the individual to overconsume medical services and his doctor to overtreat. It has nothing to do with morality but represents a misallocation of resources by a particular method of finance. Since the third party, be it the government or the insurance company pays the full cost, the individual bears no financial burden or faces a zero price for medical care.

Michael D. Barr, *Medical Savings Accounts in Singapore: A Critical Inquiry*, 26 J. HEALTH POL. POL'Y & L. 709, 716 (2001) (quoting TOH MUN HENG & LINDA LOW, HEALTH CARE ECONOMICS, POLICIES, AND ISSUES IN SINGAPORE 9 (1991)).

60. Vogel, *supra* note 59, at 990.

61. *See id.* at 991.

might be more careless about their health and will take imprudent risks because they know that they can receive high quality care in case of illness or injury.⁶² In order to address concerns of moral hazard, insurers exclude coverage for treatments that are not "medically necessary" and lower individual policy premium rates for people who live healthy lifestyles, thus creating incentive to refrain from risky behavior, such as smoking.⁶³

2. Social Pooling vs. Individual Advantage

The availability of health insurance enables each person to diminish his or her own risk of devastating medical expenses. This system of "social pooling" fosters an environment of mutual aid and social responsibility.⁶⁴ All purchasers of insurance pay premiums whether or not they will incur any health care costs during the relevant period, and as a consequence of insurance coverage, theoretically no insured should suffer a catastrophic loss.⁶⁵

In truth, however, consumers do not purchase insurance for altruistic reasons or out of a sense of social responsibility. Rather, they try to obtain maximum protection for the cheapest rate, to their own advantage. The more insurers make distinctions based on rating, coverage, and underwriting, the more they undermine the goal of social pooling and promote risk segmentation and individual advantage.⁶⁶ This is exacerbated by the competitive private insurance market in which insurers vie with each other to attract low risk clients by offering them appealing coverage packages. The health insurance system thus embodies a tension between social pooling and individual advantage.

3. Fair and Unfair Discrimination: The Concept of Actuarial Fairness

The private insurance system is by nature discriminatory.⁶⁷ Individuals or groups that represent a higher risk routinely pay higher premium costs.⁶⁸ Discrimination, in fact, may be perceived as part of an insurer's responsibility. Commentators have stated that "[a]n insurance company has the responsibility to treat all its policyholders fairly by establishing premiums at a level consistent with the risk represented by each individual policyholder."⁶⁹ Thus, insurers engage in a process of risk segmentation, assigning different costs to high-risk and low-risk insureds.⁷⁰

While discrimination is inherent in the insurance system, not all forms of

62. *See id.* at 990.

63. *See id.* at 991.

64. *See Jacobi, supra* note 38, at 312.

65. Individuals remain vulnerable to financial catastrophe, however, if coverage for their loss is excluded or limited by the policy terms.

66. *See Jacobi, supra* note 38, at 312, 367.

67. Stano, *supra* note 14, at 275.

68. *Id.*

69. Clifford & Iuculano, *supra* note 35, at 1808. *See also* Herman T. Bailey et al., *The Regulatory Challenge to Life Insurance Classification*, 25 DRAKE L. REV. 779, 780 (1976) ("[b]asic to the concept of providing insurance to persons of different ages, sexes, . . . occupations and health histories . . . [is] the right of the insurer to create classifications to recognize the many differences which exist among individuals").

70. *See Jacobi, supra* note 38, at 364.

discrimination are considered acceptable. The insurance literature is fraught with references to "unfair discrimination," a practice that is rejected, at least in principle.⁷¹ The Unfair Trade Practices Act ("UTPA"), which was developed by the National Association of Insurance Commissioners ("NAIC") and was adopted in some form by all fifty states,⁷² defines "unfair discrimination" as follows:

Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any accident or health insurance policy or in the benefits payable thereunder, or in any of the terms or conditions of such policy, or in any other manner.⁷³

In other words, unfair discrimination occurs when there is no valid actuarial or medical justification for risk classification, and thus, equal risks are treated differently and unequal risks are treated the same.⁷⁴ As one commentator stated, "[t]he recognized goal of risk classification is not equality of treatment of insureds, but their equitable assignment to the risk category each represents."⁷⁵

In a document entitled *Risk Classification Statement of Principles*, the American Academy of Actuaries ("The Academy") stated that the risk classification process should serve three primary goals: protection of the insurance system's financial soundness, fairness, and promotion of economic incentives that will encourage broad availability of coverage.⁷⁶ The Academy listed the following principles as essential to the achievement of these objectives:

The system should reflect expected cost differences [in coverage for different individuals].

The system should distinguish among risks on the basis of relevant cost-related factors.

The system should be applied objectively.

The system should be practical and cost-effective.

The system should be acceptable to the public.⁷⁷

"Fair discrimination" in the insurance realm is widely perceived as dependent upon actuarial fairness. So long as the insurance system reflects expected cost differences among individuals, distinguishes among risks based on economic

71. Stano, *supra* note 14, at 275.

72. Clifford and Iuculano, *supra* note 35, at 1809-10.

73. NAIC MODEL LAWS, REGULATIONS AND GUIDELINES 880-4 (1998). The Act also prohibits "[r]efusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the sex, marital status, race, religion or national origin of the individual." *Id.* It does not, however, address the permissibility of *rate differentiation* based on gender, marital status, race, religion, or national origin.

74. Clifford and Iuculano, *supra* note 35, at 1809-10; Am. Acad. of Actuaries Comm. on Risk Classification, *supra* note 12, at 140.

75. Stano, *supra* note 14, at 276.

76. Comm. on Risk Classification Am. Acad. of Actuaries, *supra* note 12, at 133.

77. *Id.* at 133-34.

factors, and treats equal risks equally, it is considered "fair." Actuarial fairness provides some protection to consumers because it prohibits insurers from implementing exclusions and limitations that are arbitrary or based purely on prejudice. The protection, however, is limited, because once insurers can justify their discriminatory terms by citing an economic reason for them, the doctrine of actuarial fairness demands nothing further. Actuarial fairness is therefore different from "fairness" as it is commonly understood in other realms, that is, moral fairness.⁷⁸

C. The Unrecognized Value: Moral Fairness

AIDS caps and exclusions of coverage for mental health care might be actuarially fair if they can be economically justified by an insurer. However, insurance terms that preclude coverage of treatment for life-threatening diseases such as AIDS or severe mental illness are not morally fair. Moral fairness requires equity and just distribution of societal goods and would forbid abandonment of the sick and disabled.⁷⁹

American society has demonstrated a growing concern about moral fairness in the health care arena. The establishment of Medicaid constitutes a clear expression of the public's willingness to assist the disadvantaged, even at significant taxpayer expense.⁸⁰ Another notable example is the Emergency Medical Treatment and Active Labor Act ("EMTALA"),⁸¹ which requires hospitals to screen all patients who arrive at their emergency departments⁸² and to stabilize them if they are found to be in an emergency condition, regardless of the patients' ability to pay for these services.⁸³ In addition, we have taken important steps to impose a system of moral fairness on the insurance industry. Legislatures have passed many statutes that deem certain types of discrimination to be unacceptable even if they are grounded in sound actuarial analysis.⁸⁴ Thus, while the prevalent assumption is that insurers are subjected only to the limitations of actuarial fairness, in truth, they are increasingly obligated to embrace the value of moral fairness and to offer products that reflect it.

One might ask why moral fairness is a legitimate consideration in the health insurance context. Many scholars answer that question by noting that health care is

78. See DANIELS, *supra* note 15, at 84 ("These are two altogether different notions: Actuarial fairness is neither a necessary nor a sufficient condition for moral fairness or justice in an insurance scheme—most especially not in a health insurance scheme.")

79. See *id.*; Gostin, *supra* note 9, at 26-29. See also Deborah S. Hellman, *Is Actuarially Fair Insurance Pricing Actually Fair?: A Case Study in Insuring Battered Women*, 32 HARV. C.R.-C.L. L. REV. 355, 403 (1997) ("[T]he debate about whether the actuarial fairness principle ought to govern health insurance pricing is a debate about whether ours is a community that is committed to the provision of aid to those who are sick or disabled."). The concept of moral fairness is analyzed in detail *infra* Parts III and IV.

80. NORMAN DANIELS ET AL., BENCHMARKS OF FAIRNESS FOR HEALTH CARE REFORM 17 (1996); Murray, *supra* note 24, at 16-17.

81. 42 U.S.C. § 1395dd (2000).

82. 42 U.S.C. § 1395dd(a) (2000).

83. 42 U.S.C. § 1395d (b) (2000).

84. DANIELS, *supra* note 15, at 90. For a description of these laws, see discussion *infra* Part II.

different from other commodities and services, because one's ability to exercise any life function is often tied to one's health status. Norman Daniels argues that reasonable access to health care is necessary to promote fair equality of opportunity for all members of society to achieve normal functioning.⁸⁵ Another scholar asserts that reasonably good health is necessary in order to earn a livelihood, to exercise the fundamental rights of liberty and autonomy, and to achieve personal satisfaction, happiness, and fulfilling personal relationships.⁸⁶ Therefore, health insurance serves the important social function of providing people with access to health care so that they can have a fair opportunity to enjoy and succeed in life.⁸⁷ Even the very conservative thinker, Richard Epstein, acknowledges that "the strongest defender of the market faith has to blanch visibly when the logic of voluntary exchanges is applied to a newborn infant left malnourished on the doorstep of a public hospital."⁸⁸

Yet another justification for concern about moral fairness in the health care arena is presented by Deborah Stone, who critiques managed care. Contemporary patients have experienced a significant change in the nature of their relationships with doctors operating within the incentive systems of managed care.⁸⁹ Doctors must now consider the financial impact of their clinical decisions upon their own incomes, and therefore, economic considerations are now central to their clinical practices.⁹⁰ According to Stone, this transformation has led to a situation in which lives are commodities and patients "enter doctors' offices and other health care institutions with price tags from payers telling what their life is worth to the provider."⁹¹ Doctors, therefore, may sometimes have incentives to sacrifice patient welfare for the sake of financial gain. In light of the unique importance of health services and managed care's influence on medical practice, societal concern about moral fairness in the health insurance context is both understandable and justifiable.

85. DANIELS, *supra* note 15, at 11.

86. Gostin, *supra* note 9, at 12-13.

87. Murray, *supra* note 24, at 16; Murray & Moseley, *supra* note 11, at 254 ("in some ways . . . reasonably good health is the precondition for the pursuit of all the other things that are good in life.").

88. Richard A. Epstein, *Rationing Access to Medical Care: Some Sober Second Thoughts*, STAN. L. & POL'Y REV., Fall 1991, at 81, 82. Epstein continues:

Clearly there is no capacity for the archtypical voluntary exchange that drives the market. Yet deep in our bones we (and it is the primordial, collective "we") are convinced that the benefits that can be conferred upon the child in distress far outweigh the costs, necessarily borne by others, that are necessary to respond to the particular case.

Id.

89. See Deborah A. Stone, *Managed Care and the Second Great Transformation*, 24 J. HEALTH POL. POL'Y & L. 1213 (1999) [hereinafter Stone, *Managed Care*]; Deborah A. Stone, *The Doctor as Businessman: The Changing Politics of a Cultural Icon*, 22 J. HEALTH POL. POL'Y & L. 533, 533-34 (1997) [hereinafter Stone, *Doctor as Businessman*].

90. Stone, *Doctor as Businessman*, *supra* note 89, at 533-34.

91. Stone, *Managed Care*, *supra* note 89, at 1216. Stone states dramatically that managed care's market paradigm "respects no human bonds, shows no mercy, and has no use for kindness, loyalty, and other moral qualities of community." *Id.* at 1217.

II. LAWS THAT PROMOTE MORAL FAIRNESS IN HEALTH INSURANCE

Numerous federal and state laws promote moral fairness and prohibit particular types of discrimination in health insurance. None of these laws, however, provides comprehensive protection to insurance beneficiaries, and most are characterized by significant gaps and loopholes.⁹² The laws, therefore, create an extensive but costly and somewhat chaotic regulatory scheme to govern health insurance coverage matters.

The federal laws fall into a number of different categories. First, several laws establish specific coverage mandates. For example, the Mental Health Parity Act ("MHPA"),⁹³ which was passed in 1996, requires group health plans that provide both physical and mental health care benefits to apply the same aggregate lifetime limits to both. However, the law exempts all group plans for which parity would generate an increase in costs of one percent or more⁹⁴ and does not apply to employers who have fewer than fifty employees.⁹⁵

A different law, the Women's Health and Cancer Rights Act of 1998,⁹⁶ requires all group health plans and health insurance issuers offering coverage for mastectomies to provide reimbursement for reconstructive surgery that is associated with a mastectomy.⁹⁷ Yet another law creates coverage mandates relating to childbirth. It prohibits insurers from restricting hospital stays for new mothers to less than forty-eight hours following natural childbirth and less than ninety-six hours following a cesarean section.⁹⁸

A second category of federal laws does not address specific coverage requirements, but rather, prohibits discrimination in health insurance in particular circumstances. One such law, Title VII of the Civil Rights Act of 1964 ("Title VII"), prohibits employers from discriminating against individuals with respect to benefits of employment because of their "race, color, religion, sex, or national origin."⁹⁹ Title VII includes a 1978 amendment known as the Pregnancy Discrimination Act, which prohibits discrimination based on "pregnancy, childbirth, or related medical conditions" and requires that women affected by these conditions receive "benefits under fringe benefit programs" that are

92. For a thorough analysis of the statutory gaps left by the federal antidiscrimination laws, see Sharona Hoffman, *AIDS Caps, Contraceptive Coverage, and the Law: An Analysis of the Federal Anti-Discrimination Statutes' Applicability to Health Insurance*, 23 *CARDOZO L. REV.* 1315 (2002).

93. 42 U.S.C. § 300gg-5 (2000).

94. *Id.* § 300gg-5(c)(2).

95. *Id.* §§ 300gg-5(c)(1), 300gg-91(e)(4).

96. 29 U.S.C. § 1185b (2000). The Act was passed by Congress as an amendment to ERISA.

97. *Id.*

98. 42 U.S.C. § 300gg-4(a) (2000). The law was passed as an amendment to the Health Insurance Portability and Accountability Act ("HIPAA"), 42 U.S.C. §§ 300gg-300gg-92 (2000).

99. 42 U.S.C. § 2000e-2(a)(1) (1994). A covered employer is defined as "a person engaged in an industry affecting commerce who has fifteen or more employees for each working day in each of twenty or more calendar weeks in the current or preceding calendar year." 42 U.S.C. § 2000e(b) (1994). Several exemptions, however, are established in the provision. *Id.*

equivalent to those given to other employees.¹⁰⁰ Title VII, however, applies only to employment discrimination.¹⁰¹ Thus, employer-provided insurance plans may not adopt coverage distinctions based on race, national origin, religion, or sex, but benefits purchased directly from an insurance company are not governed by Title VII.¹⁰²

The Age Discrimination in Employment Act ("ADEA")¹⁰³ prohibits employment discrimination based on age¹⁰⁴ and protects individuals who are forty years old or older.¹⁰⁵ Nevertheless, the statute does not require that employers offer older employees health insurance benefits that are equivalent to those available to younger workers. Rather, it mandates only that employers spend equal amounts of money or incur equal costs for insurance benefits provided to older and younger members of the workforce.¹⁰⁶ Like Title VII, the ADEA governs the conduct of employers but not of insurers in their nonemployer capacities. Thus, no federal law prohibits private insurance companies from discriminating against customers on the basis of age, gender, religion, race, or national origin.

The Americans with Disabilities Act ("ADA") is yet another federal antidiscrimination law, and its effect on insurance benefits has generated a plethora of litigation and controversy.¹⁰⁷ In general, the ADA prohibits discrimination against individuals with disabilities because of their disabilities.¹⁰⁸ The

100. 42 U.S.C. § 2000e(k) (2000).

101. 42 U.S.C. § 2000e-2(a)(1) (2000).

102. *Id.*

103. 29 U.S.C. §§ 621-634 (2000).

104. 29 U.S.C. § 623(a) (2000). The provision reads in relevant part:

(a) It shall be unlawful for an employer—

(1) to fail or refuse to hire or to discharge any individual or otherwise discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's age.

Id.

105. 29 U.S.C. § 631(a) (2000).

106. 29 U.S.C. § 623(f)(2)(B)(i) (2000). The provision reads in relevant part:

(f) It shall not be unlawful for an employer, employment agency, or labor organization

(B) to observe the terms of a bona fide employee benefit plan—

(i) where, for each benefit or benefit package, the actual amount of payment made or cost incurred on behalf of an older worker is no less than that made or incurred on behalf of a younger worker. . . .

Id.

It should also be noted that under Medicare law, an employer must offer its Medicare-eligible employees the same health benefits that it offers similarly situated employees under the age of sixty-five. *See* 42 U.S.C. § 1395y(b)(1)(A)(i) (Supp. 2001). Thus, an employer may not take the availability of Medicare into account when establishing an employee's health benefits. *See also* *Erie County Retirees Assoc. v. County of Erie, Pa.*, 220 F.3d 193, 197-98, 216 (3d Cir. 2000) (finding that defendant who offered Medicare-eligible retirees health insurance benefits that were inferior to those provided to retirees who were not eligible for Medicare was not entitled to summary judgment unless it could show that it could meet the equal benefit or equal cost standard).

107. For a detailed analysis of the ADA's applicability to health insurance see Hoffman, *supra* note 92.

108. *See* 42 U.S.C. §§ 12112(a), 12182(a) (1994).

antidiscrimination requirement applies both to insurers¹⁰⁹ and to employers who offer health insurance as a benefit to employees.¹¹⁰

One would assume that the ADA, addressing disability discrimination by employers and insurers, would provide extensive protection for health insurance beneficiaries. This, however, is not the case. First, the ADA applies only to discrimination that is based on disability, and the courts have generally interpreted the term "disability" very narrowly.¹¹¹ Furthermore, the ADA does not per se prohibit utilization of disability-based distinctions such as AIDS caps.¹¹² Rather, it allows insurers to retain discriminatory insurance terms so long as they can prove a

109. Title III of the ADA provides that "[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation . . ." See 42 U.S.C. § 12182(a) (1994). A "place of public accommodation" includes an insurance office. 42 U.S.C. § 12182(a) (1994); *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d at 557, 558 (7th Cir. 1999).

110. Title I of the ADA provides that "[n]o covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment." 42 U.S.C. § 12112(a) (1994). The provision has been interpreted to include a prohibition against discrimination with respect to "[f]ringe benefits available by virtue of employment, whether or not administered by the [employer]." 29 C.F.R. § 1630.4(f) (2000). Employer-provided health insurance is thus a benefit covered by the statute. EEOC, APPLICATION OF THE AMERICANS WITH DISABILITY ACT OF 1990 TO DISABILITY-BASED DISTINCTION IN EMPLOYER PROVIDED HEALTH INSURANCE 915.002 (June 8, 1993).

111. See *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams* 122 S. Ct. 681, 693 (2002) (holding that in order to have a disability, "an individual must have an impairment that prevents or severely restricts the individual from doing activities that are of central importance to most people's daily lives"); *Sutton v. United Air Lines, Inc.*, 527 U.S. 471, 482-83 (1999) (holding that an individual with a physical or mental impairment whose symptoms are controlled by medication or whose condition is mitigated by the use of corrective devices does not have a disability and is not entitled to ADA protection); *Hoffman*, *supra* note 92, at 1322.

112. The ADA contains text that specifically addresses the extent to which the statute governs insurance and significantly limits the scope of its antidiscrimination mandate. The provision, known as section 501(c) of the Act, states the following:

[T]his Act shall not be construed to prohibit or restrict—

(1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of [the Act].

42 U.S.C. § 12201(c) (1995).

basis for them in sound actuarial principles, past cost experience, or evidence regarding reasonably anticipated benefit claims.¹¹³ In truth, therefore, the ADA embraces the concept of actuarial fairness and does not go beyond it to require moral fairness in cases where the insurer's benefits limitation or exclusion is actuarially justified.¹¹⁴

A third kind of federal law, the Health Insurance Portability and Accountability Act ("HIPAA"),¹¹⁵ is exclusively devoted to health insurance issues, attempting to resolve some of the most difficult problems faced by insureds and to provide them with extensive protection. HIPAA requires that all group health plans limit to no more than twelve months their period of excluded coverage for preexisting conditions; that is, conditions for which medical advice, diagnosis, care, or treatment was recommended or received in the prior six months.¹¹⁶ HIPAA's portability provisions guarantee that individuals covered by group insurance at one employer for eighteen continuous months will be granted access to any group policy offered by a new employer.¹¹⁷

HIPAA furthermore requires insurers operating in the small-group market¹¹⁸ to guarantee issue of all the products they offer in the small-group market to all small groups. In any group, all eligible members of the group must be offered enrollment, regardless of their health status.¹¹⁹ In addition, a group health plan may not require any member of a group to pay a higher premium than other members of the group

113. H.R. REP. NO. 101-485, pt. 2, at 136-37.

114. The legislative history of the ADA reveals that § 501(c), discussed *supra* note 112, was included because of a concern that without it, the ADA could destabilize the insurance industry. It is therefore "intended to afford to insurers and employers the same opportunities they would enjoy in the absence of the [ADA] to design and administer insurance products and benefit plans in a manner that is consistent with basic principles of insurance risk classification." S. REP. 101-116, at 136-37 (1989). Thus, the provision was designed, at least partly, to appease the insurance lobby and assure the insurance industry that established state regulation in the insurance field and traditional risk classification practices need not be modified in light of the ADA. David M. Studdert & Troyen A. Brennan, *HIV Infection and the Americans with Disabilities Act: An Evolving Interaction*, 549 ANNALS AM. ACAD. POL. & SOC. SCI. 84, 91 (1997).

115. 42 U.S.C. §§ 300gg-300gg-92 (1996 and Supp. 2001).

116. *Id.* § 300gg(a). In the case of a late enrollee, the period of excluded coverage may be extended to eighteen months. *Id.* In addition, group insurers must generally credit enrollees for any time during which they were previously excluded from coverage because of a preexisting condition exclusion that was applied to them while they were covered by a different insurer. *Id.* §§ 300gg(a), (c).

117. *Id.* § 300gg-11. This portability requirement is designed to alleviate the concerns of employees who were reluctant to leave current jobs for fear that they will be denied health insurance by future employers because of preexisting conditions. Len M. Nichols & Linda J. Blumberg, *A Different Kind of 'New Federalism'? The Health Insurance Portability and Accountability Act of 1996*, HEALTH AFFAIRS, May/June 1998, at 25, 32.

118. A small group is defined as consisting of two to fifty members. 42 U.S.C. §§ 300gg-91(e)(4), (5) (1996 and Supp. 2001).

119. *Id.* § 300gg-11. More specifically, HIPAA provides that insurers offering group insurance may not base rules of eligibility for enrollment on any of the following factors: health status, physical or mental illness, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. *Id.* §§ 300gg-1(a)-(h).

because of a health-status related factor.¹²⁰ The statute requires all group carriers, in both large and small group markets, to guarantee renewal of their products.¹²¹

HIPAA also reaches individual health insurance policies. It guarantees the portability of group insurance to individual insurance for certain individuals¹²² and requires that all individual policy coverage be guaranteed renewable.¹²³ The statute does not, however, restrict the amount of premium that an insurer may charge a person purchasing an individual policy.¹²⁴ It also does not address limitations and exclusions of coverage for particular treatments.

The state laws that govern health insurance coverage are numerous and varied. The laws focus on coverage issues relating to AIDS/HIV treatment; bone marrow transplants; prescription contraceptives; prosthetic devices; drug and alcohol rehabilitation services; mental health care; fertility treatments; hospice care; dental, vision, and hearing care; speech therapy; and other medical services.¹²⁵ Over half

120. *Id.* § 300gg-1(b). Different groups, however, can be charged different premiums, based on the insurers' assessment of the risk status of all members of the group. *Id.*

121. *Id.* § 300gg-12.

122. *Id.* § 300gg-41. Individuals are eligible under the following conditions: (1) they have had eighteen months of continuous prior coverage with no coverage gap lasting longer than sixty-two days and have most recently had group coverage; (2) they have exhausted any COBRA benefits available to them and have no current access to group insurance or a public program; and (3) they are eligible for some type of guaranteed issue coverage in the individual market. *See Id.* § 300gg-41(b).

123. *Id.* § 300gg-42.

124. *Id.* § 300gg-41(g)(1). The absence of regulation in this area is significant. A recent study found a vast range of annual premiums in the individual market extending from \$408 to \$30,000, with an average of \$2998 per year for healthy single people and \$3996 for those with medical problems. Aston, *supra* note 8, at 14.

125. The following are examples of various state mandates regarding health insurance coverage. The requirements vary as to their details and applicability to group and/or individual health insurance policies. They are presented here in terms of general coverage categories.

AIDS/HIV treatment: D.C. CODE ANN. § 31-1603(b)-(d) (1981-1997); FLA. STAT. ANN. § 627.429(5)(a) (West 1996 & Supp. 2001); FLA. STAT. ANN. § 627.429(5)(b) (West 1996 & Supp. 2000); KY. REV. STAT. ANN. § 304.12-013(5)(a) (Banks-Baldwin 2000); ME. REV. STAT. ANN. tit. 24-A, § 2837-G(2)(A) (West 2000); MASS. GEN. LAWS ANN. ch. 175, § 470 (2001); MO. ANN. STAT. § 191.671 (West 1996); TEX. INS. CODE art. 3.51-6 § 3C (West Supp. 2001); WIS. STAT. ANN. § 631.93 (West 1995).

Bone marrow transplants: FLA. STAT. ANN. § 627.4236(2) (West 1996 & Supp. 2001) (for cancer); GA. CODE ANN. § 33-29-3.3(a) (1996) (for breast cancer and Hodgkin's disease); MASS. GEN. LAWS ANN. ch. 175, § 47R (West 1998) (for breast cancer that has progressed to metastatic disease); MINN. STAT. ANN. § 62A.309(Subd. 2) (West 1996) (for breast cancer); MO. ANN. STAT. § 376.1200(1) (West Supp. 2001) (for breast cancer); N.H. REV. STAT. ANN. § 415:18-c (1998) (for breast cancer); N.J. STAT. ANN. § 17B:26-2.Ij (West 1996) (for cancer); N.J. STAT. ANN. § 17B:26-2.1d (West 1996) (for Wilm's tumor); TENN. CODE ANN. § 56-7-2504(a) (2000) (for cancer, in the event that such coverage is included in the TennCare program); VA. CODE ANN. § 38.2-3418.1:1(A) (Michie 1999) (for breast cancer).

FDA-approved contraceptive coverage, generally in plans that cover other prescription drugs and/or outpatient services: CAL. INS. CODE § 10123.196(a)(1) (West Supp. 2001); CONN. GEN. STAT. ANN. § 38a-503e(a) (West Supp. 2001); DEL. CODE ANN. tit. 18, § 3559(a)-(b) (Supp. 2000); GA. CODE ANN. §§ 33-24-59.6(c), (e)(2) (Supp. 2000); HAW. REV.

STAT. §§ 431:10A-116.6(a), (c) (Supp. 2000) (Hawaii mandates contraceptive coverage regardless of whether such plan covers other prescriptions.); IOWA CODE ANN. § 514C.19(1)(a) (West Supp. 2001); IOWA CODE ANN. § 514C.19(1)(b) (West Supp. 2001); ME. REV. STAT. ANN. tit. 24A, § 2756 (West 2000); MD. CODE ANN., INS. § 15-826(b)(1)-(2) (1995-1997); NEV. REV. STAT. ANN. § 689A.0415(1)(a) (Michie Supp. 1999); N.H. REV. STAT. ANN. § 415:18-i (Supp. 2000); N.C. GEN. STAT. § 58-3-178(a) (1999); N.C. GEN. STAT. § 58-3-178(b) (1999); R.I. GEN. LAWS § 27-18-57(a) (Supp. 2000); VT. STAT. ANN. tit. 8, § 4099c(a) (Supp. 2000).

Prosthetic devices: MD. CODE ANN., INS. § 15-820(b) (1995-1997) (prosthetic devices and orthopedic braces); MD. CODE ANN., INS. § 15-834(b) (Supp. 2000) (post-mastectomy prosthesis if insured/enrollee has not had breast reconstruction);

Scalp hair prostheses: MD. CODE ANN., INS. § 15-836(b) (Supp. 2000) (for hair loss resulting from chemotherapy or radiation treatment for cancer); MASS. GEN. LAWS ANN. ch. 175, § 47T(b) (West 1998) (for hair loss resulting from cancer or leukemia treatment); MINN. STAT. ANN. § 62A.28 (West 1996) (for hair loss resulting from alopecia areata); N.H. REV. STAT. ANN. § 415:18-d(I) (1998) (for hair loss resulting from alopecia areata, alopecia totalis, alopecia medicamentosa or permanent loss of scalp hair due to injury);

Alcohol/drug addiction/mental illness treatment: Twenty-three states require coverage for alcoholism and sixteen require insurers to offer an option of coverage for alcoholism. Jana K. Strain & Eleanor D. Kinney, *The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA*, 31 LOY. U. CHI. L.J. 29, 35 n.40 (1999). Thirteen states require coverage for drug abuse treatment and ten require insurance plans to offer an option of coverage for such therapy. *Id.* at n.43. Fifteen states require coverage for mental illness and sixteen require states to offer an option for such coverage. *Id.* at n.41. *See e.g.*, ALASKA STAT. § 21.42.365 (Michie 2000) (alcoholism and drug abuse); D.C. CODE ANN. § 35-2302(a) (1981-1997 & Supp. 2001) (drug abuse, alcohol abuse, and mental illness); HAW. REV. STAT. § 431M-2 (1993) (alcohol dependence, drug dependence, and mental illness treatment services); ME. REV. STAT. ANN. tit. 24-A, §§ 2842(3), 2843(5-C)(A) (West 2000) (alcoholism and other drug dependency pursuant to a treatment plan, biologically based mental disorders); MINN. STAT. ANN. § 62A.149(Subd. 1) (West 1996) (alcoholism, chemical dependency, or drug addiction); MISS. CODE ANN. §§ 83-9-27, 83-9-39 (1999) (alcoholism, mental illness); MO. ANN. STAT. § 376.779(1) (Vernon 1991 & Supp. 2001) (alcoholism); MONT. CODE ANN. § 33-22-703 (1999) (alcoholism, drug addiction, and mental illness); N.H. REV. STAT. ANN. § 415:18-a(I) (1998 & Supp. 2000) (mental illnesses and emotional disorders which are subject to "significant improvement through short-term therapy"); N.J. STAT. ANN. § 17B:25-2.1.5 (West 1996) (alcoholism, biologically based mental illness); TENN. CODE ANN. § 56-7-2601(a), 2602(b) (2000) (alcohol and drug dependency, mental conditions); TEX. INS. CODE ANN. art. 3.51-9 § 2A(a), 3.51-14 § 3(a) (Vernon 1981 & Supp. 2001) (chemical dependency, serious mental illness); VA. CODE ANN. § 38.2-3412.1(B), 38.2-3412.1:01 (Michie 1999) (mental health, substance abuse, and biologically based substance abuse);

Fertility/in vitro fertilization: Twelve states require coverage, and two require insurers to offer an option of coverage. Strain & Kinney, *supra*, at 35 n.45. *See, e.g.*, MD. CODE ANN., INS. § 15-810(b)(1) (1995-1997 & Supp. 2000); TEX. INS. CODE art. 3.51-6 § 3A(a) (West Supp. 2001);

Home health care: ME. REV. STAT. ANN. tit. 24-A, § 2837 (West 2000); MD. CODE ANN., INS. § 15-808(c) (1995-1997); N.Y. INS. LAW § 3216(i)(6) (McKinney 2000);

Hospice care: MD. CODE ANN., INS. § 15-809 (1995-19); VA. CODE ANN. § 38.2-3418.11 (Michie 1999);

Dental, vision, and hearing care: ALASKA STAT. § 21.42.385(a) (2000);

Treatment for speech, hearing, and language disorders: MASS. GEN. LAWS ANN. ch. 175, § 47U (West Supp. 2001); N.J. STAT. ANN. § 17B:26-2.1p (West Supp. 2001); TENN. CODE

of the states have enacted laws prohibiting health insurance providers from requiring genetic testing as a condition of coverage or from denying insurance or charging higher rates based upon the results of genetic tests.¹²⁶ Approximately 1000 different state mandates concerning health insurance coverage have been issued by state legislatures.¹²⁷

III. EXISTING CONCEPTIONS OF MORAL FAIRNESS

The large body of federal and state legislation discussed above evidences a deep concern about moral fairness in the realm of health insurance. Hundreds of laws have been passed in the United States that seek to enhance equity and fair distribution of health care services. The laws, however, are all limited in scope and confined in their reach. They do not create a regulatory system that provides comprehensive protection to health insurance beneficiaries or clear guidance as to how moral fairness can be achieved in the realm of health insurance. The shortcomings of existing legislation are not surprising in light of the fact that the concept of moral fairness is elusive and difficult to define.¹²⁸

The following Part discusses different conceptions of moral fairness that have been offered by a variety of scholars. Some involve a redistribution of resources in order to achieve a measure of equality, and other models are process-oriented, envisioning the promotion of moral fairness through the establishment of fair decisionmaking procedures. Each model has its shortcomings, but each also can contribute to our understanding of the concept of moral fairness. Drawing upon different aspects of the various theories, I will later develop my own analytical model.

A. Equality of Resources

One understanding of moral fairness is equality of resources, whereby each individual receives equal resources no matter what level of satisfaction the fixed amount will allow her to attain.¹²⁹ Thus, each individual, for example, would be given \$1000 per year for purposes of health care. Resources would consequently be redistributed so that all individuals would receive an equal dollar amount regardless of their social and economic status.

The problem with this approach is that while healthy people might be able to purchase more than enough care to meet their needs with the allocated amount, sick

ANN. § 56-7-2603(a)(1) (2000);

Second opinion in the event of positive or negative cancer diagnosis: N.Y. INS. LAW § 3216(i)(19)(A) (McKinney 2000);

Medical foods that are necessary for treatments of particular conditions: MD. CODE ANN., INS. §§ 15-807(a)(4), (c) (1995-1997); N.Y. INS. LAW § 3216 (i)(21) (McKinney 2000);

Gastric bypass surgery or other medically recognized methods to treat morbid obesity: VA. CODE ANN. § 38.2-3418.13(A) (Michie Supp. 2000).

126. Rothstein & Hoffman, *supra* note 21, at 867.

127. *New Study Shows 992 Mandated Benefits in the States*, *supra* note 20, at 6; Korobkin, *supra* note 20, at 2.

128. Other reasons for legislative shortcomings are discussed *infra* Part V.A.

129. Ronald Dworkin, *What is Equality? Part 1: Equality of Welfare*, 10 PHIL. & PUB. AFF. 185, 186 (1981).

people would remain miserably underserved, because \$1000 would cover only a small fraction of their needs. In the alternative, if each individual were provided a dollar amount that would be sufficient to cover her care if she became very sick, say \$200,000, the required budget would be astronomical and unrealistic for a society with limited resources.

B. Equality of Welfare

In the alternative, one might argue that just distribution requires equality of welfare and thus, that resources be allocated to make all individuals equally happy or successful, even if the actual distribution of resources is highly unequal.¹³⁰ Thus, if one individual can attain a threshold level of satisfaction with her health by spending \$1000, and another individual will attain that threshold level of satisfaction only if she spends \$10,000, society should give \$1000 to the first person and \$10,000 to the second. The concept of equality of welfare, however, raises the problem of "expensive tastes."¹³¹ In the words of Ronald Dworkin, "[e]quality of welfare seems to recommend that those with champagne taste, who need more income simply to achieve the same level of welfare as those with less expensive tastes, should have more income on that account."¹³²

Dworkin provides the example of a parent who wishes to divide his estate among five children: one blind, another a playboy with expensive tastes, a third an ambitious politician who must finance his campaigns, a fourth a poet with modest needs, and a fifth a sculptor who requires costly material. Equality of welfare would dictate that the children with expensive tastes or needs receive larger portions than the others.¹³³ In the health care arena, one would similarly have to defer to individual preferences under the equality of welfare principle. If one person was content living with certain aches and functional limitations that could be alleviated with medication while another insisted that she is miserable without expensive plastic surgery that will enhance her social and career opportunities, society would have to leave the first untreated and provide the surgery to the second so that she too could be content.

C. Equality of Opportunity

A much more persuasive conception of moral fairness in the context of health insurance is one offered by Norman Daniels. Daniels views moral fairness as being achieved when all individuals are given an equal opportunity to enjoy and succeed in life.¹³⁴ He therefore believes that society has an obligation to provide all its members with health care services "that promote normal functioning."¹³⁵ He draws an analogy to education, explaining that health care, like education, is essential to

130. See Dworkin, *supra* note 129, at 186; JOHN E. ROEMER, THEORIES OF DISTRIBUTIVE JUSTICE 237-52 (1996); Maxwell J. Mehlman, *The Law of Above Averages: Leveling the New Genetic Enhancement Playing Field*, 85 IOWA L. REV. 517, 543 (2000).

131. Dworkin, *supra* note 129, at 228.

132. *Id.*

133. See Dworkin, *supra* note 129, at 186-87.

134. DANIELS, *supra* note 15, at 10-11.

135. *Id.*

the protection of fair equality of opportunity in society.¹³⁶

Another scholar, Lawrence Gostin, clearly explains the analogy as follows:

Government is prepared to provide a public education to all children of school age. Access to education is presumably justified by the importance of education in furnishing fair opportunities for all children, irrespective of their social or economic class. Like education, a certain level of health care is essential to a person's ability to pursue life's opportunities on some roughly equitable basis. Health care, at least in some fundamental ways, is as important to equal opportunity as education. While health care does not provide opportunities by facilitating basic knowledge and skill, it does so by enabling the person to function mentally and physically in the application of that knowledge and skill.¹³⁷

A similar vision is embraced by the Nobel Prize-winning economist, Amartya Sen, who speaks not of health care, but of economic development. Dr. Sen argues that wealth is useful not as an end in itself, but because it allows individuals to achieve substantive freedom and to live lives that are valuable in their own eyes.¹³⁸ Economic welfare should therefore be evaluated in terms of the capabilities it affords people, that is, what individuals are actually doing with their lives and what they have the opportunity to do.¹³⁹ By extension, it could be assumed that Sen would argue that health care is important because it affords patients the opportunity to live valuable and satisfying lives, free from the constraints of debilitating illness.

Norman Daniels's model, like those previously discussed, is vulnerable to criticism. It does not provide clear guidance concerning many important questions. What does "normal functioning" mean? Who will decide what "normal functioning" is? In order to promote "normal functioning," should people be given state-of-the-art care (for example, expensive magnetic resonance imaging for every injury), experimental therapy, or just standard therapy in every case? In sum, how exactly should Daniel's concepts be translated into practice?¹⁴⁰ Nevertheless, in suggesting that, to the extent possible, all individuals should be brought to a baseline level of physical and mental functioning through adequate health care, Daniels provides a useful model for moral fairness.

D. Significant Net Health Benefits

Another commentator argues that coverage should be extended to health care services that are proved to provide a "significant net health benefit."¹⁴¹ He suggests that "net health benefit" be defined in the following terms: "the expected health benefit (that is, increased life expectancy, relief of pain, reduction in anxiety, improved functional capacity) exceeds the expected negative consequences (that is, mortality, morbidity, anxiety of anticipating the procedure, pain produced by the

136. NORMAN DANIELS, *JUST HEALTH CARE* 46-47 (1985).

137. Gostin, *supra* note 9, at 27.

138. AMARTYA SEN, *DEVELOPMENT AS FREEDOM* 14 (1999).

139. *Id.* at 75, 85.

140. See David C. Hadorn, *Emerging Parallels in the American Health Care and Legal-Judicial Systems*, 18 AM. J.L. & MED. 73, 86 (1992).

141. *Id.* at 92.

procedure, time lost from work)."¹⁴² Before mandating coverage of a particular treatment, policymakers could be required to show that a net health benefit is "reasonably expected," "reasonably well demonstrated," or "clearly demonstrated," depending on how strict society wishes its standard of proof to be.¹⁴³

The net health benefit standard, like all other standards, is somewhat vague. It will often be impossible to measure with exactitude elements such as pain, relief, and anxiety, and therefore determining the "net benefit" of a particular therapy could be extremely difficult. Moreover, the net health benefits model does not adequately consider the cost of treatments.¹⁴⁴ Society could not afford to provide all services with a net health benefit to all people. This is especially true in the case of therapies that are not "medically necessary."¹⁴⁵ Treatments such as plastic surgery that often have a net health benefit because they make people feel better about themselves, but as a luxury, are unlikely to be included in any national benefits package and are not essential to the fulfillment of a moral fairness mandate. Nevertheless, the net health benefits model is instructive in that it urges policymakers to consider the advantages and disadvantages of various treatments when contemplating coverage decisions.

E. The Veil of Ignorance

The philosopher John Rawls focuses on the process of decisionmaking. He argues that in an ideal world, policymakers would establish policy principles from behind a "veil of ignorance" that would prevent them from knowing their individual traits or having insight into what their futures hold.¹⁴⁶ Since the

142. *Id.* (citing Tolls R. Park et al., *Physician Ratings of Appropriate Indications for Six Medical and Surgical Procedures*, 76 AM. J. PUB. HEALTH 766, 767 (1986)).

143. *Id.*

144. The author addresses the cost issue as follows:

Importantly, consideration of treatment effectiveness and net benefit judgments would take place without direct regard to the costs of services. Service costs would be considered *indirectly* during the formulation of guidelines, however, since judgments of *net* health benefit require that the expected harms or risks of treatment be weighed against the value of any expected health benefits. Importantly, these burdens often are directly correlated with the financial costs of that treatment. For example, patients subjected to several days in an intensive care unit or to major surgery often pay a heavy physical and psychological toll for any benefits that they receive. (emphasis in original).

Id. at 93.

145. For a discussion of the difficulties of determining which treatments are in fact "medically necessary," see *infra* Part IV.B.

146. JOHN RAWLS, A THEORY OF JUSTICE 118 (1999). Specifically, Rawls writes that for the veil of ignorance to exist, the following must be true:

First of all, no one knows his place in society, his class position or social status; nor does he know his fortune in the distribution of natural assets and abilities, his intelligence and strength, and the like. Nor, again, does anyone know his conception of the good, the particulars of his rational plan of life, or even the special features of his psychology such as his aversion to risk or liability to optimism or pessimism. More than this, I assume that the parties do not know the particular circumstances of their own society. That is, they do not know its economic or political situation, or the level of civilization and culture it has

decisionmakers would be ignorant of how they might personally be affected by the rules, they would create policies that would be fair to everyone. The veil of ignorance would ensure that no individual policymaker could incorporate elements that would be to her personal advantage or to the disadvantage of another particular individual or group.¹⁴⁷

In the area of health care, it is realistically impossible for policymakers to function behind a true Rawlsian veil of ignorance in formulating coverage decisions.¹⁴⁸ Policy officials will be aware of their own traits and health status, and in light of family histories or genetic testing, they may even know what illnesses they are likely to develop in the future.

Ronald Dworkin, however, relies on the veil of ignorance concept in developing the "prudent insurance" approach to just distribution of health services.¹⁴⁹ Dworkin bases his approach on three assumptions that would be present in an ideal world: (1) the distribution of wealth and income among Americans is as equal as possible; (2) every American has state-of-the-art knowledge about the value, cost, and side effects of all medical procedures; and (3) no one has any information concerning how likely any particular individual is to suffer from any specific disease or to be injured in any kind of accident.¹⁵⁰ Dworkin argues that moral fairness will be achieved if all individuals receive a level of health care that most people would think prudent for themselves if the above conditions existed.¹⁵¹ Therefore, if nearly all prudent people would buy insurance covering routine medical care, necessary hospitalization, prenatal and well-child care, and preventive medicine, a universal health care system should provide such care to all Americans.¹⁵² By contrast, if most prudent insureds of average income would not wish to pay high premium prices to cover expensive treatment for unconscious, demented, or terminally ill patients or for babies with severe defects who are unlikely to live more than a few weeks, then moral fairness would not demand coverage for such services.¹⁵³

Dworkin himself, however, acknowledges that different people would apply the prudent insurance test differently and reach different conclusions concerning

been able to achieve. The persons in the original position have no information as to which generation they belong.

Id. at 137.

147. *Id.* at 136 ("Somehow we must nullify the effects of specific contingencies which put men at odds and tempt them to exploit social and natural circumstances to their own advantage.").

148. *Id.* at 118.

149. RONALD DWORIN, SOVEREIGN VIRTUE 311 (2000).

150. *Id.* at 311-12.

151. *Id.* at 314-15.

152. *Id.* at 315.

153. *Id.* Dworkin summarizes his approach as follows:

The test asks what people would decide to spend on their own medical care, as individuals, if they were buying insurance under fair free-market conditions, and it insists, first, that we as a nation should spend what individuals would spend, collectively, under those conditions; and, second, that we should use that aggregate expenditure to make sure that all have now, as individuals, what they would have then.

Id. at 317.

particular treatments.¹⁵⁴ His proposal, therefore, offers only a way of thinking about moral fairness in the health care arena but not a clear formula for achieving it. Dworkin concludes that policymakers must obtain input from a variety of groups that are likely to reach different conclusions about what services should and should not be covered.¹⁵⁵

F. Participatory Process

By asserting that input must be obtained from a broad spectrum of sources, Dworkin suggests that a participatory decisionmaking process should be established. The question of how essential policy decisions should be reached in a diverse and democratic society has occupied the minds of many other thinkers as well.

The philosopher Hannah Arendt conceived of the public realm as based upon the "simultaneous presence of innumerable perspectives and aspects in which the common world presents itself and for which no common measurement or denominator can ever be devised."¹⁵⁶ Arendt emphasized the importance of maintaining the natural diversity of aspects and perspectives with which the public views the common world.¹⁵⁷ Another scholar, Iris Marion Young, develops a conception of communicative democracy.¹⁵⁸ She argues that if individuals wish to address collective problems, they must acknowledge and understand one another's perspectives and recognize that their own perspectives are limited.¹⁵⁹ She views democratic discourse as involving communication of differences, an understanding of which enables society to make just and wise decisions.¹⁶⁰ In the words of yet another commentator, "justice . . . involves reconciling diversities into a restored and new multiple unity. Justice requires a unity of differences; mutuality and incorporation rather than annihilation of opposites and distinctions."¹⁶¹

Different members of American society will, therefore, continue to disagree about precisely which coverage mandates maximize the just distribution of health care services. What is important is to construct a means by which we can achieve moral compromise even without moral consensus.

A theoretical basis for this approach can be drawn from the area of organizational ethics, embodied in the "stakeholder theory of the modern corporation."¹⁶² The theory, which can be applied to health care entities, argues that

154. *Id.*

155. *Id.*

156. HANNAH ARENDT, *THE HUMAN CONDITION* 57 (1958).

157. *Id.* at 57-58.

158. IRIS MARION YOUNG, *INCLUSION AND DEMOCRACY* 112 (2000).

159. *Id.* at 118 ("Paying specific attention to differentiated social groups in democratic discussion and encouraging public expression of their situated knowledge thus often makes it more possible than it would otherwise be for people to transform conflict and disagreement into agreement.").

160. *Id.* at 115-16 ("Inclusion of and attention to socially differentiated positions in democratic discussion tends to correct biases and situate the partial perspectives of participants in debate.").

161. JANE FLAX, *The Play of Justice, in DISPUTED SUBJECTS: ESSAYS ON PSYCHOANALYSIS, POLITICS AND PHILOSOPHY* 111, 123-24 (1993).

162. R. Edward Freeman, *A Stakeholder Theory of the Modern Corporation, in*

business managers must focus on the following question: “[f]or whose benefit and at whose expense should the firm be managed?”¹⁶³ In other words, it is essential to identify and respond to all stakeholders in company policy, which include not only stockholders, but also suppliers, customers, employees, and the local community.¹⁶⁴ One theorist, R. Edward Freeman, identifies six ground rules for ethical corporate behavior, several of which establish fair process.¹⁶⁵

In the arena of health insurance coverage it is likewise important to identify all stakeholders and to obtain input from them for decisionmaking purposes. Stakeholders will include patients, doctors, medical researchers, sponsors of research,¹⁶⁶ and insurers. In order to promote moral fairness, it is essential to establish a process by which the meaningful participation of all stakeholder groups is guaranteed.

IV. A NEW ANALYTICAL METHOD: THE PRINCIPLES OF MORAL FAIRNESS

No existing model provides a comprehensive answer to the question of what constitutes moral fairness in health insurance coverage. Drawing upon different aspects of the theories critiqued above, however, some general principles can be delineated to guide policy officials in making morally fair coverage decisions. These principles address several different priorities. The first, universality, mandates a redistribution of resources to address the problem of the uninsured. The next two provide specific guidelines for the crafting of coverage decisions and the establishment of an acceptable classification system. Next, the methodology of decisionmaking is addressed by the principle of participatory process. The final two principles argue for the rejection of approaches that are inappropriate for health

PERSPECTIVES IN BUSINESS ETHICS 171 (Laura Pincus Hartman ed., 2002).

163. *Id.* at 172.

164. *Id.* at 171.

165. *Id.* at 179. The rules are the following:

- 1) “The Principle of Entry and Exit.” Contracts must have clearly defined entry, exit, and renegotiation conditions, or at least have methods or processes for defining these conditions.
- 2) “The Principle of Governance.” Procedures for changing the rules of the game must be decided by unanimous consent.
- 3) “The Principle of Externalities.” If a contract between two parties imposes costs on a third party, the third party should have the option of becoming a party to the contract, and the terms of the contract should be renegotiated.
- 4) “The Principle of Contracting Costs.” All parties to the contract must share in the costs of contracting.
- 5) “The Agency Principle.” All agents should serve the interests of all stakeholders.
- 6) “The Principle of Limited Immortality.” The corporation should be run as though it can continue to serve the interests of stakeholders indefinitely.

Id.

166. Sponsors of medical research include pharmaceutical companies, governmental agencies such as NIH, and all others who sponsor and pay for research. Stuart E. Lind, *Financial Issues and Incentives Related to Clinical Research and Innovative Therapies*, in THE ETHICS OF RESEARCH INVOLVING HUMAN SUBJECTS 193-94 (Harold J. Vanderpool ed., 1996).

care coverage determinations.

A. Universality

The first principle addresses the problem of the unjust distribution of health care resources. In the United States, a large segment of the population is uninsured.¹⁶⁷ A system that does not embrace the value of universality cannot be considered morally fair.¹⁶⁸ If some members of society have hope of living long and comfortable lives and others are deprived of that hope because they know that when they become ill their needs will be neglected, the system does not justly distribute its resources. The principle of universality grows out of the concept of social pooling.¹⁶⁹ Insurance already is understood as a mechanism for risk spreading among a large group of people, in order to protect each member from potentially devastating financial loss.¹⁷⁰ It is not perceived as a luxury reserved for the elite that should be unavailable to people without financial means. In the last decade there has been growing discomfort with the failure of the American system to provide health care coverage to its entire population and many proposals for reform have been made.¹⁷¹ Studies have shown that the uninsured in this country suffer a decline in health when compared to those with insurance, and therefore, lack of health benefits is in fact associated with adverse health outcomes.¹⁷² Laws such as HIPAA and EMTALA have already taken steps to reduce the number of uninsured and to ensure that every American can receive at least a minimal level of emergency care.¹⁷³ Following these precedents, therefore, it would be natural to extend the concept of social pooling even further, to include everyone within the covered pool.

Universality is also consistent with many of the theories of moral fairness described above. Equality of resources, equality of welfare, and equality of opportunity are all models that contemplate equality of one character or another for all members of a society. None of these models supports the exclusion of a large segment of society based on its inability to pay for adequate health care.

167. Over 42 million Americans are uninsured. See Blakely, *supra* note 8, at 1; Schroeder, *supra* note 8, at 847.

168. See Dan W. Brock & Norman Daniels, *Ethical Foundations of the Clinton Administration's Proposed Health Care System*, 271 JAMA 1189, 1189 (1994); Zoloth, *supra* note 10, at 36.

169. See *supra* Part I.B.2.

170. *Id.*

171. See *infra* Part V.C.1.

172. David W. Baker et al., *Lack of Health Insurance and Decline in Overall Health in Late Middle Age*, 345 NEW ENG. J. MED. 1106, 1108 (2001). The study, which involved 7577 individuals between the ages of fifty-one and sixty-one, found that "continuously uninsured participants were 63 percent more likely than the privately insured participants to have a decline in their overall health between 1992 and 1996 and 23 percent more likely to have a new physical difficulty that affected walking or climbing stairs (i.e., a difficulty with mobility)." *Id.* These findings were consistent with conclusions from two previous, smaller studies. *Id.* See also Jack Hadley, *Sicker and Poorer: The Consequences of Being Uninsured*, The Kaiser Commission on Medicaid and the Uninsured (May 2002) available at <http://www.kff.org/content/2002/20020510>.

173. See *supra* Part I.C.

Evidence that universality is a widely accepted principle can be drawn from international experience. All other developed countries in the world provide universal coverage to their populations.¹⁷⁴ Chile has gone as far as to adopt a constitutional provision that guarantees its residents a right to buy private health insurance.¹⁷⁵

Universality is not an uncontroversial proposition and may be in tension with other important values such as high quality of care and prudent resource allocation. In light of budgetary constraints and finite economic resources, as coverage is extended to people who cannot pay for it, the quality of medical care received by those who currently have insurance could deteriorate.¹⁷⁶ Furthermore, in order to reduce the number of uninsured significantly, the government would have to increase its spending on health care and possibly cut other programs that enhance public welfare and safety.¹⁷⁷ Universality may require significant trade-offs, and there is no definitive answer to the question of how an optimal balance can be achieved. Nevertheless, a morally fair system of health coverage cannot be indifferent to the problem of the uninsured and should promote the principle of universality.¹⁷⁸

174. Andre Hampton, *Markets, Myths, and A Man on the Moon: Aiding and Abetting America's Flight from Health Insurance*, 52 RUTGERS L. REV. 987, 992 (2000); Gostin, *supra* note 9, at 17; Donald W. Light, *Health Care for All*, COMMONWEAL February 22, 2002, at 14 ("Now that South Africa has legislated universal access to medical services, the United States remains the only industrialized or second-tier country in the world that fails to guarantee its citizens access to medical services.").

175. Timothy Stoltzfus Jost, *Managed Care Regulation: Can We Learn from Others? The Chilean Experience*, 32 U. MICH. J.L. REFORM 863, 866 (1999). The provision reads:

The Right to Health Protection

The State protects free and equal access to actions for the promotion, protection, and recovery of health and for rehabilitation of the individual.

The coordination and control of the activities related to health shall also rest with the State. A primary duty of the State is to guarantee the execution of health activities, whether provided by public or private institutions, in the manner and under the conditions established by law, which may provide for mandatory payments.

Each person shall have the right to choose the health system, whether State or private, that he wishes to join.

Id.

176. See Henry N. Butler, *The Political Market for Mandated Health Care Benefits Under the Proposed National Health Security Act*, 3 KAN. J. L. & PUB. POL'Y 113, 118 (1993/1994) (discussing President Clinton's proposed health care reform, which mandated universal coverage and insurance premium caps, and warning that it would lead to reduced use of services, "substitution of alternative, lower-cost services," and to some insureds having to forgo care in various instances). The problem, however, could be addressed through opt-out provisions and supplemental policies. See discussion *infra* Part V.D.2.

177. See *id.* at 117 (stating that "Medicaid has become the fastest growing item in state budgets, crowding out expenditures for schools, roads, and prisons."). See also David M. Cutler, *A Guide to Health Care Reform*, 8 J. ECON. PERSP. 13, 24 (1994) (explaining that "universal coverage requires subsidies and thus increased federal spending" and, in addition, that it could "provide incentives for some people who are working to leave the labor force" since insurance will no longer be tied to employment in most cases.).

178. See Jonathan Cohn, *Health Scare*, NEW REPUBLIC, Dec. 24, 2001, at 19 (warning

B. Priority Should Be Given to Standard Therapies that Are Medically Necessary to Cure or Alleviate the Symptoms of Mental or Physical Impairments that Substantially Limit Major Life Activities

The second and third principles address not the question of who should be included in the system, but the issue of which services should be covered in a national benefits package in order to avoid unfair discrimination in coverage terms. It is important to ensure that those who need health care services the most and can benefit from them to the greatest extent receive the needed treatments. While some seek medical intervention unnecessarily for viruses or common colds, many others seek it because they have severe disabilities or life-threatening diseases. Health care does its finest service when it saves lives, restores functionality, or diminishes the consequences of lasting disability.

Norman Daniels articulates this view when he suggests that moral fairness will be achieved if all members of society have an opportunity to receive health care services "that promote normal functioning."¹⁷⁹ Daniels, however, does not elucidate what constitutes "normal functioning." To refine Daniel's proposal one can turn to the ADA's definition of the term "disability."

The ADA defines "disability," in relevant part, as a "physical or mental impairment that substantially limits one or more of the major life activities of . . . [an] individual."¹⁸⁰ The federal regulations provide that major life activities include, but are not limited to, functions such as "caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."¹⁸¹ Accordingly, one cannot be said to be functioning normally if one suffers from a "disability," as the term is defined by the ADA. Although a universal, national health benefits package will not be able to provide all Americans with all of the health care services they desire at all times, the package should provide basic care to those who need it most. It should, therefore, include standard therapies that are medically necessary to cure or alleviate physical or mental impairments that substantially limit major life activities.

The courts have decided many cases that evaluate what conditions actually constitute disabilities for ADA purposes. While some of these cases may be a useful resource for policy makers, many of them will be inapplicable in the health care coverage context. For example, temporary conditions, such as infections that

that in light of rising unemployment and recession, the number of uninsured could increase to 45 million by the end of 2002). For further discussion of the advantages, disadvantages, and implications of universality, *see infra* Part V.D.

179. DANIELS, *supra* note 15, at 11.

180. 42 U.S.C. § 12102(2) (1995). The regulations promulgated pursuant to the ADA explain that a physical or mental impairment means:

(1) Any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, and endocrine; or

(2) Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

29 C.F.R. § 1630.2(h) (2001).

181. *Id.* § 1630.2(i).

are treatable with antibiotics, are not considered disabilities for ADA purposes.¹⁸² It would be unreasonable to exclude from coverage therapies for conditions that are ordinarily temporary, since these conditions are often easily and inexpensively cured and could develop into much more serious and costly ailments if they are not treated at their inception. Consequently, therapy for conditions that are debilitating for a short period of time should be covered in a national benefits package.

Furthermore, in *Sutton v. United Air Lines*,¹⁸³ the Supreme Court ruled that an individual whose physical or mental impairment is corrected by medication or other treatments does not have a "disability" and is not entitled to ADA protection.¹⁸⁴ A person with diabetes or epilepsy whose symptoms are effectively controlled by drug therapy, therefore, will not be considered disabled according to the Supreme Court. This decision would obviously be inapplicable in the health insurance context because it would be ludicrous to exclude from coverage treatments that are necessary to control the symptoms of serious illnesses in order to render them nondisabling. The *Sutton* case, in fact, seems to assume that everyone has access to all necessary medications and medical devices.

The term "disability" can provide useful guidance by elucidating that priority should be given to standard treatments that eliminate or alleviate physical and mental impairments that substantially limit major life activities. Policymakers must use discretion, however, when turning to cases that have interpreted the term under the ADA.

A few more details regarding the standard should be noted. The principle mandates coverage for treatment of both physical and mental conditions and thus follows in the footsteps of the MHPA, which sought to diminish the disparity in coverage between the two types of ailments.¹⁸⁵ There is no morally fair justification for discriminating against those who require treatment for disabling mental conditions and ignoring their serious needs.¹⁸⁶ Mental illness can be as debilitating as physical illness when it prevents people from working and caring for themselves, and it can be life-threatening if violent tendencies or suicidal ideations develop.

The principle is cost-sensitive in that it requires coverage only for standard therapy and not for experimental or unconventional treatments. In light of limited

182. The federal regulations establish that three factors should be considered in determining whether one is substantially limited in a major life activity:

- (i) The nature and severity of the impairment;
- (ii) The duration or expected duration of the impairment; and
- (iii) The permanent or long term impact, or the expected permanent or long term impact of or resulting from the impairment.

Id. § 1630.2(j)(2).

183. 527 U.S. 471 (1999).

184. *Id.* at 482-83. The case involved severely myopic airplane pilots who were denied employment by United Airlines and subsequently challenged United's minimum vision requirement. The Court ruled that they were not "disabled" under the ADA because their vision was corrected with eyeglasses, and thus they were not entitled to statutory protections. *Id.* at 488.

185. 42 U.S.C. § 300gg-5 (Supp. 2002).

186. See Light, *supra* note 174, at 14 ("mild depression and anxiety disorders . . . cripple the spirit as well as the body and can be more *physically* disabling than many physical disorders.") (emphasis in original).

resources and the need for prioritization, the national benefits package need not include treatments that are unproven or of questionable efficacy. Furthermore, the principle requires coverage only for therapy that is deemed medically necessary to treat the condition at issue and therefore incorporates the "medically necessary" standard that governs Medicare coverage.¹⁸⁷

It must be acknowledged that the concept of "medical necessity" is itself problematic.¹⁸⁸ First, there is often disagreement among physicians as to which treatments are medically necessary. Studies have found significant differences in the rates of utilization of certain procedures among similar patient populations. Cesarean section surgeries, coronary artery bypass surgeries, and pacemaker implantations are performed more or less frequently in different settings, with little correlation to patient need.¹⁸⁹ In one study conducted in Great Britain, twenty-five nephrologists were presented with forty patients and were asked to choose thirty for kidney disease treatment, based on supposedly established medical criteria. Only thirteen were deemed by all of the physicians to need treatment, and none was rejected by every doctor.¹⁹⁰

A second potential problem is that the concept of medical necessity creates a system of professional dominance, allowing doctors to determine independently what care patients will receive rather than providing patients with choices and allowing them to make autonomous decisions based on their own perceived needs and preferences. If the system requires doctors to make rigid or formulaic judgments about "medical necessity" without considering their patients' unique circumstances and personal descriptions of significant pain, discomfort, or anxiety, the system might force doctors sometimes to neglect their patients' most pressing physical and psychological needs.

Nevertheless, in order to be economically viable, a national benefits package would have to limit the services it covers. Some decisions concerning what

187. The Social Security Act provides that services eligible for Medicare coverage must be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. § 1395y(a)(1)(A) (1992).

188. See Timothy Stoltzfus Jost, *The American Difference in Health Care Costs: Is There A Problem? Is Medical Necessity the Solution?* 43 ST. LOUIS U. L.J. 1, 13 (1999). The author notes that the term "medical necessity" can have a variety of different definitions. He states the following:

First, it might mean that a procedure or test is simply not appropriate or effective for addressing a patient's condition. (citation omitted). Second, it might mean that the marginal value of a test or treatment (that is generally accepted as appropriate) over the next best test or treatment for the same condition is likely to be minimal in comparison to the marginal cost of the test or treatment over the next best test or treatment. (citation omitted). Third, it might mean that whether or not the test or procedure is beneficial to the patient is not known, or is not yet fully known: the procedure is experimental. (citation omitted).

Id.

189. *Id.* at 2 (noting that in the United States the use of cesarean section increased from 5% to 25% between 1965 and 1988 and is performed between 9.6% and 31.8% of the time in different settings, suggesting frequent inappropriate or unnecessary use of the procedure).

190. Maxwell J. Mehlman, *Rationing Expensive Lifesaving Medical Treatments*, 1985 WIS. L. REV. 239, 267 (1985).

constitutes standard therapy or medically necessary care will admittedly be controversial. Certain safeguards against irresponsible decisionmaking will be suggested below. These include the establishment of a central governmental agency that will continuously review emerging data concerning treatment efficacy and developing technology, supplemental insurance that will cover services not included in the national package, and a mechanism allowing patients to appeal adverse coverage decisions.¹⁹¹

Finally, the principle is consistent not only with Daniels's fair opportunity for normal functioning model, but also with Dworkin's prudent insurance theory¹⁹² and the significant net health benefit theory of moral fairness.¹⁹³ It is reasonable to assume that individuals of average means who know nothing about their future health status would purchase coverage for standard treatments that are medically necessary to cure or alleviate the symptoms of impairments that substantially limit major life activities. Few would wish to be left untreated for severe impairments. Furthermore, therapies that are medically necessary and are proven effective in treating disabling conditions will generally have a net health benefit because the positive gains from their use will outweigh any potential negative consequences.

C. Priority Should Be Given to Standard Preventative Care

Based again upon Norman Daniels's argument that all individuals should have the opportunity to receive health care that promotes normal functioning, the national benefits package should give priority to standard preventative care.¹⁹⁴ Medical interventions such as immunizations, routine check-ups, pap smears, and well-child visits, should be covered by a national benefits package because they are potentially life-saving, and they reduce the likelihood that individuals will suffer long-term disability or prolonged pain from serious illnesses. Diseases that are detected at their earliest stages can often be treated relatively quickly, with few, if any, long-term effects for patients. Moral fairness cannot be achieved if those without financial means do not have access to detection and prevention mechanisms that could save their lives.

This principle, like its predecessor, is consistent not only with Daniels's concept of equal opportunity for normal functioning, but also with the prudent insurance model and the significant net health benefits concept. Because prevention and early detection of disease can be invaluable in enhancing the quality and length of one's life, it is reasonable to assume that an average prudent purchaser of insurance would find preventative care to be a worthwhile investment. In addition, the health benefits of routine check-ups, vaccinations and standard diagnostic tests generally outweigh their negative consequences, such as pain or anxiety, which are often

191. See *infra* Part V.C.2 and V.D.2.

192. See *supra* Part III.E.

193. See *supra* Part III.D.

194. In some cases patients might seek extreme or experimental preventative measures. For example, patients who learn they have the BRCA1 or BRCA2 genetic abnormalities that indicate a high susceptibility to breast and ovarian cancer might seek prophylactic mastectomies or oophorectomies. See Rothstein & Hoffman, *supra* note 21, at 878. This principle does not require coverage of nonstandard prophylactic measures.

negligible.¹⁹⁵

D. A Participatory Process Must Be Established

Of great importance to the promotion of moral fairness is the establishment of a participatory decisionmaking process. No matter what general principles are adopted, they will still be vague, contain words that are ambiguous, and require case-by-case assessments in individual circumstances. For example, when implementing the principles articulated above, decisionmakers will need to grapple with the meaning of terms such as "standard treatment," "medically necessary," "substantially limit," "major life activity," and "preventive care." No general principles can escape such ambiguities because medical knowledge and technology are ever-evolving, and patient needs are specific and unpredictable.

Furthermore, the requirements of moral fairness cannot be scientifically or empirically ascertained. We are a morally pluralistic society.¹⁹⁶ In a diverse and democratic society, the government can impose policies on individuals but cannot dictate their way of thinking. Therefore, there can never be absolute consensus as to which policies are in fact morally fair.¹⁹⁷ In philosophical terms, moral fairness is an "essentially contested concept," a concept for which there is no single definition that can be deemed "the correct or standard use."¹⁹⁸ The best we can hope for is to develop a thoughtful and reliable process for the development of national coverage guidelines that are as fair as possible. A just and legitimate process can be established even without universal agreement as to the precise meaning of the term "moral fairness."¹⁹⁹

195. It is important to note that in economic terms, preventive care is not necessarily efficient since it often does not reduce medical expenditures. Rather, prevention often "offers better health at additional cost . . ." LOUISE B. RUSSELL, *IS PREVENTION BETTER THAN CURE?* vii (1986). The author uses the example of blood pressure testing. Although the test itself is very inexpensive, testing the entire population every year or two in doctors' offices generates high costs. In addition, those whose blood pressure is deemed high must be retested and evaluated thoroughly prior to treatment. Medication for hypertension can also cost several hundred dollars per year. Although early treatment of hypertension might prevent patients from suffering some illnesses, studies have calculated that in fact, the costs of treatment are far larger than the savings. *Id.* at 4. See also *id.* at 109-12 (summarizing the author's conclusions concerning the cost of preventive care).

196. Martin Benjamin, *Between Subway and Spaceship: Practical Ethics at the Outset of the Twenty-first Century*, HASTINGS CTR. REP., July-Aug. 2001, at 24, 27 (citing JOHN RAWLS, *POLITICAL LIBERALISM* 36 (1971)).

197. *Id.* ("So long as people enjoy free association and the capacity to think and act for themselves, there will be conflicts among good and important values and principles that are not due to selfishness, prejudice, ignorance, poor reasoning, and so on.")

198. W. B. Gallie, *Essentially Contested Concepts*, in PROC. OF THE ARISTOTELIAN SOC'Y 167, 168-69 (1956).

199. Under the model suggested in this Article, the participatory process would be guided by the general principles developed above so that it would not be characterized by arbitrariness and unpredictability.

E. An Absolute Antidiscrimination Mandate Is Unrealistic

Moral fairness does not necessitate the implementation of an absolute antidiscrimination mandate. In reality, no health care system can be completely devoid of discrimination. A society that has limited resources to invest in health care will have to make rationing decisions and set certain priorities.²⁰⁰

For example, we might opt against offering unlimited coverage or even any coverage for fertility treatments because of their price. The average cost of an in-vitro fertilization ("IVF") cycle is \$8000, and often, multiple cycles are needed for a successful pregnancy, so that delivery of a baby conceived through IVF can cost tens of thousands of dollars.²⁰¹ Many experimental treatments²⁰² are also likely to be excluded, even though patients with particular diseases such as AIDS or cancer might be disproportionately affected.

A system that is workable and functions within the limitations of budgetary constraints will therefore continue to feature exclusions and limitations that could be considered discriminatory with respect to particular disabilities. Moral fairness does not require that all discriminatory practices be eliminated, because such a dictate would translate into a requirement of unlimited coverage in all instances and, therefore, potential bankruptcy of the health coverage system, in which case everyone would be worse off.

F. The Moral Culpability of Patients Should Not Be Considered By Policymakers for Purposes of Coverage Decisions

Arguably, moral fairness requires consideration of the patient's moral culpability and demands exclusion of coverage for treatment of illnesses or injuries that the patient "deserves." One might contend that health insurance should not

200. See DANIELS, *supra* note 15, at 164 ("we cannot provide everyone with *all* beneficial services.") (emphasis in original); DANIELS ET AL., *supra* note 80, at 59 (stating that society must make choices as to how much priority to give the sickest patients, how to weigh significant benefits for a few versus limited benefits for many, and how to define "needed" and "effective" services.); Leonard M. Fleck, *Just Health Care Rationing: A Democratic Decisionmaking Approach*, 140 U. PA. L. REV. 1597, 1603 (1992) ("There are limits to what we as a society ought to spend on health care because there are other competing social goods that make legitimate claims on that finite set of dollars. Hence, the need for health care rationing is inescapable.").

201. Lisa Gubernick & Dana Wechsler Linden, *Tarnished Miracle*, FORBES, Nov. 6, 1995, at 98, 98. It should be noted that infertility has been deemed a disability by the Supreme Court and thus individuals who suffer from infertility are entitled to protection under the ADA. *Bragdon v. Abbott*, 524 U.S. 624, 641 (1998). Plaintiffs with infertility, therefore, might challenge coverage limitations under the ADA. If a national benefits package were to be established, the ADA might have to be amended to address the issue of the program's potential conflicts with statutory requirements.

202. See Sharona Hoffman, *A Proposal for Federal Legislation to Address Health Insurance Coverage for Experimental and Investigational Treatments*, 78 OR. L. REV. 203 (1999), arguing that Phase III clinical trials should be covered by health insurance in some circumstances. While experimental treatments are likely to be excluded from coverage in the basic, national health care package, some could be included in supplemental insurance programs. See *infra* Part V.D.2.

cover treatment of conditions that were caused by a patient's voluntarily chosen behavior or risk-taking, such as smoking or car racing.²⁰³ It is perhaps unfair to raise premiums for those who are careful about their habits and take good care of their health because of costly treatments needed by those who are irresponsible or reckless. In addition, if parents know that their infant will be born with very severe disabilities and choose not to abort the fetus, they arguably should not receive reimbursement for the millions of dollars worth of treatment needed by their child, because others will have to suffer the consequences of these high costs.

Morally fair coverage decisions, however, should not be based on judgments regarding individuals' moral culpability. First, there is a problem of causation. The precise cause of an illness is often difficult or even impossible to establish. A patient's cancerous lung tumor might be the result of her smoking or might have developed whether or not she smoked.²⁰⁴ Furthermore, individuals might engage in risky or reckless behavior because of underlying mental illness or because they were abused as children, and thus the conduct that leads to their injuries is not purely their "fault." It might also be extremely difficult to determine whether the patient engaged in hazardous behavior if she does not admit to doing so. Who will monitor and record whether an individual smoked at any time in her life, ate an excessive amount of fatty foods, or engaged in unprotected sexual activity?

Second, there is the danger of a slippery slope. While some might find the case for denying coverage for treatment to a smoker or race car driver easy to make, it would be extraordinarily difficult to establish ethical guidelines for which risk-taking behavior deserves to be punished and where the line should be drawn. For example, women who have no children are known to have an increased risk of breast and ovarian cancer,²⁰⁵ and therefore, childless women could be considered guilty of risk-taking behavior. Would society wish to punish them if they develop those illnesses by denying reimbursement for their medical care? Treatment of a severely disabled infant whose medical condition was known before birth raises

203. See Ronald Dworkin, *What is Equality? Part 2: Equality of Resources*, 10 PHIL. & PUB. AFF. 283, 293 (1981). Dworkin distinguishes between option luck, which has to do with "deliberate and calculated gambles," and brute luck, which results from risks that are not deliberate gambles. He argues that society should remedy inequalities that result from brute luck but that it owes nothing to those with inferior resources that are attributable to option luck. *Id.* See also Robert M. Veatch, *Voluntary Risks to Health: The Ethical Issues*, 243 JAMA 50, 54 (1980) ("I reach the conclusion that it is fair, that it is just, if persons in need of health services resulting from true, voluntary risks are treated differently from those in need of the same services for other reasons.").

204. Veatch, *supra* note 203, at 51. Veatch also notes that some voluntary risks are undertaken by individuals for the benefit of society, as is the case with firefighters. Certainly, those who risk their lives for the benefit of others should not be denied coverage for treatments necessitated by their altruism. *Id.* at 53. See also Robert L. Schwartz, *Life Style, Health Status, and Distributive Justice*, 3 HEALTH MATRIX 195, 205-06 (1993); Scot D. Yoder, *Individual Responsibility for Health: Decision, not Discovery*, HASTINGS CTR. REP., Mar.-Apr. 2002, at 22, 28 ("determining causality for any state of affairs involves a decision—a selection process in which we highlight certain causal factors and relegate others to the background.").

205. American Cancer Society, *Breast Cancer Facts & Figures 2001-2002*, at 8 (Table 3); National Cancer Institute, *Genetics of Breast and Ovarian Cancer (PDQ)*, at <http://www.nci.nih.gov> (last visited Oct 15, 2002).

even more sensitive and troubling questions. Although some parents might continue the pregnancy simply because they do not contemplate its implications or social costs, many will choose to have the baby because of deeply held religious beliefs or ethical beliefs about the sanctity of unborn human life.

Many decisions are complex, multifaceted, or subconscious, so that human actors themselves are unaware of all of their motivations and reasons for particular conduct. Moreover, the ultimate evaluation required to assess true moral content is frequently beyond the capacity of human ability.²⁰⁶ It would often be impossible for any social entity to judge the moral culpability of human beings with respect to health-related behavior or reproductive decisions. Any attempt to do so would itself be morally reprehensible and lead to arbitrary and capricious coverage determinations. A morally fair coverage system, therefore, should not include consideration of whether individuals deserve their medical problems or are to blame for the health care costs they have generated.

V. ALTERNATIVES FOR THE PROMOTION OF MORAL FAIRNESS IN HEALTH INSURANCE

A variety of mechanisms can be utilized to enhance moral fairness in health insurance. This part will analyze four alternatives: the passage of additional legislation, deregulation of the insurance market, the establishment of a new regulatory agency, and the implementation of a universal coverage mandate.

None of the options is devoid of potential hazards and disadvantages. Some, however, are better than others. This part argues that legislative action constitutes an inadequate remedy and that market deregulation is not advisable because the market is characterized by significant flaws. By contrast, the establishment of a federal regulatory agency and a universal coverage mandate hold significant promise for the promotion of moral fairness.

A. Gaps and Shortcomings in the Current Legislative Scheme Could Be Corrected Through Additional Legislation

I. Federal Legislation

Existing federal laws provide only limited protection to insurance customers. Several of the laws apply only to employer-provided insurance benefits.²⁰⁷ Some create significant defenses for insurers, which allow them to justify discriminatory benefit terms.²⁰⁸ Thus, insurers can establish AIDS caps, can refuse to cover hearing aids, can often drastically limit or exclude coverage for mental health care,²⁰⁹ and can offer older employees far less insurance coverage than younger workers. Moreover, none of the civil rights laws protects people on the basis of

206. In the words of the poet Yeats, "That only God, my dear / Could love you for yourself alone / And not your yellow hair." William Butler Yeats, *For Anne Gregory*, in THE COLLECTED POEMS OF W. B. YEATS 245 (Richard J. Finneran ed., 1983).

207. See, e.g., Title VII, 42 U.S.C. § 2000 (1994); EPA, 42 U.S.C. § 4321 (1994); ADEA, 29 U.S.C. § 621 (1999). See *supra* Part II.

208. See ADA, 42 U.S.C. § 12201(c) (1995); ADEA, 29 U.S.C. § 623(f)(2)(B)(i) (1999).

209. See discussion of Mental Health Parity Act, *supra* Part II.

economic status, which is often the most significant determinant of the level of insurance obtainable by individuals. Consequently, we have in the United States approximately 42 million uninsured people who are not eligible for Medicaid or Medicare coverage.²¹⁰

One might suggest that enhanced protection against unfair discrimination should be achieved through additional federal legislation. Congress, in fact, seems to be perpetually inundated with new legislative proposals concerning specific coverage mandates.²¹¹ Legislation could be designed to advance several of the principles of moral fairness. Statutes could mandate coverage of standard preventive care and of standard therapies that are medically necessary to cure or alleviate the symptoms of mental or physical impairments that substantially limit major life activities. They can also prohibit consideration of patients' moral culpability for purposes of coverage decisions. Nevertheless, while specific statutes might provide quick fixes for particular coverage gaps, the legislative approach is ultimately a severely flawed mechanism by which to address the shortcomings of the health insurance system.

Federal regulation that requires increasingly extensive coverage while leaving the private insurance system otherwise unchanged could ultimately harm rather than help the American public and could further undermine the value of universality. With additional limitations on their risk classification practices, insurance companies would likely continue to raise premiums in order to maintain profitability.²¹² In 2002 the cost of employer-provided health insurance rose by 14.7%,²¹³ following an 11% increase in 2001 and an 8.3% increase in 2000.²¹⁴ A persistent trend in this direction could lead to adverse selection wherein low-risk individuals opt out of the health insurance market and are not available to subsidize

210. See *supra* note 8.

211. For example, numerous bills prohibiting particular forms of discrimination or proposing specific coverage mandates were introduced in the 106th Congress. These included, among others, the following: Equity in Fertility Coverage Act of 2000, H.R. 4532; Comprehensive Insurance Coverage of Childhood Immunization Act of 2000, H.R. 4563, S. 2444; Fair Access to Infertility Treatment and Hope Act of 2000, S. 2160; Bone Marrow Blood Testing Coverage Act of 1999, H.R. 2021; Seniors' Access to Continuing Care Act of 1999, S. 1142; Mammogram Availability Act of 1999, H.R. 1132; Reconstructive Surgery Act of 1999, S. 585; Hospital Length of Stay Act of 1999, H.R. 989, S. 265; Access to Emergency Medical Services Act of 1999, S. 517; Osteoporosis Early Detection and Prevention Act of 1999, H.R. 925; Equity in Womens Health Act, S. 479; Screening Mammography Act of 1999, H.R. 524; Breast Cancer Patient Protection Act of 1999, S. 681, H.R. 116; Genetic Information Nondiscrimination in Health Insurance Act of 1999, H.R. 306, S. 543.

212. See Kristin Olson-Garewal & Kristen Hessler, *Arizona's Cancer Clinical Trials Law: Flawed Process, Flawed Product*, HASTINGS CENTER. REP., May-June 2001, at 22, 23 ("Mandating specific insurance benefits assigns additional costs to insurers without providing additional funds. The predictable result is an increase in premiums for private insurers . . .").

213. Barbara Martinez, *Health Benefits Post Highest Gain in Cost Since '90*, WALL ST. J., Dec. 9, 2002, at A6. For small to medium sized companies, the cost increase was 18.1%. *Id.*

214. Amy Snow Landa, *Health Insurance Prices Show Highest Increase Since 1992*, AM. MED. NEWS, Sept. 24, 2001, at 10.

high-risk patients with significant medical costs.²¹⁵ Adverse selection could result in a "death spiral" of premiums, which could destabilize or even bankrupt the insurance industry.²¹⁶

Furthermore, ever-increasing insurance costs could induce employers to stop providing health insurance to their employees. Employers are not required by law to provide insurance benefits²¹⁷ and do so at least in part because the cost of supplying these benefits is tax deductible.²¹⁸ According to one survey, eighty-five percent of workers in firms with one-hundred or more employees are offered health insurance coverage, but only fifty-seven percent of those in firms with fewer than one-hundred employees, and thus more limited resources, are offered health benefits.²¹⁹ While large employers often believe that offering insurance benefits enhances their success in employee recruitment and retention, increases productivity, and reduces absenteeism, many small employers indicate that they choose not to provide employee benefits because of cost concerns.²²⁰ With rising expenses, fewer and fewer employers may choose to be generous with employees in the realm of benefits, especially in times of recession and economic hardship.²²¹

Legislative mandates, in fact, mislead the public into believing that the government can promote moral fairness at no cost. The laws place various requirements and burdens on insurers without alerting insurance beneficiaries to the cost consequences. The public demands additional laws, believing that it can enjoy enhanced coverage protection while continuing to expect low out-of-pocket costs and premiums. Legislative initiatives therefore obfuscate the tension between social pooling and individual advantage.²²²

An additional objection is based on the fact that federal law often is not sufficiently lucid. The statutes have generated considerable litigation, which is

215. See discussion *supra* Part I.B.1.

216. *Id.*

217. See Jeffrey G. Lenhart, *ERISA Preemption: The Effect of Stop-Loss Insurance on Self-Insured Health Plans*, 14 VA. TAX REV. 615, 618 (1995) ("employers are not required to provide any health coverage to their workers."); Blakely, *supra* note 8, at 1 ("Employers are not legally required to provide coverage to their workers, and individuals are not legally required to maintain coverage.")

218. David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 25 (2001); Jerry L. Mashaw & Theodore R. Marmor, *Conceptualizing, Estimating, and Reforming Fraud, Waste, and Abuse in Healthcare Spending*, 11 YALE J. ON REG. 455, 478 (1994) (noting that "[e]mployer-based health insurance receives a substantial tax subsidy through both its deductibility to the employer and the failure of the Internal Revenue Code to count health insurance benefits as income to the employee."); Larry M. Pollack, *Medical Maloccurrence Insurance (MMI): A First-Party, No-Fault Insurance Proposal for Resolving the Medical Malpractice Controversy*, 23 TORT & INS. L.J. 552, 562 n.54 (1988) ("Under federal tax provisions, employers can deduct the cost of their employee health insurance plans, and employees can exempt both health insurance benefits and payments received through such benefits . . . from taxable income.")

219. Paul Fronstin & Ruth Helman, *Small Employers and Health Benefits: Findings from the 2000 Small Employer Health Benefits Survey*, EBRI ISSUE BRIEF, Oct. 2000, at 4.

220. *Id.* at 4, 8, 15. For employers with 3 to 199 workers, the average cost of health insurance is \$189 per employee per month. *Id.* at 16.

221. See *supra* notes 213-14 and accompanying text.

222. See discussion *supra* Part I.B.2.

costly for plaintiffs, defendants, and taxpayers. Inconsistent decisions issued by different courts also may cause confusion for insurers seeking judicial guidance concerning insurance terms.²²³ Federal antidiscrimination laws are the product of extensive lobbying and political compromise. Consequently, they often contain equivocal and imprecise language, which is open to varying interpretations.²²⁴

2. State Legislation

One might argue that regulation concerning health insurance coverage should be left to the states. In 1945, in the McCarran-Ferguson Act,²²⁵ Congress delegated to the states regulatory responsibility for insurance markets,²²⁶ and the states have

223. For example, courts have issued contradictory decisions concerning whether the ADA regulates the contents of health insurance policies. *See* *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1115 (9th Cir. 2000) (“an insurance office must be physically accessible to the disabled but need not provide insurance that treats the disabled equally with the non-disabled”) (citation omitted); *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557, 562 (7th Cir. 1999) (stating that the ADA “regulates only access and not content”); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 608 (3rd Cir. 1998) (“So long as every employee is offered the same plan regardless of that employee’s contemporary or future disability status, then no discrimination has occurred even if the plan offers different coverage for various disabilities.”); *Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006, 1012 (6th Cir. 1997) (“Title III does not govern the content of a long-term disability policy offered by an employer.”).

Some district courts have found to the contrary, and have held that the ADA regulates the contents of insurance policies and requires insurers to provide actuarial justifications for their disability-based distinctions. *See* *Lewis v. Aetna Life Ins. Co.*, 982 F. Supp. 1158, 1169 (E.D. Va. 1997) (“the Aetna plan’s distinction between physical and mental disabilities may survive scrutiny under the ADA only if it is based on actuarial principles or other competent factual information.”); *World Ins. Co. v. Branch*, 966 F. Supp. 1203, 1208 (N.D. Ga. 1997) (“[The ADA] requires that underwriting and classification of risks be based on sound actuarial principles or be related to actual or reasonably anticipated experience.”); *Cloutier v. Prudential Ins. Co. of Am.*, 964 F. Supp. 299, 304 (N.D. Cal. 1997) (“insurers retain their § 501(c) exemption so long as their underwriting decisions are in accord with either (a) sound actuarial principles, or (b) actual or reasonably anticipated experience.”); *Doukas v. Metropolitan Life Ins. Co.*, 950 F. Supp. 422, 432 (D. N.H. 1996) (“while insurers retain the ability to follow practices consistent with insurance risk classification accepted under state law, these methods must still be based on sound actuarial principles or related to actual or reasonably anticipated experience.”).

224. ANTONIN SCALIA, *A MATTER OF INTERPRETATION: FEDERAL COURTS AND THE LAW: AN ESSAY* 34 (1997) (discussing the involvement of lobbyists in the crafting of legislative history) *Butler*, *supra* note 176, at 115 (asserting that state mandates concerning health insurance coverage have proliferated because of the influence of special interest groups).

225. 15 U.S.C. §§ 1011-1015 (1997).

226. 15 U.S.C. § 1012. The statute provides in relevant part:

(a) State regulation

The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) Federal regulation

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of

traditionally been the primary actors in this realm. State legislation, however, is characterized by its own flaws and limitations.

State mandates will not protect those who are enrolled in self-funded employee benefit plans²²⁷ because under a federal law called ERISA,²²⁸ state laws regulating insurance are preempted with respect to self-funded plans and cannot be enforced.²²⁹ This exception is quite consequential because a growing number of employers are self-insured.²³⁰ One scholar estimates that in 1993, 93% of employers with more than 40,000 employees were self-insured, as were eighty-five percent of employers with 5000 to 40,000 employees, and 37% of those with 50 to 199 employees.²³¹ Furthermore, state regulation, like federal regulation, can generate problems of adverse selection and reduced employee benefits and can lead to costly litigation due to ambiguous drafting.²³²

Piecemeal legislation does not necessarily promote overall moral fairness at either state or federal level for yet another reason. Legislation is often a response to public pressure and political concern. Groups with strong lobbyists or prominent representatives might succeed in promulgating legislation that benefits their special interests, while equally deserving groups may fail because of much weaker lobbying abilities and less prominence. For example, end stage renal disease patients are entitled to coverage of dialysis treatments under Medicare,²³³ though the program does not extend benefits to nonelderly individuals with other diseases. Similarly, the Women's Health and Cancer Rights Act of 1998²³⁴ provides significant benefits for breast cancer patients,²³⁵ while those suffering from other cancers do not have the benefit of legislation that addresses their specific coverage issues. The absence of a comprehensive legislative remedy for the uninsured may also be due in part to their generally weak political voice.²³⁶

The point is illustrated most clearly, perhaps, by an Assembly Insurance

insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance

Id.

227. Employers who choose self funded plans pay their employees' medical claims on their own rather than contracting with a commercial insurer that collects premiums and serves as a third party payer. Every medical claim translates into an out-of-pocket expense for these employers. They are thus known as self-insured employers. Mark A. Rothstein, *The Law of Medical and Genetic Privacy in the Workplace*, in *GENETIC SECRETS: PROTECTING PRIVACY AND CONFIDENTIALITY IN THE GENETIC ERA* 281, 293-94 (Mark A. Rothstein ed., 1997).

228. 29 U.S.C. §§ 1001-1461 (1999).

229. See Hoffman, *supra* note 202, at 241-43; *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (We read the . . . [statute] to exempt self-funded ERISA plans from state laws that 'regulat[e] insurance') (alterations in original).

230. Rothstein, *supra* note 227.

231. *Id.* at 234.

232. See discussion *supra* Part V.A.1.

233. 42 U.S.C. § 1395rr (Supp. 2002).

234. 29 U.S.C. § 1185b (Supp. 2002).

235. See *supra* Part II.

236. Stone, *Managed Care*, *supra* note 89, at 1215 ("the insured are more likely than the uninsured to be active political constituents—people who vote and call their legislators to complain or ask for help.").

Committee Statement regarding a New Jersey law that mandates reimbursement for the treatment of Wilm's tumor by high dose chemotherapy and an autologous bone marrow transplant.²³⁷ It states in relevant part:

This bill has been referred to as the "Tishna Rollo Bill." Tishna Rollo is an eight-year-old Glen Ridge girl who is battling Wilm's tumor, a rare form of cancer which generally affects the kidneys before spreading to other parts of the body. Recently, Tishna's case has received much attention because her doctors have concluded that the transplants are the one chance they have to cure her disease, yet her family's health insurer initially refused to provide coverage for the treatment because it asserted that such treatment was not covered in her health insurance contract as it is considered "experimental" or "investigational." Court action on the issue is pending. This bill will eliminate the controversy surrounding the treatment and, in effect, absolve health insurers, and ultimately the courts, of the responsibility of making any determination regarding this issue.²³⁸

Promoting moral fairness through legislation is consistent with the principle of participatory process, but only to a limited extent. Legislatures are democratically elected and must respond to their constituents in order to build a base of support.²³⁹ However, in truth, not every patient is Tishna Rollo, with a high-profile case and access to the media and legislators. Specific legislative mandates are often influenced primarily by those with a strong political voice and not by the citizenry as a whole. The legislative process, therefore, does not necessarily safeguard overall moral fairness.

B. Health Insurance Regulation Could Be Abandoned so that Unregulated Competition Shapes Moral Fairness

Another alternative is to abandon regulation of the health insurance market. If American society in fact demands moral fairness with respect to health insurance coverage, one might assume that health insurers would voluntarily incorporate that value into their policies. Arguably, the competitive marketplace would, on its own, safeguard moral fairness, because insurance policies with unfairly discriminatory limitations and exclusions would be unappealing to consumers and would not be purchased. The contents of insurance policies, therefore, would require no regulation because the competitive market would not allow insurers who defied moral fairness to survive.

Thus, the prominent scholar, Richard Epstein, argues that:

when direct and indirect effects are taken into account, the classical regimes of contract, property, and tort do a better job in organizing our social relationships than the torrent of regulations and judicial decisions that seek to create positive rights to health care on the one hand, or interfere with the contractual choices

237. N.J. STAT. ANN. § 17:48-6f note (West 1996) (Assembly Insurance Committee Statement).

238. *Id.*

239. See Butler, *supra* note 176, at 115-16.

of autonomous individuals on the other.²⁴⁰

Epstein acknowledges that the "undeniable problems of poor people in need is a vital consideration"²⁴¹ He believes, however, that market transactions should be supplemented primarily by care provided by charitable organizations, though he does raise the possibility of limited public services that are supported by tax dollars.²⁴²

In the area of health care coverage, therefore, Epstein himself recognizes that the free market does not fully serve societal needs. In my view, Epstein's suggestions for remedying its deficiencies do not go far enough. Moral fairness cannot be left largely to the forces of an unregulated market.

First, universality is not a market-driven principle. Extending coverage to those who cannot afford to pay for it must be achieved through government regulation since no rational seller would offer goods to those who have no means of purchasing them.²⁴³ Leaving the care of the uninsured to charitable organizations is also not an effective solution, because these organizations do not have the resources necessary to care for the millions in need.²⁴⁴ As noted earlier, studies reveal that the uninsured in this country in fact suffer a decline in health when compared to those with insurance, and therefore, it is evident that they do not receive adequate care.²⁴⁵ Absent extensive governmental intervention to infuse resources into the charitable care system, the system cannot be relied upon to adequately serve the needs of the uninsured.

Second, several market flaws generate nonoptimal outcomes in the health insurance market and justify governmental intervention to regulate the conduct of health insurers. These are information imbalance, disparity of bargaining power, and externalities.²⁴⁶

Insurers have exclusive control over the statistics and other information utilized to classify risks.²⁴⁷ Potential customers often have little information about health risks and medical technology, and therefore, cannot judge how particular

240. Richard A. Epstein, *Living Dangerously: A Defense of Mortal Peril*, 1998 U. ILL. L. REV. 909, 952.

241. Epstein, *supra* note 88, at 88.

242. *Id.*; Epstein, *supra* note 240, at 920.

243. See Epstein, *supra* note 88, at 88 (arguing that our heavily regulated and subsidized system of medical care already cannot be considered market-driven and "is no more a market than the systems of state provided care that are found in Canada and Europe . . .").

244. JOSEPH WHITE, *COMPETING SOLUTIONS: AMERICAN HEALTH CARE PROPOSALS AND INTERNATIONAL EXPERIENCE* 53-54 (1995) ("Such [charity] hospitals . . . have interns and residents to do the work because of their relationships with a training program, but nowhere near the resources of a freestanding university hospital.").

245. Baker et al., *supra* note 172, at 1108. The study, which involved 7577 individuals between the ages of fifty-one and sixty-one found that "continuously uninsured participants were 63 percent more likely than the privately insured participants to have a decline in their overall health between 1992 and 1996 and 23 percent more likely to have a new physical difficulty that affected walking or climbing stairs (i.e., a difficulty with mobility)." *Id.* These findings were consistent with conclusions from two previous, smaller studies. *Id.* See also, Hadley, *supra* note 172.

246. ABRAHAM, *supra* note 25, at 32; GAO REPORT, *supra* note 51, at 10-13.

247. ABRAHAM, *supra* note 25, at 32.

exclusions or limitations might be harmful to them.²⁴⁸ For example, they might not realize that a coverage exclusion for mammograms could significantly reduce the likelihood of detecting a common disease at an early and easily curable stage.²⁴⁹ Furthermore, health insurance policies can be very lengthy, and their language is often complex, abstruse, and ambiguous.²⁵⁰ The average American has approximately an eighth-grade reading comprehension level.²⁵¹ Consumers, therefore, are unlikely to thoroughly read lengthy and complicated documents and are even less likely to understand the details of policy terms, including coverage restrictions and exclusions.

Unequal bargaining power is also a basis for governmental intervention in the insurance market. Insurers dictate and control the terms of insurance, and customers have no opportunity to bargain over particular provisions that are unfairly discriminatory.²⁵² They can either accept the package offered by the insurer or turn to other providers, who may have similarly discriminatory terms. For the 155 million Americans who obtain health insurance through employment, there is even less choice.²⁵³ Their bargaining power is diminished by the fact that they must accept whatever single plan is offered by their employer or, at best, can select from among a very limited number of options that are provided. A recent study by the American Medical Association found that "health insurance markets are dominated by a few companies that have significant power over the marketplace" and "significant leverage over patients and physicians in determining the scope, coverage, and quality of health care in this country."²⁵⁴ Consumers are therefore often significantly disadvantaged by bargaining power disparities.

248. MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS 43-44 (1997).

249. It should be noted that recently a controversy has developed concerning the value of mammograms. Seven large studies that were conducted in the past were reanalyzed and found to be severely flawed. Their conclusion that mammography saves lives is therefore questioned, but most breast cancer specialists still urge women to undergo routine mammograms. John Crewdson, *Cancer Studies May Have Bias: Some Deaths Likely Attributed to Other, Non-cancer Causes*, CHI. TRIB., Feb. 6, 2002, at 1; Tara Parker-Pope, *Women Are Still Urged to Get Mammograms Despite New Controversy*, WALL ST. J., Feb. 8, 2002, at B1; Craig Stoltz, *The Mammogram Debate*, WASH. POST, Feb. 5, 2002, at F7.

250. ABRAHAM, *supra* note 25, at 32.

251. See Terry C. Davis, et al., *Reading Ability of Parents Compared with Reading Level of Pediatric Patient Education Materials*, 93 PEDIATRICS 460, 461-62 (1994); Stuart A. Grossman et al., *Are Informed Consent Forms That Describe Clinical Oncology Research Protocols Readable By Most Patients and Their Families?* 12 J. CLIN. ONCOL. 2211, 2212 (1994).

252. See ABRAHAM, *supra* note 25, at 33-34.

253. Fronstin and Helman, *supra* note 219, at 4. The survey found that "[e]mployment-based health insurance is by far the most common form of health insurance coverage in the United States." *Id.* Almost 100 million workers obtained such insurance, and, including their dependents, approximately 155 million Americans under the age of sixty-five, or 65% of the nonelderly population, were covered by employer-provided health benefits. *Id.*; Hyman & Hall, *supra* note 218, at 23 (estimating that the number of Americans who have employment-based health insurance is 177 million).

254. American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, (Executive Summary Nov. 2001), available at <http://www.ama-assn.org/ama/upload/mm/31/execsummary.doc> (last visited Oct. 16, 2002).

The insurance market is also characterized by externalities.²⁵⁵ Externalities are costs that fall on third parties rather than on the individual who generated the expenses, and, therefore, they produce an inefficient use of resources.²⁵⁶ The problem of externalities resulting from deficient insurance coverage has high societal and economic costs. People who have exhausted their AIDS caps or who have severe psychiatric problems with no coverage for mental health care will receive high-cost treatment through emergency rooms and will often require drastic interventions.²⁵⁷ Had these individuals been able to obtain routine medical care in a doctor's office at an earlier point, their conditions might have been treated through inexpensive medication or other less costly means. Furthermore, people with inadequate medical care because of insurance exclusions and limitations are likely to be less productive members of society and might need public assistance in the form of a variety of social services.²⁵⁸ The cost of these treatments and services is ultimately absorbed by taxpayers. Governmental intervention constraining insurers' ability to exclude coverage for necessary services can reduce externalities and diminish their adverse societal consequences.

C. A Centralized, Publicly Accountable Governmental Agency Could Be Established to Regulate Health Care Coverage

A third option is the establishment of a centralized, publicly accountable entity with regulatory powers over the health insurance industry. Many other industries are already regulated by powerful administrative agencies. For example, the Federal Aviation Administration ("FAA") regulates the aviation industry,²⁵⁹ the Environmental Protection Agency ("EPA") regulates activities that affect the environment,²⁶⁰ and the Food and Drug Administration ("FDA") regulates food and drug products.²⁶¹ There is no reason why health insurance should not be subject to similar governmental oversight.

1. Models for a Regulatory Agency

The idea of governmental regulation of health insurance coverage is not revolutionary. The Medicare system already relies on the regulatory authority of the Centers for Medicare & Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"),²⁶² to make nationally binding coverage decisions.²⁶³ The Social Security Act provides guidelines as to what services will

255. GAO REPORT, *supra* note 51, at 12.

256. *Id.* at 10.

257. Blakely, *supra* note 8, at 1 ("Economists say these costs are picked up in various ways: by businesses and their employees, in the form of higher premiums for their insurance; by workers, in the form of taxes; and by all Americans, in the form of an opportunity cost in lost value to the U.S. economy.")

258. *See id.* at 2-3.

259. 49 U.S.C. § 106 (1997).

260. *See* 42 U.S.C. § 4321 (1994) (Reorganization Plan No. 3 of 1970, Section 1).

261. 21 U.S.C. § 393 (1999).

262. For discussion of the name change, see <http://www.cms.gov/about/reorg.asp>.

263. 42 U.S.C. § 1395hh(a)(2) (1992).

be covered by Medicare.²⁶⁴ For example, generally, services must be “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”²⁶⁵ Within these guidelines, CMS makes national coverage decisions that grant, limit, or exclude Medicare coverage for particular medical services, procedures, and devices.²⁶⁶ One of CMS’s functions, therefore, is to serve as a regulatory agency that creates a Medicare benefits package.

In addition, the establishment of a central regulatory agency was contemplated in numerous health care reform proposals that were debated by the 103d Congress during the Clinton era.²⁶⁷ The proposed independent federal agencies would have had broad authority to institute nationally binding health insurance coverage packages.²⁶⁸

The most well known of the bills was President Clinton’s Health Security Act (“HSA”).²⁶⁹ The HSA tried to achieve a compromise between a single-payer, public insurance scheme, such as Canada’s, and proposals that relied on managed market forces with weak or nonexistent government intervention.²⁷⁰ Under the bill, individuals would obtain health coverage through health alliances that would negotiate favorable prices from competing qualified health plans.²⁷¹ Clinton’s plan required employers to provide insurance for all full-time and part-time employees and their families but mandated that they pay at most eighty percent of the premiums of basic plans, while employees would pay the remaining twenty

264. *Id.* § 1395y.

265. *Id.* § 1395y(a)(1)(A).

266. 64 Fed. Reg. 22,619, 22,621 (Apr. 27, 1999). The agency initiates its review process for making national coverage decisions when it internally identifies issues that should be considered or when it receives a formal request for review of an issue. *Id.* The Medicare system, however, has been criticized for the length of time it takes to approve new technology for coverage. Jane Cys, *Technology Approval Process Under Fire*, AM. MED. NEWS, Mar. 19, 2001, at 5, 5. In response, it created the Medicare Coverage Advisory Commission in June 1999, consisting of nationally recognized experts whose input can facilitate the decisionmaking process. *Id.* at 6.

Medicare also contracts with private insurance companies, known as carriers and intermediaries, to process Medicare claims submitted by providers; and peer review organizations (“PROs”) review hospital services. 64 Fed. Reg. at 22,621; Diane F. Paulson, *Estate Planning for the Aging or Incapacitated Client in Massachusetts: Protecting Legal Rights, Preserving Resources and Providing Health Care Options, Program Eligibility and Coverage, Medicare*, EPAIII MA-CLE 31-1 §§ 31.1.2 & 31.6.1(a) (1998). If no specific national coverage decision addresses the service at issue, coverage decisions are left to the discretion of the local contractors. 64 Fed. Reg. at 22,621.

267. Eleanor D. Kinney, *Protecting Consumers and Providers Under Health Reform: An Overview of the Major Administrative Law Issues*, 5 HEALTH MATRIX 83, 84-85 (1995).

268. *Id.* at 123.

269. H.R. 3600, S. 1757, 103d Cong., 1st Sess. (1993) [hereinafter HSA].

270. DANIELS, *supra* note 15, at 157.

271. H.R. 3600 § 1202(b)(2). Regional alliances would be established by each state, and corporate alliances would be established by employers with over 5000 employees who choose to form alliances. *Id.* §§ 1201, 1311(b). States would also be permitted to create a single payer system. *Id.* § 1221. If family members could obtain coverage through more than one corporate alliance or a corporate alliance and a regional alliance, they would generally be free to choose their preferred alliance. *Id.* § 1013.

percent.²⁷² The self-employed would also purchase benefits through health alliances, and government subsidies would assist the unemployed.²⁷³

The HSA would have established the National Health Board, an executive agency consisting of seven individuals appointed by the President for staggered four-year terms.²⁷⁴ The Board would formulate a comprehensive benefits package, develop a national health care budget, and engage in quality assurance activities.²⁷⁵ The statute would have outlawed discrimination or rate differentials based on age, sex, and medical conditions, and health plans would have been required to enroll all who wished to join them.²⁷⁶ Clinton's plan, therefore, guaranteed universal health coverage and a nationally mandated benefits package that would be determined and regulated by a federal agency. It did not, however, establish a national health care system by which all physicians would become employees of the federal government.

By contrast, a bill sponsored by Representative McDermott and Senator Wellstone, the American Health Security Act,²⁷⁷ called for the elimination not only of all private insurers but also of Medicare and Medicaid,²⁷⁸ replacing them with a single, government-sponsored insurance plan financed through taxes.²⁷⁹ Thus, the money currently spent by federal and state governments and individuals on health insurance and medical care would be rechanneled into the plan, known as a "single-payer plan" because it would direct all funds to a single source that would pay for health care.²⁸⁰ All services would be free at the point of delivery, and the plan would approximate the Canadian health care system.²⁸¹

Like the HSA, the McDermott/Wellstone bill established an independent federal entity with broad powers to institute policy and create a national benefits program.²⁸² The American Health Security Standards Board was to be composed of the Secretary of Health and Human Services and six other presidentially appointed individuals²⁸³ who would have authority to hire other staff members.²⁸⁴ The Board's duties would include developing policies, procedures, guidelines and requirements concerning eligibility, enrollment, benefits, and coverage of particular

272. STAFF OF JOINT COMM. ON TAXATION, 103D CONG., DESCRIPTION AND ANALYSIS OF TITLE VII OF H.R. 3600, S. 1757, AND S. 1775 ("HEALTH SECURITY ACT") 4 (Comm. Print 1993) [hereinafter Joint Committee]. Small businesses would receive subsidies for the cost of employee benefits premiums through discounts in the cost of health plans. H.R. 3600 § 6123.

273. Joint Committee, *supra* note 272, at 5-6.

274. H.R. 3600 § 1501.

275. *Id.* § 1503. The Board would have the power to appoint an executive director and hire additional officers and employees. *Id.* § 1505.

276. THE WHITE HOUSE DOMESTIC POLICY COUNCIL, HEALTH SECURITY: THE PRESIDENT'S REPORT TO THE AMERICAN PEOPLE 33 (1993). See H.R. 3600 § 1402.

277. H.R. 1200, S. 491, 103d Cong., 1st Sess. (1993).

278. *Id.* § 106.

279. *Id.* §§ 801, 811-14.

280. DANIELS ET AL., *supra* note 80, at 73.

281. *Id.*; H.R. 1200 § 201.

282. H.R. 1200 § 401.

283. *Id.* § 401(b)(1).

284. *Id.* § 401(j).

services.²⁸⁵

A third reform was a proposal sponsored by Representative Cooper and Senator Breaux, The Managed Competition Act of 1993.²⁸⁶ The bill's approach involved a combination of market force regulation and voluntary participation.²⁸⁷ It proposed a system of state and regional purchasing pools,²⁸⁸ eliminated Medicaid²⁸⁹ in favor of a low-income assistance plan that would allow the poor to purchase private insurance,²⁹⁰ and reformed Medicare to slow expenditures.²⁹¹ Like the other reform proposals, the Cooper bill established a federal agency—the Health Care Standards Commission, that was to design a standard benefits package.²⁹²

2. Procedures and Standards to Be Utilized by a Regulatory Agency

A regulatory agency could advance many of the principles of moral fairness delineated in this Article. It could require insurers to cover at a minimum standard preventive care and standard therapies that are medically necessary to cure or alleviate the symptoms of mental or physical impairments that substantially limit major life activities. The agency could also prohibit insurers from considering the moral culpability of patients in making coverage decisions, a practice in which they do not currently engage. The regulatory body is also more likely to be sensitive to economic issues than are legislatures.²⁹³ While legislative mandates might be passed without sufficient consideration of the overall cost of all coverage requirements,²⁹⁴ a federal agency would focus on the global cost of the benefits package it designs and would ideally create coverage requirements in light of both patient needs and the reality of finite resources.²⁹⁵

Furthermore, the agency could promote the value of participatory decisionmaking by establishing processes that include input from all stakeholders in the health care field, including patients, doctors, researchers, research sponsors, and insurers. Implementing appropriate procedures and standards for the regulatory process, however, is a significant challenge. While a participatory policymaking

285. *Id.* § 401(f).

286. H.R. 3222, S. 1579, 103d Cong., 1st Sess. (1993).

287. DANIELS ET AL., *supra* note 80, at 72.

288. H.R. 3222 § 1101.

289. *Id.* § 2301.

290. *Id.* §§ 2001-2004.

291. *Id.* §§ 2201-2208.

292. Managed Competition Act of 1993, H.R. 3222, 103d Cong., 2d Sess., and S. 1579, 103d Cong., 1st Sess. (1993) at §§ 1301-1313.

293. See Butler, *supra* note 176, at 115 (discussing the 1,000 state mandates that have been passed, in part as a result of special interest lobbying efforts). Goodman estimates one-quarter of persons currently uninsured could afford basic no-frills health insurance if some or all of these state mandates were repealed. *Id.* (citing JOHN C. GOODMAN & GERALD L. MUSGRAVE, *PATIENT POWER* 47 (1992)).

294. Stone, *Managed Care*, *supra* note 89, at 1215 ("it doesn't cost a nickel to pass legislation prohibiting managed care plans from doing this or that or to declare high-sounding rights for consumers."). See also *supra* Part V.A.

295. If a public health care system were adopted, Congress would establish a set budget for the program each year. See discussion of the option of nationalizing health care, *infra* Part V.D.1.

process is important to the promotion of moral fairness, it also can create several problems that must be considered. These include paralysis of the system due to excessive debate, discrimination against patients with unpopular illnesses, and excessive influence of particular interest groups.

Determining the degree to which the public should participate in health care regulation is particularly difficult. A system of open, community-based deliberations concerning benefits criteria can lead to thoughtful decisions that are embraced by the public because outcomes are commonly chosen and understood.²⁹⁶ Some argue, however, that the public should not participate in making "tragic choices," that is, painful rationing decisions that involve limiting life-enhancing or life-extending treatments.²⁹⁷ According to this argument, the social cost of challenging fundamental values, such as the sanctity of life, in a public way is too high, and therefore such necessary but controversial decisions should be hidden from the public or disguised.²⁹⁸

Indeed, extensive public debate concerning every coverage decision could significantly slow or paralyze the system. The agency would need the flexibility to adjust its coverage mandates quickly in light of emerging research data concerning the effectiveness of various therapies, new technology, and other factors that might influence treatment priorities. When a new drug, device, or procedure becomes available, it should promptly be considered by the agency to determine whether it should be included in the mandatory benefits package. Unlimited public discussion could delay public access to advanced therapies and cost lives.

Ironically, too much reliance on customer preference can also introduce new forms of discrimination into the health care system, resulting either from public ignorance or prejudice. The experience of Oregon's Medicaid reform is illuminating in this regard. In the early 1990s, Oregon decided to increase the number of its Medicaid enrollees by limiting the medical procedures it covered so that reimbursement could be obtained only for the services that were of most benefit to patients.²⁹⁹ Oregon ranked over 700 condition-treatment pairs (such as appendicitis and surgery to remove the appendix) according to the degree of medical benefit produced by the therapy that was intended to alleviate the ailment.³⁰⁰ Actuaries determined how much each treatment would cost and estimated the number of people who would enroll in the program.³⁰¹ The state's legislature then decided where the line would be drawn, that is, how many of the ranked services Medicaid would cover during the next budget cycle.³⁰² To form its ranking list, Oregon first utilized a strict cost effectiveness evaluation, but it was harshly criticized for doing so.³⁰³ In a second endeavor, it combined effectiveness ratings with consumer preferences for quality-of-life factors, but it was then

296. DANIELS ET AL., *supra* note 80, at 57; HALL, *supra* note 248, at 92; Fleck, *supra* note 200, at 1598.

297. GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES 17-19 (1978).

298. *Id.* at 53-64; DANIELS ET AL., *supra* note 80, at 58.

299. HALL, *supra* note 248, at 75-76.

300. *Id.* at 76.

301. Maxwell J. Mehlman, *The Oregon Medicaid Program: Is It Just?*, 1 HEALTH MATRIX 175, 176-77 (1991).

302. *Id.* at 177. Oregon is on a two-year budget cycle.

303. HALL, *supra* note 248, at 76.

criticized for creating a ranking that involved disability discrimination because of biased public perception concerning the quality of life of those with certain disabilities.³⁰⁴ Finally, in a third ranking, Oregon eliminated consideration of quality of life and focused almost solely on medical effectiveness.

To obtain public input, Oregon held approximately forty-seven forums with over 1000 participants and conducted random telephone surveys of 1000 Oregon residents.³⁰⁵ In light of the public's expressed preferences, the first draft listed inexpensive office visits for thumb sucking and tooth capping much higher than high-cost, life-saving procedures such as surgery for appendicitis and ectopic pregnancy. The second draft, emphasizing quality of life, listed "burn over large areas of the body" as equivalent to "upset stomach." Many of these flaws were ultimately corrected in the final, enacted list, but only because some public choices were ignored or overruled by bureaucrats.³⁰⁶

A public agency that is established to regulate health care coverage should obtain public input, but not through random polling of people who might often express uneducated or biased opinions. Leonard Fleck suggests a model of public deliberations that he calls the "informed democratic consensus model."³⁰⁷ He envisions a system in which fifty citizen/patients constitute a "district health council" in each congressional district.³⁰⁸ Each district health council would elect a member to serve in a "national health congress."³⁰⁹ Every district would reach a local consensus, and its representative would participate in national meetings, explaining and advancing the local council's views.³¹⁰ Ultimately, according to Fleck, a national consensus would emerge as to the specifics of health care coverage.³¹¹

Fleck's model could be utilized to construct a system of local bodies and national representatives that would participate in the deliberations of a future federal regulatory agency. Local offices of the national administrative agency could facilitate the establishment of district councils in their locales and could recruit members through advertisements and personal contact with various organizations. District councils could periodically send reports with their recommendations to the national headquarters. In the alternative, meetings with headquarters personnel could be periodically scheduled, to be attended by a representative from each of the district councils. If a public health care system were adopted,³¹² Congress would

304. *Id.*

305. Fleck, *supra* note 200, at 1628. See also Daniel M. Fox & Howard M. Leichter, *Rationing Care in Oregon: The New Accountability*, HEALTH AFF., Summer 1991, at 7, 21. According to the authors, almost 70% of attendees at the forums were health care professionals, and therefore they did not represent a broad cross-section of the public. *Id.*

306. HALL, *supra* note 248, at 93.

307. Fleck, *supra* note 200, at 1617.

308. *Id.* at 1624. According to Fleck, health service providers should be denied membership in the councils, though their expert advice could be sought.

309. *Id.*

310. *Id.* at 1624-25.

311. *Id.* at 1625. Fleck acknowledges that these councils might have to discuss thousands of diseases and thousands of therapeutic options. He believes the task is manageable, however, because "there would be a very large core of health services for which we would have a very high degree of consensus that the value of the services was worth the costs." *Id.*

312. See discussion *infra* Part V.D.1.

determine its national budget, and citizens would be involved in the budgetary process through the traditional means of lobbying and communication with their representatives. The district councils could then participate in deliberations concerning how much money is to be allocated by the administrative agency to different geographic areas and what services are to be included in the national benefits package.

This model, however, raises the potential problems of public choice and special interest group influence. The concern of public choice theorists is that "political decision-makers behave just like consumers and businesses—they attempt to maximize their own self interest."³¹³ Accordingly, a system that is open to public influence is likely to be exploited by interest groups and lobbyists that are seeking special favors and private profit.³¹⁴ The philosopher John Rawls expressed a related concern when he urged that policy decisions be made behind a veil of ignorance.³¹⁵ If an informed democratic consensus model were established, those most interested in serving on the district health councils would be physicians and other health professionals. These individuals would have an interest in ensuring that their services are included in a national coverage mandate and, therefore, large numbers of them would wish to serve on the councils.³¹⁶ Not surprisingly, the majority of attendees at the forums held in Oregon in conjunction with the state's Medicaid reform were health care professionals.³¹⁷ Even if they do not directly serve on the district health councils, special interest representatives might overwhelm council members with their lobbying efforts, much as they currently lobby legislatures for specific legislative mandates.³¹⁸ In the words of one commentator: "two phenomena work to imbalance political arenas: unequal interests and disproportionate resources. The two are interrelated—groups with more at stake will invest more to secure an outcome."³¹⁹ The public choice problem would need to be openly recognized. Safeguards would have to be implemented to ensure diverse representation on district health councils and to establish resistance to undue

313. Butler, *supra* note 176, at 114; *see also* DENNIS C. MUELLER, PUBLIC CHOICE II 1 (1989) ("Public choice can be defined as the economic study of nonmarket decision making, or simply the application of economics to political science.").

314. Butler, *supra* note 176, at 114. Political activity by those wishing to gain special favors is known as "rent-seeking."

315. RAWLS, *supra* note 146, at 118. *See* discussion *supra* Part III.E.

316. Butler, *supra* note 176, at 116 ("For example, chiropractors, optometrists, dentists, podiatrists, and allergists should be willing to invest substantial sums to make sure that their services are covered as part of the [National Benefits] Package."). If council members were to be popularly elected, these medical professionals would be willing to invest significant money and time in campaigning for council positions. In the alternative, if members were appointed by some central authority, the individuals would likely aggressively lobby those in charge of the appointment process in order to gain positions on the councils.

317. Fleck, *supra* note 200, at 1628 (citing Fox & Leichter, *supra* note 305, at 21).

318. *See* Butler, *supra* note 176, at 116.

319. James Morone & Theodore R. Marmor, *Representing Consumer Interests: The Case of American Health Planning*, CITIZENS AND HEALTH CARE 25, 41-42 (Barry Checkoway ed., 1981). The chapter critiques the concept of Health Systems Agencies ("HSAs"), a network of planning bodies that were to be established under the National Health Planning and Resources Development Act of 1974 and were to be dominated by consumers. The difficulties of achieving meaningful consumer representation are discussed in detail.

influence by individual interest groups.

For example, the councils could be composed of unpaid volunteers³²⁰ who would be recruited by the regulatory agency from among each of the stakeholder groups: patients, doctors, researchers, research sponsors, and insurers, with a set number of representatives from each group.³²¹ The councils could include an equal number of members from each stakeholder group, or to minimize the likelihood that patients, as lay people, would be intimidated by the medical professionals, patients could be allowed a larger membership than other stakeholders. In addition, members could be recruited from specific organizations or advocacy groups so that diverse opinions are represented and different interests are balanced against each other.³²²

One additional issue should be addressed. The existence of a federal agency that develops a national benefits package will not eliminate all coverage disputes. While the regulatory entity could establish national coverage mandates, administrators will have to make individual benefit decisions that are consistent with the federal guidelines. Administrators will still have discretion to determine, for example, whether a specific therapy is medically necessary in a particular instance. Consequently, disagreements will still arise and the public will continue to need mechanisms by which to challenge unfavorable coverage decisions and resolve disputes. This can be accomplished through independent review boards.³²³ Already, at least thirty-seven states and the District of Columbia have laws that allow patients to request independent reviews of adverse reimbursement determinations,³²⁴ and some have advocated the inclusion of an independent review

320. I would not support the selection of council members through popular elections because those without significant financial means would be unlikely to run successful campaigns. In addition, patients who are battling illness and who might have valuable input and insights as representatives on local councils would not have the energy and stamina to campaign for positions. Election results are often determined by the amount of money spent on media exposure or by the support of a powerful politician rather than the merit of the candidate. In addition, voter apathy and low turnouts at the polls often mean that only members of particular interest groups actually vote in local elections so that those elected do not necessarily have a popular mandate. Morone & Marmor, *supra* note 319, at 44-45 ("In practice, electoral apathy of most consumers undermines direct elections as the mechanism of accountability to consumer constituencies.").

321. In Ontario, Canada, the Ministry of Health established a system of District Health Councils with authority to assist in overseeing the health services of their regions. They are composed of volunteers and professional staff. John D. Blum, *Universality, Quality & Economics: Finding A Balance in Ontario and British Columbia*, 20 AM. J.L. & MED. 203, 211-12 (1994) (citing District Health Councils: Partners in Health Planning, ONTARIO MINISTRY OF HEALTH NEWS RELEASE (Ontario Ministry of Health, Toronto, Ont., Can.), Oct. 1989).

322. See Morone & Marmor, *supra* note 319, at 43-45 ("Representatives from these groups will have clearly defined constituencies, experience in organizational politics, and resources at their disposal. These attributes will help them both in identifying group interests and in pursuing them, regardless of their other characteristics").

323. See Hoffman, *supra* note 202, at 260-63 and 270-73 for a discussion of a proposed independent review process.

324. Tom Ramstack, *Lawsuits Few So Far in States with Patients' Bill of Rights, Officials Say*, KNIGHT-RIDDER TRIB. BUS. NEWS, 2001 WL 24477730 (July 11, 2001). The article reports that the states generally utilize an independent review organization of experts

process in whatever Patients' Bill of Rights legislation is ultimately passed by Congress.³²⁵ Medicare likewise provides mechanisms for review and reconsideration of disputed determinations.³²⁶

D. The Establishment of a Regulatory Agency Could Be Accompanied by a Universal Coverage Mandate

As discussed above, a federal regulatory agency could advance many of the principles of moral fairness by developing a national benefits package and a participatory decisionmaking process. However, it would not necessarily promote universality. National requirements concerning what services are to be covered by insurers will not assist the millions of Americans who have no insurance. To achieve universality, we would have to establish a universal coverage mandate. Universal coverage is the most controversial of the proposals analyzed in this Article. Several potential ways of establishing a universal coverage system are discussed in this part along with their advantages, disadvantages, and implications.

1. Designing a Universal Coverage System

Universal coverage can be implemented through a variety of mechanisms. First, the government can establish a national health care system with public insurance, by which the government pays for medical services, employs the health care providers, and owns all hospitals and medical facilities.³²⁷ In the alternative, the government can provide health coverage for the public while exercising less control over providers and delivery systems.³²⁸ Doctors, therefore, could work as independent contractors for the government, as is done in Canada and Denmark,³²⁹ and hospitals could be private nonprofits or religiously affiliated.³³⁰

who decide the claim at issue within fifteen to thirty days or twenty-four to seventy-two hours for urgent cases. Many commentators favor establishment of these boards because they resolve disputes without litigation and thus prevent insurers from incurring legal costs that would ultimately be passed on to consumers. *See also Supreme Court's 2001-2002 Term May Be Eventful for HMOs, Health Law*, 10 HEALTH LAW REP. 1473, 1473 (Sept. 27, 2001) (stating that "some 37 states and the District of Columbia . . . require independent review of HMO decisions.").

325. *See* Tom Ramstack, *Patients' Rights Lawsuits Few So Far: States Using Review Boards to Settle Case Against HMOs*, WASH. TIMES, July 11, 2001, at B6; *Transcript of Ari Fleischer's June 27 Daily Press Briefing*, U.S. NEWswire, 2001 WL 21895343, June 27, 2001; Timothy Pajak, *Gore for President: Is It Good for HR?*, HR WIRE, September 4, 2000.

326. *See* 42 C.F.R. §§ 405.801-877 (2000).

327. Hampton, *supra* note 174, at 1026 (indicating that "[s]ome countries have opted for pure socialized medicine."); Timothy S. Jost, *Private or Public Approaches to Insuring the Uninsured: Lessons from International Experience with Private Insurance*, 76 N.Y.U. L. REV. 419, 436 (2001) (discussing tax-based insurance programs, Sweden's health care program that provides services through the employment of salaried professionals, and other national health care programs).

328. Hampton, *supra* note 174, at 1027.

329. Jost, *supra* note 327, at 436.

330. *Id.* This is the case in the Netherlands.

A "mandatory private insurance" system can also be utilized.³³¹ Under such a scheme, all individuals are required to obtain health insurance, just as they are obligated to purchase auto insurance, and the insurance industry is extensively regulated by the government. Insurers are prohibited from denying coverage to any eligible individual; the government dictates the premiums that insurers can charge and the benefits they must cover; and individual risk underwriting is disallowed.³³²

Finally, the existing private insurance system could remain intact, and Medicaid programs could be expanded to cover all those who are otherwise uninsured. Vermont, for example, has moved close to this approach. The state enhanced its Medicaid program for children so that only 4% of children are without health insurance, and it allows adults in families whose incomes are less than 150% of the poverty line to purchase Medicaid coverage for small payments.³³³ In 2002 Vermont's overall uninsured rate was just eight percent.³³⁴

Universal health care can be funded through general taxes, as are many other federal programs.³³⁵ Alternatively, coverage for members of the workforce and their dependents can be funded by payroll taxes paid either by employees or by employers.³³⁶ Under this system, workers would be required to purchase insurance, whether it be public insurance or mandatory private insurance. Individuals who are unemployed can receive public subsidies or be placed in a separate, Medicaid-type system.³³⁷ A third option was delineated in the Clinton plan, which would have avoided a tax-based system by requiring employers to pay eighty percent of the cost of insurance for all full-time and part-time employees.³³⁸ Government subsidies would have assisted the unemployed.³³⁹

Universal health care can be a potent tool for promoting moral fairness in health coverage. It would eliminate the large segment of the American population that is currently uninsured and suffers from deteriorating health due to medical neglect.³⁴⁰ It would eliminate externalities associated with the provision of medical care in emergency rooms and clinics to those who could afford insurance but choose not to

331. Hampton, *supra* note 174, at 1028.

332. *Id.* at 1029 (Switzerland has implemented "a system of tightly regulated mandatory private health insurance"); *see also* Jost, *supra* note 327, at 479-80 (discussing the effects of unregulated private insurance on high-risk individuals and the necessary checks or limitations placed on insurance providers to guarantee access to insurance).

333. Jonathan Cohn, *Invisible Man*, NEW REPUBLIC, July 1, 2002, available at <http://www.tnr.com>.

334. *Id.*

335. Jost, *supra* note 327, at 435-36 (explaining that general tax-based insurance programs exist in England, the Scandinavian countries, Spain, Portugal, Italy, and many developing nations. In addition, the Medicaid program in the U.S. is essentially such a system).

336. *Id.* at 434-35.

337. *Id.* at 436-37.

338. Joint Committee on Taxation, Description and Analysis of Title VII of H.R. 3600, S. 1757 ("Health Security Act") (JC-20-93), Dec. 20, 1993, at 4; HSA, H.R. 3600, S. 1757, 103d Cong., 1st Sess. (1993) § 6123 *See supra* Part V.C.1 for further discussion of the Clinton plan.

339. Joint Committee, *supra* note 272, at 5-6.

340. *See* Cutler, *supra* note 177, at 20; Baker et al., *supra* note 172, at 1108 (reporting on a study that found that lack of health benefits is associated with adverse health outcomes.).

purchase it.³⁴¹ It may also diminish incentives for some to remain on welfare rather than work in order to receive Medicaid benefits.³⁴²

Universal coverage, however, has significant potential drawbacks. If employers are required to provide insurance to their employees, some might reduce their workforces to diminish health benefit costs or eliminate pensions and reduce salaries to offset higher benefit expenses. Nevertheless, the need to remain competitive in the market, to maintain a profitable level of productivity, and to attract highly qualified workers, might dissuade employers from shrinking their workforces or taking other steps that will be unappealing to employees.

If universal coverage is publicly supported, it will require substantial federal spending, which would have to be financed through taxes or cuts in other programs.³⁴³ International experience, however, provides some encouraging indications concerning the cost of universal coverage. The cost of administering public health systems can be relatively low because funds are collected through taxes and paid directly to providers for services rendered.³⁴⁴ Furthermore, many of the expenses absorbed by private insurers are avoided by a public system, including marketing costs, underwriting costs, and commission payments for insurance policy sales.³⁴⁵

Scholars have noted that countries with universal coverage uniformly spend a smaller percentage of their GNPs on health care than does the U.S.³⁴⁶ In addition, the United States has far less success in controlling health care costs than do other nations.³⁴⁷ Scholars have argued that in the American health care system, an

341. See Cutler, *supra* note 177, at 20. The author describes this as the "free-rider" problem.

342. *Id.* at 20. According to the author, "[e]mpirical estimates suggest that up to one-quarter of the approximately 4 million welfare recipients would enter the labor force if health insurance were available continuously." *Id.*

343. See *id.* at 24; Butler, *supra* note 176, at 116-17.

344. Jost, *supra* note 327, at 426.

345. *Id.* at 427. The author notes that commissions for initial sales are often ten to twenty percent and are set at five percent for renewals. See also Light, *supra* note 174, at 16 ("Private health insurance is much more costly and inefficient than universal health insurance.").

346. Stephen Heffler et al., *Health Spending Growth Up in 1999; Faster Growth Expected in the Future*, HEALTH AFFAIRS, March-April 2001, at 193, 193 (noting that health care spending grew just 4.8% in 1998 but was up 5.6% in 1999 and projecting an "average annual growth rate of 7.2 percent for 1998-2010," so that health spending will account for 15.9% of GDP by 2010); Jason B. Saunders, Note, *International Health Care: Will the United States Ever Adopt Health Care for All?—A Comparison Between Proposed United States Approaches to Health Care and the Single-Source Financing Systems of Denmark and The Netherlands*, 18 SUFFOLK TRANSNAT'L L. REV. 711, 733 (1995) (stating that "[u]nder the current health care system in the United States, health care expenditure is the highest in the world." Further, according to the article, "[a]s a percent of GNP in U.S. dollars, the United States leads the world in cost of health care at 11.2% versus 6% in Denmark (the lowest percent). *Id.* at 733 n.86. See also Jost, *supra* note 188, at 4-5 (noting that in 1996 the U.S. spent 14.2% of its gross domestic product (GDP) on health care, or \$3708 per individual, while "Germany spent 10.5% of GDP, \$2222 per person; Canada, 9.2% of GDP, \$2002 per person; Japan, 7.2% of GDP, \$1581 per person; and the U.K., 6.9% of GDP, \$1304 per person."))

347. Hampton, *supra* note 174, at 1031-32, n.202 (citing George Schieber, *Health*

“excess administrative apparatus” accounts for ten percent of spending,³⁴⁸ that compared with Canada’s national health program, the U.S. system is inefficient because of its administrative structure,³⁴⁹ and that the administrative costs of hospitals in the United States are more than double the costs of those in Canada.³⁵⁰ In the words of one commentator:

[W]e generally see that private insurance programs pay more for services—not less—than public programs. When we leave the nirvana of economic models and return to the real world, the superiority of private to public systems seems much less clear cut; indeed, public programs may come out on top.³⁵¹

In order to control universal health care costs, the federal government could follow a model established by other countries with universal health care.³⁵² The regulatory agency could negotiate fee schedules with a collective organization that represents the physicians in a particular region.³⁵³ In addition, a national or regional budgetary cap could be set to limit overall expenditures for physician services, based on historical cost information and political realities.³⁵⁴ If physicians exceed the expenditure cap, they would suffer a reduction in the following year’s national or regional fee schedule, and thus doctors would have an incentive to police each other to ensure professionalism and cost containment.³⁵⁵ This system may not be a radical departure from physicians’ current practice environment. Under managed care, doctors have already become accustomed to operating under significant administrative constraints and to considering the financial implications of their

Spending Deliver, and Outcomes in OECD Countries Data Watch, HEALTH AFF., Summer 1993, at 120, 125):

Excess health care inflation is a far more serious problem in the United States than in other countries [B]etween 1985 and 1991 U.S. nominal per capita health spending each year increased 70% faster than nominal per capita GDP . . . compared with only 35% in Canada, 19% in France, 13% in the United Kingdom and 10% in Japan.

348. David U. Himmelstein & Steffie Woolhandler, *Cost Without Benefit: Administrative Waste in U.S. Health Care*, 314 NEW ENG. J. MED. 441, 443 (1986).

349. David U. Himmelstein & Steffie Woolhandler, *The Deteriorating Administrative Efficiency of the U.S. Health Care System*, 324 NEW ENG. J. MED. 1253, 1253 (1991); Jost, *supra* note 188, at 7 (“In 1987, health care administrative costs in the United States amounted to between 19.3 and 24.1% of total costs, compared to between 8.4% and 11.1% in Canada.”).

350. David U. Himmelstein & Steffie Woolhandler, *Administrative Costs in U.S. Hospitals*, 329 NEW ENG. J. MED. 400, 400 (1993).

351. Jost, *supra* note 327, at 431-32 (footnote omitted). See also Steffie Woolhandler and David U. Himmelstein, *Paying for National Health Insurance—And Not Getting It*, HEALTH AFF., Summer 2002, at 88, 88-96 (arguing that tax-funded health spending in the United States is currently higher than it is in every nation other than Switzerland and that national health insurance would, in reality, require smaller tax increases than popularly assumed).

352. Hampton, *supra* note 174, at 1034-35.

353. *Id.* The regions could be statewide or could be divisions within the states so that some differentiation is made between urban and rural areas.

354. *Id.* at 1036.

355. *Id.* at 1036-37.

treatment decisions.³⁵⁶

Nevertheless, while fixed fees and budgetary caps might be necessary, they introduce their own complexities and problems. One commentator warns that excessive price controls will lead to the following: "quantity demanded will either be too high or price will be held down so that quantity supplied will be too low. In either case, some insureds will have to go without care."³⁵⁷ Universal health coverage might therefore cause the average quality of the health care received by current insureds to diminish because limited resources will have to be distributed among many more people than are now consistently served by the system. For example, patients might have to endure longer waiting periods, have fewer services covered, and be restricted in their choice of physicians.³⁵⁸ A recent survey of individuals who are insured through their employers revealed that eighty-eight percent of respondents were extremely satisfied, very satisfied, or at least somewhat satisfied with their health plans.³⁵⁹ The development of a national benefits package that extends basic coverage to all Americans might reduce this level of satisfaction because those who are accustomed to extensive coverage might be reimbursed for fewer services under the basic national plan. Several mechanisms for addressing these concerns are available and are analyzed in the following part.

2. Opt-out Provisions and Supplemental Coverage

One possibility is to establish a public insurance system but allow individuals to opt out and purchase private insurance if they can afford to do so.³⁶⁰ In Germany, for example, people with an annual income of less than 6450 DM (\$3200) are required to enroll in the social insurance program, but all others can choose whether to obtain social health insurance or private health insurance.³⁶¹ Similarly, in Chile, all individuals are subject to a tax of seven percent of their wages with which they are required to purchase health insurance, but they can choose to obtain either social insurance coverage or a private health plan.³⁶²

Many individuals might find an opt-out provision appealing. With private insurance, they could enjoy shorter waiting periods for appointments, choose their own doctors, and have access to specialists who are not routinely available to those

356. See Stone, *Doctor As Businessman*, *supra* note 89 at 545-51 (discussing the evolution of the doctor as a person who could not consider economics in decisions to the current trend of having doctors considering cost in their decisions); Rothstein & Hoffman, *supra* note 21, at 857 (discussing the common use of primary care physicians and the resulting consideration of cost in determining whether another doctor with more expertise should be considered in a particular situation).

357. Butler, *supra* note 176, at 118.

358. *But see* WHITE, *supra* note 244, at 139-40 ("Because choice of physician is clearly greater in Canada than in America, the charge that universal coverage and cost control must reduce Americans' choices is evidently false.").

359. *Satisfaction with Health Care and Health Plans*, EBRI Online, available at <http://www.ebri.org/hcs/2001/sat-fs.pdf> (last visited Nov. 23, 2002). Of the respondents, 11% indicated that they were extremely satisfied, 41% were very satisfied, and 36% were somewhat satisfied with their health plans.

360. Jost, *supra* note 327, at 439.

361. *Id.*

362. *Id.*

utilizing the national health care system. In addition, private insurance could serve as a partial antidote to the moral hazard problem. If copayments are charged for services, people with private insurance are less likely to seek unnecessary treatment.

The existence of a parallel private insurance system, however, could threaten the integrity of the public insurance system.³⁶³ If the public system is tax-funded, and every worker must contribute a certain percentage of her wages, the system's survival would depend upon the participation of high earners. If wealthy Americans are allowed to opt out, the system might be forced to operate on a shoe-string budget, based on minimal tax revenues collected from the poor and governmental subsidies. Similarly, if people of means can choose to purchase private insurance, they will not be personally invested in supporting the public health system. Without the political support of individuals who make large campaign contributions, have lobbying power, and enjoy access to the media, the public health system is unlikely to thrive.³⁶⁴ In addition, a parallel private insurance system might induce providers to generate artificial shortages and waiting lists in the public health system in order to encourage individuals to switch to the private system, in which providers can charge higher prices.³⁶⁵

Some of these potential problems, however, could be combated through regulatory measures. Germany, for example, has established several incentives for joining its "sickness funds," as a result of which only ten percent of the population has opted to purchase private insurance.³⁶⁶ German insurers charge different premiums to individuals of different ages, so that persons who purchase insurance at a young age pay lower prices than purchasers of a more advanced age who are more likely to become ill in the near future.³⁶⁷ Individuals who wait to purchase private insurance at an age at which they are more likely to require extensive medical treatment are charged relatively high premiums, but young purchasers pay premium prices that exceed the cost of services that they are likely to utilize at that age.³⁶⁸ These costs make private insurance unappealing to many consumers. In addition, those who opt out of the sickness fund system by purchasing private insurance generally cannot opt back in.³⁶⁹ Consequently, they must continue to pay the high cost of private insurance even if they later decide that the money is not

363. A similar debate about parallel coverage systems was generated by the KYL Amendment, which was enacted as part of the Balanced Budget Act of 1997 and permits Medicare patients to enter into private contracts with physicians in limited circumstances. 42 U.S.C. § 1395a (Supp. 2001). Opponents of the provision criticized it for undermining the universalistic and equality-oriented principles of Medicare. Others supported the amendment as enhancing individual freedom but criticized the limitations it placed on private contracting. Maxwell J. Mehlman, *Introduction: KYL Amendment Symposium*, 10 HEALTH MATRIX 1, 1 (2000); see also Thomas W. Greeson & Heather L. Gunas, *Section 4507 and the Importance of Private Contracts*, 10 HEALTH MATRIX 35, 35 (2000) (discussing the controversy surrounding the ability of medicare patients to enter into private contracts for healthcare services).

364. Jost, *supra* note 327, at 491.

365. *Id.*

366. WHITE, *supra* note 244, at 75.

367. *Id.* at 77.

368. *Id.*

369. *Id.* at 78.

well spent. Finally, legislation could render it unlawful for doctors to create artificial shortages in the public system, and aggressive prosecution of violators could serve as a deterrent for such conduct.

A second option would be to allow people to choose to remain uninsured and avoid the cost of private insurance or receive a tax refund if the system is publicly funded. This option, however, might result in adverse selection and externalities.³⁷⁰ Those who would choose to be uninsured would likely be the healthiest individuals who need few, if any, services. It is these individuals who subsidize expenditures for the very sick. If healthy individuals are allowed to opt out of the insurance system, the system's expenditures may exceed its revenues from taxes or premium payments. Consequently, taxes or premium prices would have to be raised, and the system could become unaffordable.

Furthermore, in reality, it is unlikely that uninsured individuals will be bound by their choice to opt out of the system to the extent that they would be refused care when they suffer catastrophic illness or injury. Today, we treat the uninsured (albeit inadequately) in emergency rooms and public clinics. It is likely that we would continue to provide limited care to the uninsured under a reformed system and would not require the sick to endure terrible suffering without any medical attention whatsoever even if they were uninsured solely because they had chosen to opt out of the universal coverage system. These individuals would therefore contribute no money to the health care budget but would receive treatment at public cost, thus generating externalities.

A separate question relates to whether individuals who are enrolled in the public system should have the option of purchasing private insurance to supplement the services they receive through the national benefits package.³⁷¹ Private insurance supplementation is available in many countries with tax-based insurance programs.³⁷² In Canada, for example, almost fifteen million individuals have private health insurance to cover hearing aids, vision and dental care, private hospital rooms, prescription drugs, and chiropractors, which are not covered by the public system.³⁷³ In the United States, Medigap policies are available to supplement Medicare coverage for the elderly.³⁷⁴ Pursuant to the Omnibus Budget Reconciliation Act of 1990 ("OBRA-90"),³⁷⁵ private insurers may sell ten standardized policies to Medicare enrollees, identified by the letters A through J.³⁷⁶

370. See *supra* Parts I.B.1 and V.B for explanations of the terms "adverse selection" and "externalities," respectively.

371. The Clinton plan, for example, would have allowed individuals to purchase supplemental health insurance that would cover services not included in the national benefits package. Joint Committee, *supra* note 272, at 2.

372. Jost, *supra* note 327, at 439-40. In some countries, private insurance covers products and services not included in the public insurance package. In the United Kingdom and Australia private insurance is purchased by those who are fully insured under the public system as double coverage, to assure "prompter or more convenient access to health care, more control over choice of provider, or access to better quality health care." *Id.* at 440.

373. *Id.* at 468-69.

374. PETER D. FOX ET AL., *Medigap Regulation: Lessons for Health Care Reform*, 20 J. HEALTH POL. POL'Y & L. 31, 31-32 (1995).

375. 42 U.S.C. § 1395 (Supp. 2001).

376. *Id.* The comprehensiveness of supplementation increases from policies A to J, with high end policies paying for preventive care, at-home recovery, and prescription drugs.

The availability of supplemental plans in the non-Medicare market would allow insurers to continue to compete and profit in the marketplace despite extensive regulation with respect to the basic benefits package. Supplemental plans may also benefit medical researchers because some newly developed treatments or even experimental therapies could be covered by these plans while they are excluded from the national benefits package.

The idea of supplemental coverage, however, is also vulnerable to criticism. First, the supplemental coverage market might be characterized by adverse selection, wherein only those who actually need extra services purchase the plans.³⁷⁷ Supplemental coverage plans might, therefore, be faced with very high expenditures requiring frequent increases in premium prices and might ultimately become unaffordable. The existence of supplemental coverage might also cause policy-makers to be less conscientious about decisions concerning the basic benefit package, since they would be assured that services not covered in the basic plan would become available through supplemental policies.³⁷⁸ Finally, supplemental coverage might be perceived by some as being morally unfair and as undermining the value of universality. One could object that it is unjust to allow wealthier patients who have supplemental plans to receive treatments that are not available to those of lesser means who have only the basic benefits package. On the other hand, absolute equality may well be an unrealistic and inappropriate goal.³⁷⁹ In the words of the scholar Charles Fried, "as long as our society considers that inequalities of wealth and income are morally acceptable . . . it is anomalous to carve out a sector like health care and say that there equality must reign."³⁸⁰ Whether moral fairness demands absolute equality is a subject for further debate.

Constructing an optimal system for the implementation of universal coverage is beyond the scope of this Article. The idea of universal coverage will generate passionate opposition and raises very significant policy problems. One scholar reminds us, however, that those who oppose change, such as the limitations created by managed care, are generally those who are privileged under the status quo. He states:

all the parties to the controversy over managed care are the "haves"—the insured population that worries about denial of beneficial care, the payers who

Lauren A. McCormack et al., *Medigap Reform Legislation of 1990: Have the Objectives Been Met?* 18 HEALTH CARE FINANCING REV. 157, 159-60 (1996).

377. Peter A. Diamond, *Two Improvements on the Clinton Framework*, 8 J. ECON. PERSP. 61, 66 (1994).

378. *See id.* (discussing the difficulty of "drawing lines between basic and supplementary coverage").

379. *See* WHITE, *supra* note 244, at 140 (stating that those in rural areas receive inferior care when compared to those in urban areas and that "[i]n all systems, those who are more aggressive, charming, or able to communicate with doctors and medical staff have a better chance of getting explanations or choices or attention."); Ezekiel Emanuel, *Health Care Reform: Still Possible*, HASTINGS CENTER REP., March-April 2002, at 32, 33 ("Justice does not require that every person receive the same health care services").

380. Charles Fried, *Equality and Rights in Medical Care*, HASTINGS CENTER REPORT, February 1976, at 29, 32. (arguing that "[t]o say there is a right to health care does not imply a right to equal access, a right that whatever is available to any shall be available to all."). *Id.* at 29.

want to control costs, and the providers who fear losing their professional autonomy and forfeiting patient trust. Conspicuously absent from this triad are the millions of uninsured.³⁸¹

A health care system that strives to promote moral fairness cannot continue to turn an indifferent shoulder towards the uninsured.

VI. CONCLUSION

The American public has already demonstrated that it is concerned about moral fairness in health insurance coverage. Numerous polls and surveys reveal that a majority of the population believes that all Americans should have a right to adequate health care.³⁸² Federal and state statutes have taken important steps to address the problem of unfair discrimination in health insurance. However, legislative mandates are inadequate as safeguards of moral fairness because of their limited reach, significant loopholes, and piecemeal approach. We still have over forty-two million Americans uninsured, as well as AIDS caps, exclusions or limitations of coverage for mental health care, and refusals to reimburse for hearing aids, among many other discriminatory benefit terms.

This Article has analyzed the concept of moral fairness and has developed principles of moral fairness that should guide policymakers. It has also explored a variety of mechanisms for the promotion of moral fairness in the realm of health insurance. All mechanisms raise significant concerns and would require consideration of substantial trade-offs. The issue of just distribution of health care coverage is as complex as it is important, and no perfect resolution can be developed for it.

In the 1990s, many reforms were contemplated, though none were ultimately passed. American society still might not be prepared to expend the financial and human resources necessary to achieve meaningful change, and therefore, significant reform might not be politically feasible at this time. When asked whether they are willing to pay more money out-of-pocket for their own medical care in order to allow for universal coverage, only about half of respondents to a large survey answered in the affirmative.³⁸³ According to one commentator,

[t]he considerable inertia of the American political system, the generous campaign contributions available from health insurers, and the antigovernment ideological bent of the American people and their elected politicians present a phalanx too powerful to be overcome by mere empirical evidence and reason [concerning the desirability of a public system of health care financing].³⁸⁴

Others, however, warn that with rising unemployment, as well as rapidly increasing medical and health insurance premium costs, the United States is about

381. Allen Buchanan, *Managed Care: Rationing Without Justice, But Not Unjustly*, 23 J. HEALTH POL. POL'Y & L. 617, 633 (1998).

382. See sources listed *supra* note 17.

383. Roper Center for Public Opinion Research, *supra* note 17.

384. Jost, *supra* note 327, at 491-92. See also Zoloth, *supra* note 10, at 36 ("[I]t will be a hard task politically. The forces that coalesced in 1992 were defeated very soundly.").

to face a serious health care crisis.³⁸⁵ It is time to revive the debate concerning health care reform. This Article has made an effort to analyze some of its most controversial aspects and to generate questions for further thought. Without significant reform, American society will continue to absorb the high social and financial costs of the uninsured and underinsured, and the goal of moral fairness in health coverage will remain unattainable.

385. Cohn, *supra* note 178, at 19-22; Emanuel, *supra* note 379, at 32. See also Robert Pear, *Propelled by Drug and Hospital Costs, Health Spending Surged in 2000*, N.Y. TIMES, Jan. 8, 2002, at A14 (reporting that “[n]ational health spending shot up 6.9 percent to \$1.3 trillion in 2000.”); Drew E. Altman & Larry Levitt, *The Sad History of Health Care Cost Containment as Told in One Chart*, HEALTH AFF. (Jan. 23, 2002), at http://www.healthaffairs.org/WebExclusives/Altman_Web_Excl_012302.htm. The authors state that “[t]he problem of rising health care costs is reemerging as a national issue.” They note that during the past thirty-five years, none of the efforts undertaken to control health care costs in this country has had lasting success. While managed care and the “threat of the Clinton health care reform plan” significantly slowed the rate of increase in private spending in the mid-1990s, spending rose again in the late 1990s and reached double digit levels of increase by 2001.