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There Is No Perfect Solution to Health Care in America

Caroline Sommers

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THERE IS NO PERFECT SOLUTION TO HEALTH CARE IN AMERICA

CAROLINE SOMMERS¹

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I. INTRODUCTION

There are two main competing views of health care in the United States. Some Americans view health care as an inherent individual right where the "humblest patient [should be] entitled to the best of medical service."² Most Americans use this position when advocating for increased government involvement in the United States' health care system.³ Others view health care as

¹ Caroline Sommers is a 2010 JD/MBA Candidate at Pepperdine University. This article was written prior to President Barack Obama winning the Democratic nomination and the presidential election. While there are some differences between President Obama's proposed health care reform and Hillary Clinton's American Health Choices Plan, they are not substantive. For a brief discussion of the main differences and similarities between the two plans *see infra* note 133.

² DONALD A. BARR, INTRODUCTION TO U.S. HEALTH POLICY 1 (2d ed., The John Hopkins University Press 2007) (2002) (quoting Dr. John Bowman, Director of the Board of Regents of the America College of Surgeons).

³ *Id.*

a business.⁴ They see health care not as a right or privilege, but rather as “a service that is provided by doctors and others to people who wish to purchase it.”⁵

Thus far, the United States has taken a market approach to health care, viewing health care as a business rather than an inherent right.⁶ However, this approach does have its problems.⁷ The Organization for Economic Co-operation and Development (OECD) stated that the United States spends more on health care than any other OECD country.⁸ In addition, the World Health System ranked the United States’ performance thirty-seventh out of 191 member countries, behind Chile, Costa Rica, Cuba, Dominica, and Slovenia.⁹ Many critics of the United States’ health care system attribute this inefficiency to “wasteful duplication of facilities and administrative infrastructure (due to lack of centralization), wasteful competition among health service providers, and the provision of unnecessary services by profit seeking providers.”¹⁰

Pressure has increased on legislatures to find a means to deal with the

⁴ *Id.*

⁵ *Id.* (quoting Dr. R.M. Sade who was published in the New England Journal of Medicine).

⁶ *Id.* at 2.

⁷ ROBERT L. OHSFELDT & JOHN E. SCHNEIDER, *THE BUSINESS OF HEALTH: THE ROLE OF COMPETITION, MARKETS, AND REGULATION* 5 (American Enterprise Institute 2006).

⁸ *Id.* OECD was established in 1960 and consists of thirty countries: Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, the Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Spain, Sweden, Switzerland, Turkey, United Kingdom, and The United States. Organization for Economic Co-Operation and Development, http://www.oecd.org/pages/0,3417,en_36734052_36761800_1_1_1_1_1,00.html (last visited Mar. 1, 2009). The main goal of the OECD is to bring together the governments of countries from around the world, which are committed to democracy and the market economy, to support sustainable economic growth, boost employment, raise living standards, maintain financial stability, assist other countries’ economic development, and contribute to growth in world trade. *Id.* The Organization compiles economic and other statistics for these thirty leading developed countries. *See id.*

⁹ OHSFELDT & SCHNEIDER, *supra* note 7, at 1. However, many have a distorted view of the effectiveness of the United States’ health care system since to the United States has poor results when looking at the population health outcomes. *See id.* at 16. For instance, the United States’ high child mortality rate may actually be due to the fact that the United States classifies a premature birth resulting in nearly instantaneous death as an infant death where other countries classify it as a fetal death. *Id.* In addition, the United States’ abnormally high child mortality rate is generally due to the fact that the United States has a higher rate of death from injury, birth intentional and unintentional, than other OECD countries. *Id.* at 18.

In the United States, unintentional injury was the fifth leading cause of death in the year 2000 overall, but was the leading cause of death among individuals between the ages of one and thirty-four, and was the second and third most common cause of death among individuals between the ages of thirty-five and forty-four and forty-five and fifty-four, respectively. By contrast, among individuals sixty-five years of age and over, unintentional injury was the ninth leading cause of death. The unusually high death rates from unintentional injury among young Americans reduce the estimated life expectancy at birth for the United States, but they do not necessarily signal a deficiency in the U.S. health care system.

Id. at 19.

¹⁰ OHSFELDT & SCHNEIDER, *supra* note 7, at 1.

increasing cost of health care and the increasing demands of the United States' aging population.¹¹ As the cost of health care in the United States continues to rise, many Americans are forced to go without health insurance.¹² In 2005, about forty-seven million Americans were without health insurance.¹³ Moreover, in any two-year period, almost eighty-two million people are on the brink of losing their health care coverage.¹⁴ In addition, the increased cost of health care has significantly reduced the number of businesses offering health care benefits to their employees.¹⁵ For instance, the overall percentage of businesses offering health care has fallen from sixty-nine percent in 2000 to sixty-one percent in 2006.¹⁶ With such alarming statistics many Americans have begun to wonder if the United States' health care system now is too ineffective and whether an increase in government involvement in the health care system would not be better for all Americans.¹⁷

There are several types of health care systems throughout the world. A

¹¹ LAURENE A. GRAIG, *HEALTH OF NATIONS* 1 (3d. ed., Congressional Quarterly Inc. 1999). Americans consistently rank health care high among the issues that they wish Washington to address, trailing only Iraq and terrorism. Andrew Cline, *Hard to Swallow*, AM. SPECTATOR ONLINE, Sept. 18, 2007, available at <http://spectator.org/archives/2007/09/18/hard-to-swallow>. According to a CBS and New York Times Poll conducted in March 2007 only eight percent of Americans felt the United States health care system needed only "minor changes." *Id.*

¹² Marie Gottschalk, *Back to the Future? Health Benefits, Organized Labor and Universal Health Care*, 32 J. HEALTH POL. POL'Y & L. 923, 927-28 (2007).

¹³ *Id.* This figure represents about sixteen percent of the current American population and has increased from fourteen percent since the early 1990s. *Id.* Nearly eighteen percent of the non-elderly American population is without health care insurance. William P. Gunnar, M.D., *The Fundamental Law That Shapes the United States Health Care System: Is Universal Health Care Realistic Within The Established Paradigm?*, 15 ANNALS HEALTH L. 151, 154 (2006). However, this figure also represents some "thirty-three million non-citizen immigrants currently residing in the United States, about nine million of whom are here illegally and are presumed to be uninsured." *Id.* at 155 (citing Seam Park, *Substantial Barriers in Illegal Immigrant Access to Publicly-Funded Health Care: Reasons and Recommendations for Change*, 18 GEO. IMMIGR. L.J. 567, 568 (2004)). In fact, "the number of illegal immigrants is expected to increase by 500,000 per year." *Id.* In 2007, the number of uninsured rose five percent despite the fact that the average household income increased. Catherine Arnst, *The Politics of Health-Care Reform*, BUS. WK., Sept. 17, 2007, available at http://www.businessweek.com/technology/content/sep2007/tc20070914_836209.htm.

¹⁴ Gottschalk, *supra* note 12, at 927-28.

¹⁵ *Id.*

Between 1991 and 2003, the proportion of full-time employees participating in employer-sponsored health plans at medium-sized and large firms plummeted from 83 percent to 65 percent. In 1980, the figure was 97 percent. For workers at small firms, the contraction was even more severe, from 69 percent in 1990 to just 42 percent in 2003. [In 2006], just over one-half of workers employed in the private sector participated in employment-based health plans.

Id.

¹⁶ *Id.*

¹⁷ Cline, *supra* note 11. In February, 2007, "a Quinnipiac University poll found that [fifty-seven] percent of Americans agreed with the statement that 'it's the government's responsibility to make sure everyone in the United States has adequate health care'." *Id.* A poll conducted by the Washington Post and ABC News in 2003 also found that sixty-four percent of Americans favored universal health care. *Id.*

market based health care system views health care as a business, allowing the market to determine the cost of products and services.¹⁸ There are two different types of market based systems, employer based and consumer directed. Currently the United States has an employment-based health care system where employers and individuals pay for health care, backed by government policy such as Medicaid and Medicare.¹⁹ Money for services is collected from a number of sources, such as private insurance companies, individuals, businesses, and the government.²⁰ In a consumer directed health care system, “consumers occupy the primary decision-making role regarding the health care they receive.”²¹ Consumers purchase, and employers can contribute to, a tax free account with low cost, high deductible health coverage, such as Health Savings Accounts (HAS) and Health Reimbursement Arrangements (HRA).²² Another health care system is the single payer system which has developed in Canada, Sweden, and Denmark.²³ Under the single payer system, health care is financed through the government.²⁴ The government is responsible for collecting money from individuals and businesses through taxes and reimbursing the health care providers.²⁵ This system is different from socialized medicine, where “the government owns the health care facilities and physicians work for the government.”²⁶ Under a universal health

¹⁸ OHSFELDT & SCHNEIDER, *supra* note 7, at 48.

¹⁹ Gottschalk, *supra* note 12, at 924-25. Medicare is a federal program which provides universal health care for everyone sixty-five years of age or older. BARR, *supra* note 2, at 113. It is paid for through a “Medicare withholding tax and the general federal withholding tax.” *Id.* Medicaid is the result of a federal and state partnership “to provide medical insurance to poor and disabled people” and is paid for through state and federal taxes. *Id.*

²⁰ AMSA, *Single Payer 101*, <http://www.amsa.org/uhc/SinglePayer101.pdf> (last visited Mar. 1, 2009).

The collection of money is the joint responsibility of the private insurance industry, which collects premiums and other payments from individuals and businesses, and the government, which collects taxes from individuals. Similarly, reimbursement responsibilities fall on both the private insurance industry, which reimburses providers for health care services delivered to privately insured individuals, and the government, which reimburses providers for health care services delivered to publicly insured individuals.

Id.

²¹ John Goodman, *Consumer Directed Health Care*, NETWORKS FIN. INST., Dec. 2006, at 1, available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=985572.

²² *Id.*; Oxford Analytica, *Consumer-Driven Health Care Faces Test*, FORBES, Dec. 18, 2006, available at http://www.forbes.com/2006/12/15/health-savings-patients-business-cx_1218oxford.html; Amy Feldman, *Are You Ready to Own Your Health Care?*, CNNMONEY.com, Jan. 24, 2005, http://money.cnn.com/2004/10/22/pf/insurance/healthcare_cdhc_0411/index.htm.

²³ AMSA, *supra* note 20.

²⁴ *Id.* “Physicians can be either in private practice or public practice, and hospitals can be both publicly and privately owner.” *Id.*

²⁵ *Id.*

²⁶ *Id.* For example, the United Kingdom has a National Health Service of the U.K., in which the mechanisms of delivery of health care are owned by the government. *Id.*

care system every citizen is provided health care coverage.²⁷

This article will argue that Hillary Clinton's American Health Choices Plan is a poor solution for America's health care problems. Instead, this article will show that the best solution for America is to reform the current market based health care system by increasing competition between the insurance companies to help drive down costs. The first part of this article will look into the United States' current health care system. It will show how the current United States' market based system has developed to allow physicians to charge market price for each service provided to patients. The article will also look at why America has an employer based health care system. It will also look at the health care system's current problems as well as the positive aspects of a market based health care system. It will show how higher health care expenditures will have a devastating effect on the government's revenue. This article will explain that there are stronger factors than simply waste and inefficiency which explain the United States' higher than expected health care expenditures. It will show that the current increased cost of health care has had a devastating effect on many small businesses and explain why employers are reducing or eliminating employee health care coverage. The second part of this article will look at Hillary Clinton's American Health Choices Plan. It will delve into her proposed policy and show both the positive and negative aspects. This article will show that Hillary Clinton's American Health Choices Plan provides for a mandated employer health care system in order to ensure that to all Americans are able to purchase "affordable quality health insurance." However, it will also show that the mandate will not provide affordable health insurance for everyone since its proposed lower premiums for the sick and elderly will likely increase premiums for the young and healthy. Finally, this article will argue that there is no perfect solution to the current health care system's problems. It will show that reforming our current employer based system by opening the state's borders to allow consumers to purchase health care in other states, reducing state mandates, and implementing effective tort reform is the best solution for Americans. It will argue that the best solution for America is to reform our current health care system rather than to increase the government's involvement.

II. UNITED STATES' HEALTH CARE SYSTEM

A. History of the United States' Health Care

Besides the United States, all other industrialized nations "have adopted national health plans that assure citizens access to basic medical care."²⁸ Why does the United States stand alone in approaching health care as a commodity?²⁹

²⁷ AMSA, *supra* note 20.

²⁸ BARR, *supra* note 2, at 2.

²⁹ *Id.*

The reason stems from a national crisis that arose in the United States in the early twentieth century.

During the twentieth century, the medical community lacked qualifying standards for practitioners.³⁰ Physicians came from “a variety of educational backgrounds with a variety of knowledge and skills.”³¹ The United States’ government perceived this as a national crisis.³² In response, the government established a commission to make recommendations “over the organization and financing as well as the practice of medical care.”³³ In 1910, this commission published its recommendations for reforming medical education in a report commonly known as “The Flexner Report.”³⁴ Due to views expressed in this report, “state and local governments increasingly relied on the American Medical Association (AMA) . . . and on the AMA’s affiliated state and local medical associations to guide the restructuring of medical practice.”³⁵

Thus, state and local governments gave the medical community a great amount of independence over the restructuring of medical practice. This was due to the fact that physicians were viewed as “altruistic agents who possessed valuable scientific knowledge and technical skills” and always acted in the patient’s best interest.³⁶ This view led state and local governments to grant the medical community considerable authority over their organization, education, and practice of medicine.³⁷ However, while physicians were granted such authority, “they often used this power to further their own ends.”³⁸ Physicians decided to

³⁰ *Id.* at 3. “There were no standards, either legal or ethical, to maintain a consistent level of quality in the way physicians practiced medicine.” *Id.*

³¹ *Id.*

³² BARR, *supra* note 2, at 3.

³³ *Id.* In the early part of the twentieth century, the United States’ government made a decision “to vest in the medical profession substantial authority over the organization and financing as well as the practice of medical care” which helped to create the United States’ view that health care is a market commodity and not an inherent right. *Id.* Thus, the government appointed “a prestigious commission . . . to make recommendations about a thorough restructuring of medical education, and as a result, medical practice.” *Id.*

³⁴ *Id.* The report is officially titled MEDICAL EDUCATION IN THE UNITED STATES AND CANADA. BARR, *supra* note 2, at 3.

³⁵ *Id.* The AMA was established in 1847 as the principal professional association of physicians. *Id.*; AMA, Our History, <http://www.ama-assn.org/ama/pub/about-ama/our-history.shtml> (last visited Mar. 11, 2009).

³⁶ BARR, *supra* note 2, at 3. During this time, science and technology gained legitimacy. *Id.* In addition, Americans had a somewhat idealized view of physicians which helped increase the medical professions sovereignty. *Id.* The physicians “role as social agents was guided by a code of ethics that placed the utmost importance on acting at all times in the best interest of the patient.” *Id.* Therefore, physicians “could be trusted to make decisions on behalf of the patient in a paternalistic manner, acting always as a disinterested agent on the patient’s behalf.” *Id.*

³⁷ BARR, *supra* note 2, at 3. Thus, physicians were seen as “agents of reason [and] exerted substantial influence over governmental policy toward medical care” as a result. *Id.*

³⁸ *Id.* “The power of the medical profession has been used to support and protect the role of the individual physician as self-interested entrepreneur.” *Id.* at 3-4. The physicians recognized that these interests were best served in a market based health care system where “a service that is provided by

“support and protect the role of the individual physician as self-interested entrepreneur” by viewing health care as a commodity.³⁹

Thus, the United States’ system developed to allow physicians to charge market price for each service provided to patients.⁴⁰ With such a system physicians are able to act in the patient’s best interest while also looking out for their own needs.⁴¹ However, while a market based system is preferred by physicians, this system has led to many Americans being unable to afford health care as the cost of health care rises to match its market price.

B. Why America has an Employer-Based Health Care System

During World War II, the federal government imposed price and wage controls on businesses.⁴² In order to attract potential employees businesses began to provide health insurance as opposed to increased wages.⁴³ As a result, the number of individuals with insurance coverage increased from 1.3 million in 1940 to thirty-two million in 1945.⁴⁴ Tax provisions further encouraged the development of employer-based health care since employees were not required to include the employer’s payment of health insurance as part of their compensation.⁴⁵

C. The Cost of Care

In 2003, people in the United States spent on average \$5,670 per person, or a total of \$1 trillion 679 billion, on health care.⁴⁶ This represented 15.3 percent of

doctors and others to people who wish to purchase it.” *Id.* at 4. However, the view of physicians as “agents of power” caused many to feel that the medical community was controlling knowledge in order “to limit entry into the profession and . . . [to] maintain political sovereignty over the system of medical care.” BARR, *supra* note 2, at 3.

³⁹ *Id.* at 3-4.

⁴⁰ *Id.* at 4. “By creating and maintaining a system that approached medical care as a market commodity, physicians also were able to establish their right to charge a separate fee for each service they provided, and to base that fee on whatever the market would bear.” *Id.* Thus, physicians were able to help the patient and himself or herself simultaneously. *Id.* Under this system, as more procedures were performed, patients believed they were receiving quality care and physician’s income increased. BARR, *supra* note 2, at 4. Therefore, when “deciding whether a patient does or does not need additional care, the financial incentive might push the physician to provide care that otherwise might not be seen as medically necessary.” *Id.*

⁴¹ *Id.* Under a market based health care system, when more procedures are performed the patient believes he or she is receiving quality care and physicians overall income increases. *Id.* Therefore, when “deciding whether a patient does or does not need additional care, the financial incentive might push the physician to provide care that otherwise might not be seen as medically necessary.” *Id.*

⁴² SHERRY A. GLIED, CHRONIC CONDITION: WHY HEALTH REFORM FAILS 38 (Harvard University Press 1998).

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ BARR, *supra* note 2, at 5. This is “more than twice the amount of GDP apportioned to health care

the Gross Domestic Product (GDP).⁴⁷ The U.S. Centers for Medicare and Medicaid Services project that the future growth in national health care expenditures will reach 18.7 percent of the GDP by 2014.⁴⁸ If the government's projections are correct, more money will be invested into health care and less money will be spent on other sectors of the economy.⁴⁹ American companies will be placed at a competitive disadvantage compared to foreign companies that do not have such extreme health care costs.⁵⁰

Higher health care expenditures will have a devastating effect on the government's revenue.⁵¹ Tax revenue generally increases at the same rate as the GDP increases, unless tax rates change.⁵² If health care expenditures continue to rise faster than the GDP, a larger percentage of the GDP will be going to health care and tax revenues will not be able to be maintained at this high level of growth.⁵³ This creates a major problem for Americans, especially businesses, since the United States government pays forty-six cents for every dollar that health care costs increase faster than the GDP.⁵⁴ Thus, in order to pay for this increase,

just thirty-three years earlier." *Id.* In 1970, people in the United States spent on average \$341 per person, or a total of \$73 billion, on health care. *Id.* In 2003, the United States spent the largest amount of its GDP on health care when compared to other OECD countries. *Id.* The next highest OECD country was Switzerland, with a total expenditure of 11.5 percent of its GDP, followed by Germany, with an expenditure of 11.1 percent of its GDP. *Id.* However, "the rate of increase in health care costs [in the United States has] slowed somewhat, rising 7.7 percent in 2003 compared to the 9.3 percent rise seen in 2002." BARR, *supra* note 2, at 5. In addition, putting inflation aside, the cost of health care has increased only three percent between 1987 and 2000. *Id.* at 9.

⁴⁷ *Id.* at 5.

⁴⁸ *Id.* If these projections are correct then "nearly one dollar of every five in the entire national economy will be spent on health care" in 2014. *Id.* at 6. This will result in funds being transferred from other sectors of the economy, such as education and national infrastructure. BARR, *supra* note 2, at 6-7.

⁴⁹ *Id.* at 6-7. The United States "will have less money available for schools, for roads and other forms of transportation, and for investing in the capital and technology necessary for continued expansion of the economy." *Id.* at 7.

⁵⁰ *Id.*

⁵¹ *Id.*; Arnold S. Relman, *The Health-Care Cost Crisis Is All Too Real*, WALL ST. J., Nov. 26, 2007, at A19, available at http://online.wsj.com/article/SB119604751824503629.html?mod=todays_us_page_one. It is estimated that "health [care] spending increases at a constant rate of about eight percent for every \$1000 increase in GDP per capita." John R. Graham, *The Health Cost Myth*, WALL ST. J., Nov. 13, 2007, at A25, available at http://online.wsj.com/article/SB119492465851790988.html?mod=opinion_main_commentaries. Thus, health spending will increase by \$232 if the GDP per capita increases from \$30,000 to \$31,000. *Id.* In addition, if the GDP increases from \$40,000 to \$41,000, then health care spending will increase by \$500. *Id.*

⁵² BARR, *supra* note 2, at 7.

⁵³ *Id.* at 7-8. "[T]he history of health care in this country is that the cost of care rises more rapidly than the GDP," especially in times of recession since health care costs continually rise regardless of the fact that the economy is shrinking. *Id.* at 7.

⁵⁴ *Id.* at 8. Through programs such as Medicare, Medicaid, and other public expenditures, federal, state and local governments are responsible for "a combined [forty-six] percent of all health care expenditures." *Id.* at 7. The implementation of Medicare Part D, which provides beneficiaries with assistance paying for prescription drugs, in 2006 has resulted in a 10.1 percent increase in government spending. Centers for Medicare & Medicaid Services, *Sponsors of Health Care Costs: Businesses, Households, and Governments, 1987-2006*, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/bhg07.pdf> (last visited Mar. 11, 2009); Center for Medicare Advocacy, Inc., *Medicare Part*

the government can either borrow the money, which will increase its debt, or it can increase taxes.⁵⁵

There is a “strikingly large difference between actual and predicated spending per capita in the United States.”⁵⁶ The United States spends more on health care per capita than any other OECD country, but it also spends “much more than expected even given higher per-capita GDP.”⁵⁷ This higher health care spending is partially attributable to waste and inefficiency.⁵⁸ However, there are stronger factors than simply waste and inefficiency, which explain the United States’ higher than expected health care expenditures.

One possible factor is that consumers are given a preference over discretionary services.⁵⁹ Consumers in the United States prefer to purchase insurance plans that allow for greater patient choice and are “willing to pay some positive value for choice.”⁶⁰ However, many other OECD countries restrain access

D prescription Drug Coverage, http://www.medicareadvocacy.org/FAQ_PartD.htm#whatIsD (last visited Feb. 9, 2008). Since 2001, the federal government’s spending has outpaced all other contributors in five of the six years due to “the acceleration of the federal portion of [Medicaid and Medicare costs.” See Centers for Medicare & Medicaid Services, *supra*.

⁵⁵ BARR, *supra* note 2, at 8; Relman, *supra* note 51, at A19. Either option will result in “severe, long-term, destabilizing effect[s] on the U.S. economy.” BARR, *supra* note 2, at 8. However, the effects will be most severe for state and local government, “which pay about [thirteen] percent of all health costs and about [twenty-eight] percent of public health costs.” *Id.* Since many states have laws forbidding the state and local governments from running a deficit, the state and local governments will be forced to increase taxes or divert funds away from other programs, such as education. *Id.* State and local governments may also attempt to alleviate the problem by reducing the amount of health care paid by the governments. *Id.* Thus, such a situation may force those who rely on their state and local government to help pay for health care to go without health care since they will be unable to afford health care on their own. *Id.*

⁵⁶ OHSFELDT & SCHNEIDER, *supra* note 7, at 6.

⁵⁷ *Id.* This is true whether the health care costs are measured as health spending per capita, adjusted for purchasing power parity, or as a percentage of the GDP. *Id.* Since the United States has a higher GDP, it is generally expected “to translate into higher health care spending relative to other OECD countries, because health care is a ‘normal’ good.” *Id.* As income rises, consumers are able to purchase more of a normal good. *Id.* “Health spending in the United States appears to be substantially greater than expected, even after accounting for the impact of higher income on health spending.” OHSFELDT & SCHNEIDER, *supra* note 7, at 6. Thus, “the United States represents the extreme value for both health spending per and GDP per capita.” *Id.* at 7-8.

⁵⁸ *Id.* The “apparent inefficiency often is attributed to wasteful duplication of facilities and administrative infrastructure (due to lack of centralization), wasteful competition among health service providers, and the provision of unnecessary services by profit-seeking providers.” *Id.* at 5.

⁵⁹ *Id.* at 12. What is considered a discretionary service is defined along a spectrum. Margaret Ann Cross, *Deciding Factor: How Much Health Care is Discretionary?*, MANAGED CARE, Mar. 2006, <http://www.managedcaremag.com/archives/0603/0603.discretion.html>. Physicians have to take into account “the availability of scientific evidence and clinical care guidelines,” which are based on individual conditions. *Id.* The use of discretionary services “tend[s] to increase with income, in the absence of non-market constraints.” OHSFELDT & SCHNEIDER, *supra* note 7, at 12.

⁶⁰ OHSFELDT & SCHNEIDER, *supra* note 7, at 11-12. However, this willingness to pay for subtle difference is increased due to “tax incentives that insulate consumers from cost differences in employer sponsored health insurance options.” *Id.* at 12. In response, employers have moved towards more defined contribution health benefits. *Id.* at 12.

to health care that is not medically necessary.⁶¹ It is understood that if citizens in these OECD countries were provided access to, or assistance in paying for, discretionary health care, those country's health care spending per capita would most likely be closer to that of the United States.⁶²

Another possible factor for the United States' high health care spending is the fact that there is redundant capacity "in the form of underutilized capital equipment or the coexistence of similar providers or health plans within a particular market."⁶³ While this does create higher spending, many Americans prefer this system since they have the ability to choose between two similar products or services.⁶⁴ In addition, greater capacity of hospitals and capital equipment results in lower waiting times and provides sufficient ability to deal with emergency situations, such as disease outbreaks, natural or intentional disasters, or large-scale accidents.⁶⁵

The differences in "prices of inputs used to produce health care" also attribute to the larger spending in the United States' health care system.⁶⁶ For example, certain brand named prescription drugs cost more in the United States than they do in other countries.⁶⁷ In addition, the cost of health care services related to those inputs is also higher.⁶⁸ Physicians, nurses, and other skilled

⁶¹ *Id.* at 10.

⁶² *Id.* It is suggested that the citizens of these countries "place some value on the use of these services, even if they have no particularly obvious impact on health outcomes such as life expectancy." OHSFELDT & SCHNEIDER, *supra* note 7, at 10. Without access constraints, "health spending in high income countries might be closer to U.S. spending levels." *Id.*

⁶³ *Id.*

⁶⁴ *Id.* at 10-11. The authors provide a non-health related analogy for "excess capacity" by looking at an example of two gas stations on opposite corners of an intersection that have very few customers. *Id.* at 11. While some may view this as "excess capacity," many consumers see this as a positive situation. OHSFELDT & SCHNEIDER, *supra* note 7, at 11. Consumers prefer to have an increased choice since it will likely lower the waiting time for gas. *Id.* In addition, by having two competing vendors, consumers are able to choose between higher quality goods or services at a lower price than they would in the absence of competition. *Id.*

⁶⁵ *Id.* at 10.

⁶⁶ *Id.* at 12.

⁶⁷ OHSFELDT & SCHNEIDER, *supra* note 7, at 12. One possible explanation for the United States high cost for prescription drugs compared to other OECD countries is the fact that pharmaceutical companies charge "more in less price-sensitive markets." *See id.* However, reducing price controls in the other OECD countries will likely not lower the cost of prescription drugs in the United States. *Id.* In addition, adding price controls in the United States will likely not cause an increase in prescription drug costs in the other OECD countries. *Id.* This can have devastating effects for those looking to pharmaceutical companies to develop new drugs for their health problem. *See id.* A higher cost for prescription drugs enables drug manufacturers to retain "an overall return on investment sufficient to finance research and develop . . . new products." OHSFELDT & SCHNEIDER, *supra* note 7, at 12.

⁶⁸ *Id.* Thus, even if residents of the United States and another OECD country, such as Canada, "consumed exactly the same quantities of health services, expenditures per capita would be higher in the United States, even after adjusting for economy-wide differences in price levels using a total purchasing power parity index." *Id.* Canada has a single-payer national health care system. Joseph Weber, *Canada's Health-Care System Isn't A Model Anymore*, BUS. WK., Aug. 31, 1998. Canada's health care system has often been offered as a solution to America's health care problems. *Id.*

employees earn more in the United States than they do in other countries, adding to the higher expenditures per capita in the United States.⁶⁹

An additional cost to the United States health care system is tort law.⁷⁰ With so many lawsuits brought against physicians and health care providers, they are forced to practice “defensive medicine” to reduce the chance of a law suit.⁷¹ In 1993, a study revealed that defensive medicine unnecessarily increased medical spending by five to fifteen billion dollars per year.⁷² While defensive medicine may lead to better patient care by “increasing the likelihood of early detection of a disease or condition, it often results in physicians ordering a great many unnecessary diagnostic tests for legal rather than medical purposes.”⁷³ In addition, in 2002, physicians spent over six billion dollars (and hospitals and nurses spent additional billions of dollars) on medical malpractice insurance.⁷⁴ Effective tort reform potentially could reduce medical care expenditures by \$70 billion to \$140 billion per year.⁷⁵ The major part of those savings would be to simply reduce unreasonable awards for non-economic damages, estimated to be between \$60 and

However, due to price controls, physicians’ incomes have been stagnated since 1993. *Id.* In response, physicians throughout Canada have started to shut down their offices for various periods of time ranging from five days to a month. *Id.* In addition, numerous hospitals have shut down, thereby extending the amount of time a patient has to wait for a common procedure. *Id.* Finally, a number of physicians are opting out of the state program and requiring that patients pay for their services. Weber, *supra*.

⁶⁹ OHSFELDT & SCHNEIDER, *supra* note 7, at 12.

⁷⁰ *Id.* at 14. The United States’ tort system “is the most expensive in the industrialized world and this high cost inevitably translates into higher liability insurance premiums for policy holders.” Robert P. Hartwig & Claire Wilkinson, *Medical Malpractice Insurance*, 1 INS. INFO. INST. 1, 4 (2003), available at http://server.iii.org/yy_obj_data/binary/729103_1_0/Medmal.pdf. In 2001, the current tort system cost the United States over \$205 billion, translating to \$721 per American. *Id.* In addition, medical malpractice costs rose 140 percent between 1990 and 2000. *Id.*

⁷¹ OHSFELDT & SCHNEIDER, *supra* note 7, at 14; Alan Feigenbaum, *Special Juries: Deterring Spurious Medical Malpractice Litigation in State Courts*, 24 CARDOZO L. REV. 1361, 1371 (2003); Hartwig & Wilkinson, *supra* note 70, at 5. The fear of being sued for medical malpractice has caused almost eighty percent of physicians to order unnecessary tests and seventy-four percent to refer a patient to a specialist even though it was not necessary based on their professional opinion. *Id.* “The increase in medical malpractice lawsuits and the corresponding rise in medical malpractice insurance premiums led, according to the HEW Report, to the practice of defensive medicine by physicians all over the country.” Feigenbaum, *supra*, at 1370. “The HEW Report describes defensive medicine as a means by which physicians try to avoid liability by taking extra precautionary measures, such as ordering more tests, regardless of their necessity.” *Id.* It “can be detrimental to a patient’s health, and its practice ultimately increases health care costs.” *Id.* at 1371. In fact, nearly seventy-six percent of physicians state that the increased concern of being sued for medical malpractice has “hurt their ability to provide quality care to patients.” Hartwig & Wilkinson, *supra* note 70, at 5.

⁷² Feigenbaum, *supra* note 71, at 1371.

⁷³ *Id.*

⁷⁴ Hartwig & Wilkinson, *supra* note 70, at 5.

⁷⁵ OHSFELDT & SCHNEIDER, *supra* note 7, at 14. However, others studies have found that medical malpractice claims are only “modestly higher in the United States than in other high-income developed countries.” *Id.* at 14-15. Nevertheless, “it seems clear that effective tort reform would reduce spending on health care at least modestly.” *Id.* at 15. In addition, “various forms of tort reform enacted from 1984 to 1990 reduced the costs of health care without any discernable impact on patient outcomes.” *Id.* at 14.

\$108 billion a year.⁷⁶ This would ultimately reduce health care premiums and allow “an additional 2.4 to 4.3 million Americans to obtain insurance.”⁷⁷

One possible solution to the United States’ health care spending problem is to significantly reduce “payments to providers of health services.”⁷⁸ Such a reduction in the income of physicians, nurses, and other skilled health sector labor would “eliminate a substantial portion of the alleged excess in U.S. health care expenditures.”⁷⁹ However, “the return on investment in medical education is pretty much in line with the . . . return . . . for other professional occupations, such as an attorney or business executive.”⁸⁰ Thus, any reduction in income would result in a decrease in the number of individuals going into the medical profession since those individuals would get more return on their educational investment in other professions.⁸¹ In addition, any reduction could be short lived since a low supply of physicians and nurses coupled with the high demand for their services would likely drive costs back up.⁸² Finally, given the current shortage of nurses, any significant reduction in wages would only exacerbate the situation.⁸³

Another possible solution to the increased cost of health care is to reduce the amount of “wasteful” administrative costs.⁸⁴ However, this would require a

⁷⁶ Hartwig & Wilkinson, *supra* note 70, at 6.

⁷⁷ *Id.*

⁷⁸ OHSFELDT & SCHNEIDER, *supra* note 7, at 13.

⁷⁹ *Id.* It is argued that such reductions would bring the United States to Canadian levels which have not changed since 1990. *Id.*

⁸⁰ *Id.*

⁸¹ *Id.* “The health sector must compete with other sectors for labor, so it is doubtful that physicians’ incomes could be reduced substantially without adversely affecting the supply of physician services.” OHSFELDT & SCHNEIDER, *supra* note 7, at 13. In 2004, an individual had to wait between eight days in Atlanta to forty-three days in Los Angeles to be able to see an orthopedic surgeon. Catherine Arnst, *The Doctor Will See You – In Three Months*, BUS. WK., July 9, 2007, available at http://www.businessweek.com/magazine/content/07_28/b4042072.htm. In addition, forty-seven percent of Americans are able to get a same day or next day doctor appointment as compared to eighty-one percent in New Zealand. *Id.*; JUDITH FRETTER & MADHUKAR PANDE, FORECASTING GP WORKFORCE CAPACITY: TOWARDS AN UNDERSTANDING OF GP WORKFORCE CAPACITY, LONG-TERM FORECASTING AND BENCHMARKING TOOLS (2006), available at <http://www.rmzcp.org.nz/assets/Uploads/WorkforceCapacityOP84WEB.pdf>. In New Zealand the physicians/patient ratio is 1 physician to every 1,318 patients, as compared to the United States’ which has a ratio of 2.8 physicians for every 1,000 patients. FRETTER & PANDE, *supra*, at 81.

⁸² See OHSFELDT & SCHNEIDER, *supra* note 7, at 13. This would likely be the case unless costs were artificially held such as in Canada. See *id.*

⁸³ *Id.*

⁸⁴ *Id.* “Those who contend that waste and inefficiency are significant contributors to excess health spending in the United States often point to administrative costs as a salient metric.” *Id.* However, for-profit organizations generally “focus on the difference between total revenue and total costs; the share of costs classified as administrative at any point in time is not an especially salient issue.” OHSFELDT & SCHNEIDER, *supra* note 7, at 13-14. In contrast, tax-exempt organizations focus on the provision of service. *Id.* at 13. These organizations “have an incentive to use their discretion to maximize their reported levels of expenditures for services and minimize costs attributed to administration or overhead in reports to donors and regulators.” *Id.* Thus, studies finding that tax-exempt organizations have lower overall costs compared to for-profit organizations do not provide a meaningful interpretation. *Id.* at 14.

definition of what is wasteful.⁸⁵ Studies have shown that “more than one-third of the total administrative costs of commercial health insurance plans in California [were] attributed to customer service, information services, and major clinical activities, such as case management.”⁸⁶ The associated costs are necessary to properly inform customers of the services provided in a convenient and timely manner.⁸⁷ This level of service is expected by the United States consumers and is generally not considered “wasteful.”

While the United States has a higher overall level of health care spending than other OECD countries,⁸⁸ the rate of *growth* is not noticeably higher.⁸⁹ This is due to the fact that most OECD countries have experienced an increased growth in per capita spending similar to the United States.⁹⁰ For example, between 1980 and 1984, the United States and Canada’s growth in health spending per capita was tied at about nine percent.⁹¹ Between 1995 and 1999, the growth rates were almost tied again at about three percent.⁹² Why does this occur when other health care systems have access restrictions, cost-control measures, and centralized global budgeting?⁹³ It is most likely due to the fact that OECD countries are experiencing very common trends, such as an aging population.⁹⁴ Thus, while the United States spends more on health care than other OECD countries, its rate of growth is consistent with other OECD countries.⁹⁵ This suggests that any health reform similar to that of other OECD countries will not lower the United States’ high rates

⁸⁵ *Id.* at 14. “[A] managerial function is essential to the operation of any organization, and can serve to ensure access to needed services while reducing utilization of less valuable ones.” OHSFELDT & SCHNEIDER, *supra* note 7, at 14.

⁸⁶ *Id.* Those who view administrative costs as wasteful look to universal health care systems such as Canada. *See id.* However, “the Canadian health system makes very limited use of patient or provider financial incentives or utilization management mechanisms to avoid unnecessary care.” *Id.* This results in “queues for ‘free’ services, which impose substantial costs on health care consumers.” *Id.* “Thus, simply comparing self-reported costs for management effort across different types of organizations in different health systems, and asserting that this is a valid measure of waste, fails to provide any useful evidence concerning comparative efficiency.” OHSFELDT & SCHNEIDER, *supra* note 7, at 14.

⁸⁷ *Id.*

⁸⁸ *Id.* at 15. United States spends more than other countries on health care partially due to the fact that the individuals in the United States have a higher income than individuals in other countries that have implemented health care systems with stronger government involvement. Graham, *supra* note 51, at A25. Even after paying for health care, Americans have \$8,000 more than individuals in Germany or France and \$4,000 more than individuals in Canada to spend on other goods and services. *Id.*

⁸⁹ OHSFELDT & SCHNEIDER, *supra* note 7, at 15.

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.* “This similarity exists despite the higher rate of growth in GDP in the United States, and despite the administered pricing, centralized global budgeting, access restrictions, and other cost-control measures often employed in other systems.” OHSFELDT & SCHNEIDER, *supra* note 7, at 15-16.

⁹⁴ *Id.*

⁹⁵ OHSFELDT & SCHNEIDER, *supra* note 7, at 15-16.

of growth in spending.⁹⁶

D. Health Care Costs for Small Businesses

While Americans are looking for a solution to the United States' health care problems, many small business owners do not favor a system that increases the government's involvement.⁹⁷ Small businesses have a strong presence when it comes to health care reform since they create sixty to eighty percent of all new jobs and employ half of the United States' workforce.⁹⁸ Given this strong presence, health care reform must focus on the needs of small businesses.

The current increased cost of health care has had a devastating effect on many small businesses.⁹⁹ Each employee's total annual costs for health care benefits rose from \$4,440 in 2000 to \$6,200 in 2003.¹⁰⁰ Since 2001, health care premiums have increased by seventy-eight percent.¹⁰¹ In 2003, "private business [health care] expenditures reached \$423 billion."¹⁰² Of the \$423 billion, employers paid seventy-six percent in employer-sponsored health insurance premiums and fifteen percent in employer payroll taxes for Medicare.¹⁰³ This cost

⁹⁶ See *id.* "Whatever the defects of the U.S. system, if they contribute to an unusually high level of spending, they cannot also be said to contribute to unusually high rates of growth in spending." *Id.*

at 16.

⁹⁷ See Steve Garmhausen, *States & Localities: Prognosis Upgraded*, C.Q. WKLY., May 21, 2007, available at <http://public.cq.com/docs/cqw/weeklyreport110-000002515498.html>. A study of 135 top executives revealed that "eighty-seven percent of employers do not wish to abandon employer-sponsored health insurance." *Id.*

⁹⁸ Douglas MacMillan, *Who is the "Small Business" President?*, BUS. WK., Nov. 15, 2007, available at http://www.businessweek.com/smallbiz/content/nov2007/sb20071114_720181.htm; SUSAN STARR SERED & RUSHIKA FERNANDOPULLE, *UNINSURED IN AMERICA: LIFE AND DEATH IN THE LAND OF OPPORTUNITY* 113 (University of California Press 2005).

⁹⁹ See SERED & FERNANDOPULLE, *supra* note 98, at 115. A study conducted by the Entrepreneurs' Organization in 2007 showed that more than three-fourths of small business owners who made at least one million dollars in annual revenues were "very concerned" or "concerned" with the rising health care cost on their business. MacMillan, *supra* note 98. However, one proposed solution to reduce the costs of health care for businesses is to implement a single-payer health care system similar to Canada or Germany. Gottschalk, *supra* note 12, at 954. However, many of the businesses and individuals in these single-payer health care systems pay a large amount of indirect taxes "to support more extensive public welfare states." *Id.* at 949. Generally, these costs exceed the highest costs an American business spends on its employees. *Id.* For example, in Germany, "the cost of employment-related health benefits as a percentage of payroll is nearly [fifty] percent greater . . . than in the United States." *Id.*

¹⁰⁰ See SERED & FERNANDOPULLE, *supra* note 98, at 115. The health care cost included "both employer and employee contributions for health, dental, and vision insurance and take into account dependant coverage." *Id.*

¹⁰¹ Arnst, *supra* note 13.

¹⁰² Cathy A. Cowan & Micah B. Hartman, *Financing Health Care: Businesses, Households, and Governments, 1987-2003*, HEALTH CARE FINANCING REV., July 2005, at 7, <http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/bhg-article-04.pdf> (last visited Feb. 8, 2008). This is a 7.1 percent increase since 2002. *Id.*

¹⁰³ *Id.*

is simply too high for many small businesses owners.¹⁰⁴ For example, twenty percent of small businesses expected to slow hiring in 2006 due to health care costs.¹⁰⁵ The high cost of health care places small businesses at a competitive disadvantage since businesses need to offer potential and current employees health care benefits in order to be able to effectively recruit and retain employees.¹⁰⁶

Despite “ongoing state and federal efforts to address this problem through legislature,” more and more businesses are denying health care coverage to employees.¹⁰⁷ Between 2000 and 2006, the number of employers offering health insurance to their employees declined from sixty-nine percent to sixty-one percent.¹⁰⁸ This decline occurred almost entirely in businesses with fewer than ten employees.¹⁰⁹ In fact, forty-six percent of small businesses with less than ten employees are unable or unwilling to provide health care for their employees, as opposed to the only five percent of large businesses with over 100 employees.¹¹⁰

Why are small businesses, not large businesses, unable to provide health care to their employees? Eighty-three percent of small businesses blame high premium costs.¹¹¹ Small businesses “lack the negotiating clout of larger businesses.”¹¹² This results in small businesses paying more for similar coverage as well as receiving greater annual premium increases.¹¹³ Also, insurance companies require

¹⁰⁴ See SERED & FERNANDOPULLE, *supra* note 98, at 115. Many small business owners agonize over the cost of health care and continually have to decide whether to keep health care and exceed profits or stop providing health care to their employees. Richard S. Dunham & Keith Epstein, *Stopping Reform Before It Starts*, BUS. WK., Apr. 16, 2007, available at http://www.businessweek.com/magazine/content/07_16/b4030078.htm.

¹⁰⁵ Tom Daschle, *Health Reform: Good Business*, BUS. WK., Apr. 10, 2006, http://www.businessweek.com/magazine/content/06_15/b3979134.htm.

¹⁰⁶ See SERED & FERNANDOPULLE, *supra* note 98, at 113.

¹⁰⁷ *Id.* For instance, in 2005, “the Massachusetts House of Representatives approved a payroll tax of [five to seven] percent to be levied on employers who have more than ten employees and do not offer health insurance.” Gottschalk, *supra* note 12, at 937. However, when the bill was finally enacted in April 2006, a number of employers did not have to pay the payroll tax and instead simply had to pay a \$295 fee for each employee not covered. *Id.* Thus, “reformers were unable to force employers to make a modest contribution toward paying for their employees’ health insurance . . .” *Id.*

¹⁰⁸ Gottschalk, *supra* note 12, at 927. From 1980 to 2003, medium and large sized businesses offering health care dropped from ninety-seven percent to sixty-five percent. *Id.* at 927-928. From 1990 to 2003, the number of small businesses offering health care benefits dropped from sixty-nine percent to forty-two percent. *Id.* at 928. In fact, in 2006, only “half of workers employed in the private sector participated in employment-based health plans.” *Id.* at 928.

¹⁰⁹ Graham, *supra* note 51, at A25.

¹¹⁰ BARR, *supra* note 2, at 13. In fact, one hundred percent of firms with over two hundred employees offered health care to their employees while only about fifty-seven percent of firms with fewer than twenty employees did. SERED & FERNANDOPULLE, *supra* note 98, at 114.

¹¹¹ SERED & FERNANDOPULLE, *supra* note 98, at 114. “In 2006, premiums for employer-sponsored health plans rose 7.7 percent on average, the lowest increase since 2000.” Gottschalk, *supra* note 12, at 948.

¹¹² SERED & FERNANDOPULLE, *supra* note 98, at 114.

¹¹³ *Id.*

small businesses to “experience rate” each employee.¹¹⁴ This results in high premiums since premiums are based on the perceived health risks of certain workers.¹¹⁵ This requirement is generally waived for large businesses.¹¹⁶ Thus, small business owners are forced to choose between providing health care to their employees or maintaining their business.¹¹⁷

Another problem facing small businesses is administrative costs.¹¹⁸ In order to process health insurance claims, most small businesses generally spend between thirty-three and thirty seven percent of the total claims on administrative costs.¹¹⁹ On the other hand, administrative costs for large businesses generally range between five and eleven percent.¹²⁰ This huge difference in percentage is due to economies of scale. No matter how many employees a company employs, there is a minimal amount of administrative cost that must be provided. This high cost of administering health care claims discourages many small businesses from providing any health care at all.

In addition, small businesses are discouraged from providing employee health care since they are subject to state mandates dealing with health insurance coverage.¹²¹ States have created almost 1,900 mandated health care benefits that employers must provide to their employees.¹²² It has been estimated that state mandates increased premiums by more than twenty percent in 2007.¹²³ On the other hand, large businesses usually are exempt from state health care mandates

¹¹⁴ *Id.* “Thus, even one sick worker (or child of a worker) can make insurance unaffordable for the whole group.” *Id.* at 114-115. One possible solution to help reduce the increased costs to businesses employing health risk individuals is to require those individuals to pay a larger share of their health benefit costs. Garmhausen, *supra* note 97. A study of 135 top executives revealed that sixty-two percent thought their company “should require employees who exhibit unhealthy behaviors—from obesity to smoking- to pay a larger share of their health benefit costs.” *Id.*

¹¹⁵ SERED & FERNANDOPULLE, *supra* note 98, at 114.

¹¹⁶ *Id.*

¹¹⁷ *Id.* at 115.

¹¹⁸ *Id.* at 114. “Administrative costs for employers, insurers, and health care providers comprise at least one-quarter of total spending on health care in the United States.” Gottschalk, *supra* note 12, at 950. It is suggested that if administrative costs were similar to Canada’s, total health care costs in the United States would be reduced by seventeen percent. *Id.*

¹¹⁹ *Id.*

¹²⁰ SERED & FERNANDOPULLE, *supra* note 98, at 114.

¹²¹ *Id.* The United States provides businesses with the ability to “opt out of the government-regulated health ‘system,’ if it allows them to be more competitive.” Graham, *supra* note 51, at A25. Thus, since small businesses have found that health care costs are unaffordable given the fact that states have implemented the “massive burden of overregulation on small-group health insurance since the early 1990s,” many are choosing to contract employment without health benefits. *Id.* For instance, small businesses in Massachusetts are required to cover infertility treatment. SERED & FERNANDOPULLE, *supra* note 98, at 114.

¹²² Glen Whitman, *Bad Medicine For Health Care*, BUS. WK., Oct. 15, 2007, available at http://www.businessweek.com/magazine/content/07_42/b4054081.htm.

¹²³ *Id.*

under the Employee Retirement Income Security Act (ERISA).¹²⁴

Finally, even one employee with a serious health problem can have devastating effects for a small business.¹²⁵ Large businesses generally do not face this problem since employees with serious health problems are relatively few and are distributed in a wider field.¹²⁶ However, in a small business, one employee with a serious health problem “can cause rates to rise to a point where the employer is forced to cancel the insurance, close the company, or release the employee (which is not legal).”¹²⁷

Small businesses are looking to the both the state and federal government “to pass a series of measures that would give small businesses more insurance choices and make the system more affordable.”¹²⁸ Mainly, small businesses are seeking to pool together with other small businesses to purchase insurance at lower premiums.¹²⁹ Small businesses are also lobbying to be able to purchase health care from any state, as opposed to only purchasing from the state of their “home base.”¹³⁰ They also want to receive the same health care tax breaks that large employers receive.¹³¹ Finally, small businesses would like to expand health savings accounts as well as receive more tax incentives in order to offer Health Security Accounts (HSAs) to their employees.¹³²

¹²⁴ SERED & FERNANDOPULLE, *supra* note 98, at 114. ERISA is a federal legislature passed in 1974 which “preempts state laws that ‘relate to any employee benefit plan’.” Gottschalk, *supra* note 12, at 955. For instance, ERISA is able to provide “an exemption for self-insured large employers from state insurance benefit regulations.” SERED & FERNANDOPULLE, *supra* note 98, at 114.

¹²⁵ SERED & FERNANDOPULLE, *supra* note 98, at 116. ERISA is a federal legislature passed in 1974 “that, among other things, exempts self-insured large employers from state insurance benefit regulations.” *Id.*

¹²⁶ *Id.*

¹²⁷ *Id.* at 114.

¹²⁸ Dunham & Epstein, *supra* note 104.

¹²⁹ *Id.* Such a policy would give small businesses a stronger negotiating clout much closer to that of the large businesses. See SERED & FERNANDOPULLE, *supra* note 98, at 114.

¹³⁰ Dunham & Epstein, *supra* note 104. This system would likely drive down costs due to the fact that insurance companies would have to compete against insurance companies in other states offering the same coverage at a lower cost. Merrill Mathews, *A Health-Insurance Solution*, WALL ST. J., Dec. 12, 2007, at A18, available at <http://online.wsj.com/article/SB119742880091722751.html>.

¹³¹ Dunham & Epstein, *supra* note 104.

¹³² *Id.* HSAs are part of a Medicare prescription-drug bill that provided for tax-free health security accounts enacted in November 2003. Gottschalk, *supra* note 12, at 938. It provides that health savings accounts be provided to anyone who is “enrolled in a catastrophic insurance plan that has high deductibles of at least \$1,000 for individuals and \$2,000 for families.” *Id.* Both employers and employees are able to contribute to the health savings accounts and the funds “are portable from job to job.” *Id.* Between 2003 and 2005, the number of employers providing employment-based health insurance plans with high deductibles has increased 15 percent. *Id.* at 938-939. However, HSAs do have their problems. *Id.* at 939. Employees are faced with “exorbitant deductibles and out-of-pocket expenses and uncertainties about what medical services are covered by HSAs.” Gottschalk, *supra* note 12, at 938. In addition, HSAs may lead to higher premiums for individuals purchasing traditional health insurance due to the fact that younger and healthier individuals are more likely to enroll in the HSAs program and will no longer offset the costs of the old and sick individuals. *Id.*

III. HILLARY CLINTON'S AMERICAN HEALTH CHOICES PLAN¹³³

A. Overview

¹³³ In 1993, Hillary Clinton proposed a 1,342 page plan to Congress for health care reform. Patrick Healy & Robin Toner, *Wary of Past, Clinton Unveils a Health Plan*, N.Y. TIMES, Sept. 18, 2007, <http://www.nytimes.com/2007/09/18/us/politics/18clinton.html?ex=1347768000&en=32445ac23a487748&ei=5088&partner=rssnyt&emc=rss> (last visited Feb. 8, 2008). The 1993 plan would have required individuals and employers to join "regional alliances" in order to purchase coverage. *Id.* Total health spending would have been controlled through a "complicated system of managed competition, and would have created a National Health Board with sweeping authority to regulate the system." *Id.* The 1993 system also would have required that all businesses provide coverage to their employees or face a heavy fine. *Id.* However, the plan left little room for compromise and almost derailed Bill Clinton's presidency. *Id.* Due to Hillary Clinton's health care reform failure in 1993-1994, candidates now limit the amount of detail they provide in their proposed health care reform since they fear that more detail will lead to more political problems, such as turning off voters. Arnst, *supra* note 13. Thus, until a candidate is elected to the presidency, Americans will not know the full extent of the candidate's proposed health care reform. *See id.* However, while candidates limit the detail of their plans, Americans are still provided with a basic model to compare each candidate's proposed solution.

Based on the information President Obama and Hillary Clinton provided about their proposed health care reform during the Democratic primaries, Americans can see that there are a number of similarities between the two plans. Both President Obama's proposed health care reform and Hillary Clinton's American Health Choices Plan provide Americans with the option to buy government-offered insurance. Hillary Clinton, *Hillary Clinton's American Health Choices Plan*, at 6, <http://www.hillaryclinton.com/feature/healthcareplan/americanhealthchoicesplan.pdf> (last visited Mar. 30, 2009); Barack Obama & Joe Biden, *Plan for a Healthy America*, <http://www.barackobama.com/issues/healthcare/> (last visited Mar. 30, 2009). In addition, for those individuals who wish to stay with their current provider, both plans require private insurers to offer policies to every American, regardless of his or her medical history. Clinton, *supra*, at 5-6; Obama & Biden, *supra*. President Obama and Hillary Clinton are essentially attempting to make health care insurance affordable to all Americans. Clinton, *supra*, at 1; Obama & Biden, *supra*.

However, there is one major difference between the two plans. While Hillary Clinton's plan would mandate health care for every American, President Obama's plan would only mandate it for children. Clinton, *supra*, at 6; *HillaryCare v. Obama*, WALL ST. J., Jan. 7, 2008, at A12, *available at* http://online.wsj.com/article/SB119966560507871097.html?mod=opinion_main_review_and_outlooks. This failure to require that every American have health care means that President Obama's plan could potentially leave up to fifteen million people uninsured, or three percent of the population, a figure similar to the number of individuals who currently need health insurance but are unable afford it under the United States' current system. Gerald McEntee, *Clinton or Obama: On Health Care the Difference is Big*, HUFFINGTON POST, Feb. 5, 2008, http://www.huffingtonpost.com/gerald-mcentee/clinton-or-obama-on-he_b_85144.html (last visited Mar. 30, 2009); *see infra* Part III.G. President Obama hopes that by making health care affordable to all Americans they all will partake in the program and he will be able to overcome this problem. Paul Krugman, *Clinton, Obama, Insurance*, N.Y. TIMES, Feb. 4, 2008, http://www.nytimes.com/2008/02/04/opinion/04krugman.html?_r=1 (last visited Mar. 30, 2009). *But see infra* Part III.G; Betsy McCaughey, *The Truth About Mandatory Health Insurance*, WALL ST. J., Jan. 4, 2008, at A11, *available at* <http://online.wsj.com/article/SB119941501118966929.html>. However, his plan runs the risk of having healthy individuals "decide to take their chances and [to not] sign up until they [have] develop[ed] medical problems, thereby raising premiums for everyone." Krugman, *supra*. In addition, a study conducted by Jonathan Gruber, an M.I.T. professor and one of the United States' leading health care economists, found that a plan without mandates, such as President Obama's plan, would cover significantly less people and would cost more per person than a plan with mandates, such as Hillary Clinton's plan. Jonathan Gruber, *Covering the Uninsured in the United States*, 46 J. ECON. LITERATURE 571 (2008). It has been determined that President Obama's plan would cost \$4,400 for each newly insured individual, while Hillary Clinton's plan would only cost \$2,700 for each newly insured individual. Krugman, *supra*.

Hillary Clinton's American Health Choices Plan provides for a mandated employer health care system.¹³⁴ The main goal is to ensure that to all Americans are able to purchase "affordable quality health insurance."¹³⁵ As it implies, her plan is designed to provide Americans with choices.¹³⁶ While Americans will be required to purchase health care, they will be able to choose between maintaining their current coverage and enrolling in a public plan.¹³⁷ Those who choose to enroll in the public plan will be able to choose from the same menu of quality private insurance options offered to members of Congress.¹³⁸ In addition, Hillary Clinton hopes to lower premiums and to provide a higher quality of health care for those Americans who keep their existing coverage by "removing hidden taxes, stressing prevention and a focus on efficiency and modernization."¹³⁹

B. Eliminating Insurance Discrimination

Another goal of the American Health Choices Plan is to eliminate insurance discrimination.¹⁴⁰ Hillary Clinton hopes that by covering all Americans, the average age of the insured will be less, thereby reducing the average premium.¹⁴¹ The plan would require that insurance companies provide coverage to anyone who applies.¹⁴² Since "insurance companies in America spend tens of billions of dollars per year figuring out how to avoid costly beneficiaries," eliminating discrimination will reduce cost and therefore premiums.¹⁴³ The American Health Choices Plan will also prohibit insurers from charging large premiums to individuals with greater health care costs or risks.¹⁴⁴ Finally, the plan will require

¹³⁴ Op-Ed, *Election 2008: Voices of Reform*, BUS. WK., Dec. 14, 2007, available at http://www.businessweek.com/magazine/content/07_72/s0712017752105.htm (last visited Feb. 9, 2008).

¹³⁵ Clinton, *supra* note 133, at 1.

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ *Id.* The public plan option is modeled after the traditional Medicare program but also offers the same benefits as a private plan offered to the members of Congress in the Health Choices Menu. *Id.* at 4. It is designed to "compete on a level playing field with traditional private insurance plans." Clinton, *supra* note 133, at 4. This government-run plan would be similar to the single-payer health care systems implemented in Canada and some European countries. Karen Tumulty, *Hillary's Health Care Do-Over*, TIME, Sept. 17, 2007, <http://www.time.com/time/politics/article/0,8599,1662655,00.html> (last visited Feb.9, 2008).

¹³⁹ Clinton, *supra* note 133, at 1.

¹⁴⁰ *Id.* at 4. The plan provides rules that health insurance companies must follow. *Id.* at 5. These rules are designed to ensure "that no American is denied coverage, refused renewal of an insurance policy, unfairly priced out of the market, or charged excessive insurance premiums." *Id.*

¹⁴¹ *Id.* at 4. This will most likely be achieved by forcing young Americans to purchase health care, thereby increasing their costs. McCaughey, *supra* note 133, at A11.

¹⁴² Clinton, *supra* note 133, at 5.

¹⁴³ *Id.* at 4.

¹⁴⁴ *Id.* at 5. Mainly, insurance companies would not be able to increase premiums for individuals due to their age, gender, or occupation. *Id.*

that insurance companies use the premiums to improve the quality of health care, as opposed to achieving excessive profits.¹⁴⁵

C. Projected Savings

The American Health Choices Plan projects to save \$120 billion per year through four distinctive means.¹⁴⁶ First, Hillary Clinton hopes to ensure that all providers and plans will use privacy protected information technology.¹⁴⁷ She believes this will give physicians “financial incentives to adopt health information technology and to facilitate adoption of a system where high quality care and better patient outcomes can be rewarded.”¹⁴⁸ It has been estimated by Hillary Clinton’s economist that this alone will save Americans seventy-seven billion dollars per year.¹⁴⁹ Second, Hillary Clinton wants to prioritize prevention in hopes of reducing the incidence of disease.¹⁵⁰ It is stated that “only half of recommended clinical preventative services are provided to adults and less than half of adults have their doctors provide them advice on weight, nutrition, or exercise.”¹⁵¹ Third, the plan proposes to improve the care of the chronically ill by promoting chronic care management and innovative models.¹⁵² Fourth, Hillary Clinton wants to fund independent research to compare the effectiveness of different treatments, distributing this research to patients and doctors in order to increase the quality of care and thus reduce costs.¹⁵³

¹⁴⁵ *Id.*

¹⁴⁶ Clinton, *supra* note 133, at 5-6.

¹⁴⁷ *Id.* at 5. Hillary Clinton wants to get rid of paper-based medical records and billing by implementing privacy protected information technology. Hillary Clinton, *Hillary Clinton Announces Agenda to Lower Health Care Costs and Improve Value for All Americans*, <http://www.hillaryclinton.com/feature/healthcare/> (last visited Feb. 9, 2008). She believes that by allowing physicians and other health care providers to communicate electronically, waste, redundancy and medical errors will be reduced. *Id.*

¹⁴⁸ Clinton, *supra* note 133, at 5.

¹⁴⁹ *Id.*

¹⁵⁰ *Id.* The limited use of preventative care imposes huge human and financial burdens since treatment costs are much more costly than preventative medicine. *Id.*

¹⁵¹ *Id.*

¹⁵² Clinton, *supra* note 133, at 5-6. Seventy-five percent of the United States’ health expenditures go towards Americans with multiple chronic diseases. *Id.* at 6. Under chronic care management “objective medical evidence [is used] to manage the care given by various providers to patients with chronic disease or patients at the end of life.” Steven Pearlstein, *A Healthy Dose of Hillary*, WASH. POST., Sept. 19, 2007, available at <http://www.washingtonpost.com/wp-dyn/content/article/2007/09/18/AR2007091802075.html?hpid=topnews>. However, in actually practicing this, it will require that “a trained health professional hired by an insurance company is going to have to tell other doctors how to practice medicine and tell patients what drugs and tests and surgical procedures [will not] be covered by insurance.” *Id.* Thus, it will result in managed care and a rationing of services provided to Americans. *Id.*

¹⁵³ Clinton, *supra* note 133, at 5. In the past decade, there has been a huge growth in effective medical diagnosis and treatment. *Id.* The plan will fund “a Best Practices Institute that would work as a partnership between the existing Agency for health care Research and Quality and the private sector

D. Promoting Shared Responsibility

Hillary Clinton's plan hopes to deal with some of the cost problems presented in the current United States' health care system by containing costs.¹⁵⁴ She hopes to achieve this by ensuring that every American contributes to the "financing and management" of the health care system.¹⁵⁵ Specifically, the plan mandates that every American purchase health care.¹⁵⁶ Individuals who do not receive coverage from their employers will be required to purchase it themselves through private insurance companies or through the government program.¹⁵⁷ The government would provide federal subsidies to those individuals who are unable to afford health care.¹⁵⁸ In addition, employers will be required to contribute to an employee's health coverage.¹⁵⁹ Large firms will be required to offer insurance to employees or contribute to a government-run pool that would help those not covered, while small businesses will be offered tax incentives to continue or to begin to provide insurance for employees.¹⁶⁰ The plan will also required insurance and drug companies to "end discrimination based on pre-existing conditions or

to fund research on what treatments work best and to help disseminate this information to patients and doctors to increase quality and reduce costs." *Id.*

¹⁵⁴ *Id.* at 6. Hillary Clinton believes that one of the major problems with the current health care system is the fact that it fails to provide incentives for people to promote their own health and instead encourages people to wait until their symptoms are more severe. *Id.* This occurs since some Americans with high deductible insurance plans often wait until their health problem is more severe simply to attempt to avoid paying the deductible. Clinton, *supra* note 133, at 6. Thus, Hillary Clinton sees the current system as paying more for an acute treatment than for preventive medicine. *Id.* Hillary Clinton states that another problem with the current health care system in the United States is that it charges insured families a "hidden tax" by raising premiums almost \$900 in order to pay for uninsured Americans. *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.* Hillary Clinton plans to mandate health care. Clinton, *supra* note 133, at 6. This is necessary for her plan to potentially succeed since insurance companies are required to offer insurance to the elderly and sick. *Id.* Hillary Clinton's plan will need to ensure that there are healthy individuals purchasing insurance in order to financially balance out the sick. Laura Meckler, *Health-Care Plans Aid Industry*, WALL ST. J., Nov. 19, 2007, at A8. In addition, some suggest that doctors, hospitals and other health care providers may benefit from mandated health care since it will likely increase the number of patients seeking care who can pay their bills. *Id.*

¹⁵⁷ Clinton, *supra* note 133, at 6.

¹⁵⁸ PAUL STEINHAUSER & CANDY CROWLEY, CLINTON UNVEILS MANDATORY HEALTH CARE INSURANCE PLAN, CNN, (2007), <http://www.cnn.com/2007/POLITICS/09/17/health.care/index.html#cnnSTCText> (last visited Feb. 5, 2008).

¹⁵⁹ Clinton, *supra* note 133, at 6.

¹⁶⁰ *Id.* Hillary Clinton has apparently learned from her proposed 1993 health care system which failed due to opposition from small businesses and insurance companies. See Laura Meckler & Jackie Calmes, *Clinton Health Plan Courts Business Allies*, WALL ST. J., Sept. 18, 2007, available at <http://online.wsj.com/article/SB119004213650929861>. Her current proposed plan will not require small businesses to provide health care to their employees. STEINHAUSER & CROWLEY, *supra* note 158; Dunham & Epstein, *supra* note 104. She knows that any health care which includes "government mandates or [increases] costs on the small-business sector . . . [is] going to be very difficult to pass." *Id.*

expectations of illness and ensure high value for every premium dollar.”¹⁶¹ Drug companies will be required to offer fair prices for their products and to provide accurate information to doctors and consumers.¹⁶² Finally, the government will be required to ensure that health care is affordable “through investments in tax credits and the safety net so that coverage is never again a crushing financial burden.”¹⁶³

E. Ensuring Affordable Health Coverage for All

As stated earlier, Hillary Clinton’s plan will attempt to ensure that all Americans have affordable health care. In order to achieve this goal, premium payments will be based on a percentage of the individual’s income.¹⁶⁴ Hillary Clinton also wants to “help working families afford coverage through refundable, income-related tax credits to ensure that accessible, high-quality health coverage is affordable to all.”¹⁶⁵ She also believes that lowering the cost of and improving the quality of health care will lower costs to employers, giving them the incentive to offer new health benefits to their workers.¹⁶⁶ The plan requires that large employers provide health insurance to their employees or at least make some contribution to the employee’s cost of health care.¹⁶⁷ Under the plan, small businesses will be provided a refundable tax credit if they provide quality coverage and pay for most of their workers’ premiums.¹⁶⁸ In addition, Hillary Clinton wants to strengthen Medicaid and the State Children’s Health Insurance Program in order to serve all low income individuals.¹⁶⁹ Finally, the American Health Choices Plan will provide a tax credit for qualifying private and public retiree health plans in order to offset a significant portion of catastrophic expenditures that exceed a certain threshold.¹⁷⁰

¹⁶¹ Clinton, *supra* note 133, at 6.

¹⁶² *Id.*

¹⁶³ *Id.* Clinton’s plan will provide tax credits to help those Americans who are forced to “spend more than a certain percentage of their income on insurance” pay for health care. Meckler & Calmes, *supra* note 160. In addition, the government will have to “end the upward cost spiral of the system that threatens [America’s] health and economy.” *Id.*

¹⁶⁴ Clinton, *supra* note 133, at 7. Thus, premium payments will continue to rise as an individual’s income increases. *Id.*

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ *Id.* at 7-8. This will have little to no effect on large businesses since a majority of large businesses already provide health care to their employees. Meckler & Calmes, *supra* note 160.

¹⁶⁸ Clinton, *supra* note 133, at 8. Hillary Clinton defines small businesses as those businesses which have fifteen employees or less. Meckler & Calmes, *supra* note 160. According to Neera Tanden, Hillary Clinton’s policy director, the tax credit would probably amount to about seventy-five percent of the total health care costs for the small business. Op-Ed, *supra* note 134. However, once a business reaches over twenty-five employees the tax credit would be phased out. Meckler & Calmes, *supra* note 160. Thus, this may result in small businesses refusing to grow in order to maintain the tax credit.

¹⁶⁹ Clinton, *supra* note 133, at 8.

¹⁷⁰ *Id.*

F. Projected Savings

While Hillary Clinton believes that over time her proposed health care reform will slow the United States' health care growth, funds will be needed to put the program into place.¹⁷¹ Hillary Clinton hopes to obtain these needed funds by reducing excess expenditures in the current health care system.¹⁷² Specifically, her plan estimates that ten million dollars can be saved simply by getting rid of excessive Medicare overpayments to HMO'S and other managed care plans.¹⁷³ In addition, she projects that an additional seven billion dollars can be saved by mandating that every American have health care, thereby eliminating uncompensated care payments.¹⁷⁴ She also believes that an additional four billion dollars can be saved by increasing Medicare's purchasing leverage with pharmaceutical companies to help lower prescription drug costs.¹⁷⁵ Finally, she estimates that "providing better technology and clinical best practice [will] improve quality, reduce errors, and eliminate extraordinary expensive waste," reducing costs by at least another thirty-five billion dollars.¹⁷⁶

¹⁷¹ *Id.* at 9.

¹⁷² *Id.*

¹⁷³ *Id.* Such an overpayment "reduces Medicare Trust Fund solvency and raises premiums for Medicare beneficiaries." Clinton, *supra* note 133, at 9. In addition, this reform "would include policies to improve access to programs that provide cost-sharing protections to low-income beneficiaries." *Id.*

¹⁷⁴ *Id.* Currently, the disproportionate share hospital (DSH) provides payments to providers in an attempt to reduce the burden of uncompensated care. *Id.* However, any reduction in DSH payments has to be proportionate to the increased number of currently uninsured individuals who become insured. *Id.* As the number of insured Americans increases, the "percentage of savings from reduced DSH liabilities should be reinvested in public hospitals, community health centers, and surge capacity to ensure health system capacity during natural disasters, epidemics, or when national security is threatened." Clinton, *supra* note 133, at 9.

¹⁷⁵ *Id.* Currently, Americans pay more for prescription drugs than any other country. *Id.* "In the last decade, prescription drugs accounted for [fifteen] percent of the total increase in health spending, despite the fact that they account for only about [ten] percent of all health costs." *Id.* Hillary Clinton hopes Medicare will be able "to negotiate lower drug prices; creating a pathway for biogeneric drug competition; removing barriers to generic competition; and providing more oversight over pharmaceutical companies' financial relationships and providers." *Id.*

¹⁷⁶ Clinton, *supra* note 133, at 10. "These initiatives include: information technology, prevention, chronic care coordination, and comparative effectiveness research." *Id.* Hillary Clinton's plan will also "align Medicare payments with performance to both promote quality and reduce the geographic variation in care; provide patient with information on provider performance through databases and decision tools; and ensure 'truth in advertising' to crack down on misleading and costly prescription drug advertising and direct-to-consumer advertising." *Id.* While improving the quality of health care is always desired, there is no indication that increasing government involvement in the United States health care system will in fact improve the quality of health care. See David Gratzer, *The Return of HillaryCare: Socialized Medicine is Still Not a Good Idea*, 10 WKLY. STANDARD 34, May 23, 2005. Compared to other OECD countries, which have implemented a more socialized health care system, the United States has a higher success rate for providing effective treatment. *Id.* For example, ninety-five percent of American women diagnosed with breast cancer are diagnosed in the early stages, stage I or II. *Id.* However, in other socialist OECD countries, such as Germany, Britain, France, Spain and Italy, twenty percent of women are diagnosed with breast cancer in later stages, stages III or IV. *Id.* In addition, the survival rate in the United States for leukemia is almost fifty percent, as opposed to thirty-five percent for the European countries. *Id.* Thus, while a more socialist system may seem ideal it not always the case when analyzing the facts. Gratzer, *supra*, at 34.

In addition, Hillary Clinton hopes to finance her health care reform by redirecting tax breaks.¹⁷⁷ Specifically, she wants to end “President Bush’s income tax rate cuts and exemption increases (known as PEP and Pease) for households making over \$250,000,” raising revenue by taxing the “rich.”¹⁷⁸ Additionally, since employer paid health care premiums are excluded from an employees taxes, she wants to tax employees who receive health care coverage that is better than the coverage offered in the Health Choices Plan.¹⁷⁹ She believes that the cost of the extra benefit received through high-end benefits should be at the expense of these employees and not at the taxpayer’s expense.¹⁸⁰

G. “*The Dark Side of Hillary Clinton’s Health Care Plan*”¹⁸¹

Hillary Clinton continually focuses on the estimated forty-seven million uninsured in America, stating that the health care industry is to blame.¹⁸² However, the increase in the number of uninsured “is not due to a sudden moral failure of the country or a broken health system.”¹⁸³ Instead, the cultural differences of immigrants are a major cause of the high rates of uninsured.¹⁸⁴ Since 1990, recent immigrants and their United States born children account for

¹⁷⁷ Clinton, *supra* note 133, at 10.

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*

The American Health Choices Plan rejects calls to limit the tax exclusion for middle-class Americans who have negotiated generous coverage or for those whose premiums are high due to health status, age, or high local health care costs. However, at a time of limited resources, it is neither prudent nor fair to allow the portion of a high-end plan that is in excess of the typical Health Choices Menu plan to be tax subsidized for the highest income Americans. A high-income American would still get a tax break for the employer contribution to the cost of a typical plan, like the Congressional plan, and they could still choose to get additional high-end coverage. But given that the highest income American already receives a tax benefit for purchasing a quality plan that is about twice as large as what a typical American taxpayer receives, the choice by such high-income Americans to obtain additional high-end benefits should be at their own- and not the taxpayers’-expense.

Id.

¹⁸⁰ *Id.*

¹⁸¹ Dick Morris & Eileen McGann, *The Dark Side of Hillary Clinton’s Health Care Plan*, <http://www.foxnews.com/story/0,2933,297493,00.html?CFID=368597&CFTOKEN=edd3c08f6619f6f-3D6D6F55-FF33-87D1-F7929C709F0B9CC2> (last visited Feb. 10, 2008).

¹⁸² *Id.*

¹⁸³ McCaughey, *supra* note 133, at A11.

¹⁸⁴ *Id.*; Morris & McGann, *supra* note 181. Over ten million immigrants have entered the country since 2001. McCaughey, *supra* note 133, at A11. According to a report by the Center for Immigration Studies in Washington, D.C., more than half of the ten million immigrants entering the United States are illegal. *Id.* “In the most recent Census report, the lion’s share of the increase in the uninsured occurred in five boarder states” Arizona, California, Florida, New Mexico and Texas.” *Id.* In fact, “the sheer number of Hispanic newcomers who seek care and are unable to pay is overwhelming many hospitals.” *Id.*

seventy-five percent of the increasing number of uninsured.¹⁸⁵ In fact, illegal immigrants account for ten million of the uninsured in the United States.¹⁸⁶ In addition, almost another ten million of the uninsured have household annual incomes of \$75,000 or more.¹⁸⁷ Thus, these households likely choose not to have health care as opposed to being unable to afford health care. Finally, another fourteen million uninsured Americans are “eligible for government programs such as Medicaid and the State Children’s Health Insurance Program” but have failed to apply.¹⁸⁸ Therefore, over thirty-four million “uninsured” Americans, out of a total population of over 360 million, already could be insured or are ineligible for insurance. These facts suggest that the high number of uninsured in America has little to do with the inefficiencies of the health care system. Out of the forty-seven million “uninsured,” only about fourteen million are eligible for health insurance and cannot afford it. This is less than four percent of the more than 360 million Americans.

A major part of any universal health care plan is cost control.¹⁸⁹ This is due to the fact that “without it, extending coverage just offers a blank check to patients and providers which would drive even higher the share of out economy that goes to health care.”¹⁹⁰ Thus, Hillary Clinton’s plan will ultimately require that costs be controlled.¹⁹¹ This calls into question her contention that Americans would be able to maintain their same coverage while she extended coverage to the uninsured.¹⁹² Since Hillary Clinton’s plan will need to lower health care costs in order to survive, “she would be forced to ration health care and to impose government mandated and controlled managed care on all Americans.”¹⁹³

Hillary Clinton plans to mandate that every individual have comprehensive

¹⁸⁵ McCaughey, *supra* note 133, at A11. “In 2005, Hillary co-sponsored legislation in the United States Senate to offer free health insurance, under the State Child Health Insurance Program (SCHIP) to the children of illegal immigrants who have lived in the United States for five years.” Morris & McGann, *supra* note 181. SCHIP is a federally matching block grant that emphasizes the importance of federally-subsidized health care for uninsured children without access to Medicaid. Sara Rosenbaum, *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*, 1 J. HEALTH & BIOMED. L. 1, 16-17 (2004). Under SCHIP, the state may augment Medicaid by expanding the scope of children’s health care coverage, operate SCHIP as a separate program and extend coverage to uninsured children with income above mandatory Medicaid eligibility levels, or choose a hybrid of the two options. *Id.* at 17.

¹⁸⁶ Morris & McGann, *supra* note 181. “Illegal immigrants are a disproportionately large segment of the uninsured population because legal immigrants and citizens who live in poverty are eligible for Medicaid, but illegal immigrants are not.” *Id.*

¹⁸⁷ McCaughey, *supra* note 133, at A11.

¹⁸⁸ *Id.*

¹⁸⁹ Morris & McGann, *supra* note 181.

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² *Id.*

¹⁹³ *Id.*

health insurance, which would cover preventative and routine care.¹⁹⁴ While this will likely lower premiums for the sick and elderly, it will also likely increase premiums for the young and healthy.¹⁹⁵ Hillary Clinton's plan will not allow insurance companies to "cherry pick" only healthy and young individuals.¹⁹⁶ For instance, individuals with chronic conditions will be charged the same premiums as healthy individuals.¹⁹⁷ This will result in "a major increase in health insurance premiums for the vast majority of Americans."¹⁹⁸

In addition, Hillary Clinton's mandates "would force the young [population] to subsidize the health tab for the middle-aged population while still paying a payroll tax to support Medicare recipients."¹⁹⁹ Many young Americans are just getting started financially and any increased costs will have damaging effects on their ability to pay for other necessities, such as food and shelter, and commodities. Thus, is such a plan really in the best interest of young Americans who make up a large percentage of working America?

Those who support Hillary Clinton's idea of a mandated health care system believe that a major reason for the high cost of health care is uncompensated care.²⁰⁰ However, the problem may not be as large as some believe.²⁰¹ In 2003, less than three percent of the total cost of health care was spent on uncompensated care for the uninsured.²⁰² While uncompensated care for the uninsured will theoretically no longer be an issue under Hillary Clinton's plan, the costs will still be there.²⁰³ Thus, the problem still is not really solved.²⁰⁴ Instead, Hillary Clinton's plan will force Americans to pay for these individuals in another way,

¹⁹⁴ McCaughey, *supra* note 133, at A11. This is different from mandating that everyone have catastrophic coverage. *Id.* Catastrophic coverage "would ensure that a person who is hurt in a car accident or diagnosed with a costly illness [could] pay his [or her] own medical bills, instead of being a burden on society." *Id.*

¹⁹⁵ *Id.*; Morris & McGann, *supra* note 181. Fifty-six percent of the uninsured Americans are adults between the ages of eighteen and thirty-four. McCaughey, *supra* note 133, at A11. Thus, "forcing them to be a part of a same-price-for-everyone insurance pool will likely bring down premiums." *Id.* Today, many insurance companies provide health insurance to young adults at a lower rate since young adults generally have low medical needs. *Id.* Typically, "a [twenty-five] year-old man can buy a \$1,000 deductible policy for a quarter to a third of what a [fifty-five] year-old man has to pay." *Id.*

¹⁹⁶ Morris & McGann, *supra* note 181.

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ McCaughey, *supra* note 133, at A11. "Hillary's program would really be nothing more than a cash transfer from the healthy to the sick, not an insurance program at all." Morris & McGann, *supra* note 181.

²⁰⁰ Whitman, *supra* note 122. Uncompensated care occurs when "uninsured patients receive health services but [do not] pay for them," causing other Americans to pay for the bill through increased taxes, hidden taxes, or increased costs for health care. *Id.*

²⁰¹ McCaughey, *supra* note 133, at A11.

²⁰² *Id.*

²⁰³ STEINHAUSER & CROWLEY, *supra* note 158; McCaughey, *supra* note 133, at A11.

²⁰⁴ McCaughey, *supra* note 133, at A11.

such as increased taxes.²⁰⁵

Another problem with mandating health care is the fact that there will most likely still be a significant percentage of Americans who will not purchase health care.²⁰⁶ Hillary Clinton equates mandated health care to mandated car insurance.²⁰⁷ However, the median percentage of uninsured in the forty-seven states that mandate car insurance is twelve percent.²⁰⁸ If such a high percentage of individuals do not comply with the Hillary Clinton's health care mandate, the effectiveness of the system is seriously limited.²⁰⁹

IV. THE ONLY POSSIBLE SOLUTION FOR AMERICA

There is no perfect solution to the United States' current health care problems. While there are positive aspects in every health care system throughout the world, there are also a number of negatives. Any health care reform would result in trade-offs for Americans, whether it is "incentives versus access, innovation versus stability, and adaptation versus control."²¹⁰ The best solution for America is to reform the current system as opposed to completely changing the system to another that has other problems.

A. Single Payer System

Many Americans who view health care as an inherent right have advocated for a single payer system similar to Canada and Germany. They believe that private health insurance companies in the United States, as well as physicians and hospitals, are exploiting the fact that consumers are unable to determine the value of a health care service.²¹¹ They also believe that "equality and universality are

²⁰⁵ *Id.*

²⁰⁶ *Id.*

²⁰⁷ Associated Press, *Clinton Offers Universal Health Care Plan*, ASSOCIATED PRESS, Sept. 17, 2007, <http://www.msnbc.msn.com/id/20819827/> (last visited Feb. 9, 2009).

²⁰⁸ McCaughey, *supra* note 133, at A11.

²⁰⁹ *See id.*; Glen Whitman, *Bad Medicine for Health Care: Laws that Require People to Buy Insurance Only Drive up the Costs of Policies*, BUS. WK., Oct. 15, 2007, http://zdnet.businessweek.com/magazine/content/07_42/b4054081.htm (last visited Mar. 30, 2009). Hillary Clinton's plan fails to provide information on how the government will enforce such a mandate. Meckler & Calmes, *supra* note 160. Instead, Americans will have to wait to see if she is elected since she states that the details will have to be worked out with Congress. *Id.*

²¹⁰ OHSFELDT & SCHNEIDER, *supra* note 7, at 45.

²¹¹ *Id.* at 34. There are a number of factors that go into whether or not a particular treatment is necessary, such as "the clinical features of the consumer, the appropriateness of the surgical service or product as a treatment for the clinical condition, the quality of treatment, and the extent of risk associated with variance in treatment outcomes (cure versus serious adverse effects) when treatment is performed appropriately." *Id.* Thus, physicians are generally in a much better position to determine the value of the treatment and whether or not it is necessary for the patient. *Id.* The main concern for some Americans "is that providers of health care services might exploit this 'informational asymmetry' between themselves and patients for personal gain, to the detriment of patients." *Id.*

important features of a health care system,” as opposed to the United States which theoretically provides health care services to only those who are able to pay.²¹²

A single payer system has a number of advantages for different sectors of society.²¹³ Patients are able to have access to health care with “minimal financial barriers.”²¹⁴ In addition, health care coverage is mobile since it is not tied to employment.²¹⁵ Physicians pay less in malpractice claims since individuals are unable to be awarded for future medical costs that the government will pay.²¹⁶ Clinical decisions could be made in the best interest of the patients since physicians and hospitals would not be concerned with the cost to the patient.²¹⁷ Finally, under a single payer system, businesses do not have to provide insurance coverage to their employees.²¹⁸

However, while the system will provide advantages to these sectors of society, there are a number of disadvantages. For instance, insurance companies do not stand to gain from this system since they will have only a limited role.²¹⁹ Pharmaceutical companies will also be harmed due to “price controls and bulk purchasing.”²²⁰ Furthermore, many of the businesses and individuals in these single-payer health care systems have to pay a large amount of indirect taxes “to support more extensive public welfare states.”²²¹ Generally, these costs exceed the highest costs an American business spends on its employees.²²² For example, in Germany, “the cost of employment-related health benefits as a percentage of payroll is nearly [fifty] percent greater . . . than in the United States.”²²³ In addition, price controls have caused Canadian physicians’ income to be stagnate

²¹² AMSA, *supra* note 20, at 4.

²¹³ *Id.*

²¹⁴ *Id.* at 9; Kevin C. Fleming, *High-Priced Pain: What to Expect from a Single-Payer Health Care System*, HERITAGE FOUNDATION, Sept. 22, 2006, available at <http://www.heritage.org/Research/HealthCare/bg1973.cfm>. It is argued that under a single payer system, the health of patients will be improved since greater access will lead to increasing preventative and primary care. AMSA, *supra* note 20, at 9.

²¹⁵ AMSA, *supra* note 20, at 9; Fleming, *supra* note 214.

²¹⁶ AMSA, *supra* note 20 at 9; Fleming, *supra* note 214.

²¹⁷ AMSA, *supra* note 20, at 9; Fleming, *supra* note 214.

²¹⁸ AMSA, *supra* note 20, at 9; Fleming, *supra* note 214. Businesses may be required to help subsidize the health care system through a payroll tax, but the cost would be much lower than providing health insurance for employees. AMSA, *supra* note 20, at 9. If the United States were to adopt a single payer system, those businesses which currently do not provide health care coverage for their employees would have increased costs through a payroll tax. *Id.* However, for those businesses which do currently provide employee coverage, a single payer system would improve global competitiveness since businesses would have less health care costs and could therefore lower product prices. *Id.* at 10.

²¹⁹ AMSA, *supra* note 20, at 10; Fleming, *supra* note 214.

²²⁰ AMSA, *supra* note 20, at 8; Fleming, *supra* note 214.

²²¹ Gottschalk, *supra* note 12, at 949.

²²² *Id.*

²²³ *Id.*

since 1993.²²⁴ To reduce their losses, physicians throughout Canada have started to shut down their offices for various periods of time ranging from five days to a month.²²⁵ Moreover, numerous hospitals have shut down, thereby extending the amount of time a patient has to wait for a common procedure.²²⁶ Finally, a number of physicians are opting out of the state program and requiring that patients pay for their services.²²⁷

A single payer system does have its advantages.²²⁸ For instance, administrative costs are generally lower in single payer systems since there is only one entity controlling the administration.²²⁹ However, the estimated savings are relatively minor.²³⁰ This is especially true “if the single-payer plan continues to provide a reasonable level of value-added organizational and patient-care management, including such activities as disease management, patient education, provider management, quality control, and fraud and abuse monitoring.”²³¹ While there is a reduction in duplicative services, such as excess medical equipment, they are generally attributable to the fact that the health care system is stagnant and not due to capacity control.²³²

In addition, in a single payer system, the centralized government is able to effectively control prices for the entire health care system.²³³ One example is the cost savings associated with bulk purchasing.²³⁴ However, in order for bulk

²²⁴ Weber, *supra* note 68.

²²⁵ *Id.*; see Fleming, *supra* note 214.

²²⁶ Weber, *supra* note 68; see Fleming, *supra* note 214.

²²⁷ Weber, *supra* note 68.

²²⁸ AMSA, *supra* note 20, at 8-10.

²²⁹ *Id.* at 4. The United States has high administrative costs due to the fact that there are a number of entities administering health care, each with different payment system. *Id.* at 4-5. A 2003 New England Journal of Medicine study estimated that the United States spent thirty-one percent of its health care expenditures on administrative costs. *Id.* On the other hand, Canada spent less than seventeen percent on administrative costs. *Id.* However, administrative costs are not “a major cause of health care inflation.” AMSA, *supra* note 20, at 4. Thus, simply reducing administrative costs will not slow the health care system’s growth in spending. *Id.*

²³⁰ OHSFELDT & SCHNEIDER, *supra* note 7, at 45.

²³¹ *Id.*

²³² *Id.* at 46. The author states that Canada has less medical equipment per capita than the United States. *Id.* However, this is most likely due to the health care system being stagnant since the 1960s. *Id.*

²³³ AMSA, *supra* note 20. Medicare has been very effective in controlling costs. *Id.* However, since the United States has multiple players following different rules, such as private insurance companies, it is almost impossible to institute effective cost controls. *Id.* For example, technology innovations are “limited by how much a given payer decides to use [assessment report] findings to make decisions about what services to cover.” *Id.* In the United States, private insurance companies are still able to decide for themselves whether they will cover an innovation, regardless of whether Medicare decides to or not. *Id.* However, under a single payer system, the government decides whether an innovation will be covered for the entire health care system. AMSA, *supra* note 20.

²³⁴ *Id.* The price for medication in Canada was forty percent less than in the United States since pharmaceutical companies charge “more in less price-sensitive markets.” *Id.*; OHSFELDT & SCHNEIDER, *supra* note 7, at 12.

purchasing to result in lower costs, states must be “willing to walk away from the table when a large pharmaceutical manufacturer refuses to lower the price of a patented drug.”²³⁵ This can result in abrupt withdrawals of these products.²³⁶

Single payer systems are financed through tax revenue, general collections and targeted taxes.²³⁷ Thus, health care growth is controlled by politicians as opposed to market forces and consumers.²³⁸ Politicians are responsible for adapting the system to changes in consumer demand as well as financing.²³⁹ However, “there is no guarantee that . . . politicians will be able to finance the system at a level aligned with consumer demand, nor is there any guarantee that, in the aggregate, consumers will be willing to vote in favor of tax increases sufficient to fund adaptation and growth.”²⁴⁰ In fact, residents of single payer countries continually state that the government needs to spend more money in order to improve the system.²⁴¹

Single payer systems are less able to adapt to change.²⁴² While politicians are “good at adaptation that requires a coordinated response,” the number of feasible responses is low since politicians have established routines.²⁴³ However, in a market based system, health care providers are able to quickly adapt to changing consumer demands, market prices, and operating costs.²⁴⁴

B. Hillary Clinton’s American Health Choices Plan

While Hillary Clinton does not advocate for a complete single payer system, she does advocate for increased government involvement in our current

²³⁵ OHSFELDT & SCHNEIDER, *supra* note 7, at 46.

²³⁶ *Id.* While Canada is a successful example of bulk purchasing, the success is most likely the result of strict price controls and a lower GDP per capita. *Id.*

²³⁷ *Id.* at 48.

²³⁸ *Id.* In the United States, consumer demand helps to determine the price of a service or product. *Id.* As demand for a service or product increases, market forces will determine the price based on the amount of supply. OHSFELDT & SCHNEIDER, *supra* note 7, at 48.

²³⁹ *Id.*

²⁴⁰ *Id.*

Funding adjustments are a function simultaneously of voter preferences for higher or lower taxes, competing demands from other state-funded programs, weak political property rights (such as funding or defunding to garner votes in election years), competing demands from within the system (such as the commissioner wanting to cut costs while general practitioners want to increase funds), and changes to medical practice patterns and consumer demand.

Id.

²⁴¹ *Id.* For example, in the middle and late 1990s, Canada’s budget cutbacks “resulted in a precipitous drop in the proportion of Canadians describing their health care system as excellent or very good.” OHSFELDT & SCHNEIDER, *supra* note 7, at 48.

²⁴² *Id.* at 49.

²⁴³ *Id.*

²⁴⁴ *Id.*

employment based system.²⁴⁵ She proposes that her plan will help to reduce health care premiums by requiring every American to participate in some health care plan, thereby spreading the risk among both young and old.²⁴⁶ In addition, she proposes that the government subsidize health care payments for those individuals who are unable to afford it.²⁴⁷

However, Hillary Clinton's plan has serious flaws. The problem she is attempting to solve is not as large as she is proposing since over thirty-four million of the forty-seven million "uninsured" are either ineligible for health care or are able to obtain health care without the government's help.²⁴⁸ Universal health care results in cost controls that will likely lead to a rationed health care and imposed government mandated care.²⁴⁹ Additionally, while universal health care will lower premiums for the sick and elderly, it will increase premiums for the young and healthy.²⁵⁰ She proposes to finance her plan by taxing the "rich" and everyone who has a better plan than the one offered by the government.²⁵¹ This transfer of wealth will meet strong resistance from many Americans. Finally, in order for Hillary Clinton's plan to succeed, it is imperative that every American purchases health care.²⁵² However, despite the fact that Hillary Clinton will mandate health care coverage for every American, not everyone would in reality purchase health care.²⁵³ Just look at the number of Americans who are eligible but have not applied for Medicare and Medicaid.²⁵⁴

C. Consumer-Based Health Care

As health care premiums continue to rise, more and more businesses are cutting health care coverage for their employees.²⁵⁵ While 160 million Americans are insured under the current employment based system, "the number of employers sponsoring coverage and the proportion of employees taking benefits when they are offered" are being reduced.²⁵⁶ This has resulted in "job-lock" as employees are

²⁴⁵ Clinton, *supra* note 133.

²⁴⁶ *Id.* at 6.

²⁴⁷ *Id.* at 10.

²⁴⁸ See Morris & McGann, *supra* note 181; McCaughey, *supra* note 133, at A11.

²⁴⁹ Morris & McGann, *supra* note 181; McCaughey, *supra* note 133, at A11.

²⁵⁰ McCaughey, *supra* note 133, at A11.

²⁵¹ Clinton, *supra* note 133, at 10.

²⁵² McCaughey, *supra* note 133, at A11.

²⁵³ *Id.*

²⁵⁴ See Morris & McGann, *supra* note 181.

²⁵⁵ Gottschalk, *supra* note 12, at 927; Victoria E. Knight, *Employers Explore Health-Care Options*, WALL ST. J., Jan 29, 2008, at D2, available at http://online.wsj.com/article/SB120157974014924621.html?mod=googlenews_wsj.

²⁵⁶ The Brookings Inst., *Employment-Based Health Insurance: A Prominent Past, But Does it Have a Future?*, June 16, 2006, <http://www.brookings.edu/events/2006/0616health-care.aspx> (last visited Feb. 10, 2008).

unwilling to change jobs out of fear of losing their employment-based health insurance.²⁵⁷

Some have advocated for a change in the market-based system from an employer-based system to a consumer driven system. Under a consumer driven system, “individual policies are portable, so workers [do not] have to worry about losing coverage if they change jobs.”²⁵⁸ Employers have a limited role, only participating if they wish to contribute to the employee’s Health Savings Accounts (MSA), Flexible Spending Accounts (FSA), or Health Reimbursement Arrangements (HRA).²⁵⁹ These programs cause “[p]atients [to] cut back in areas where there is presumed to be a lot of waste and [to] substitute less expensive treatment options for more expensive ones.”²⁶⁰ However, since any employer contribution to one of these programs is tax-deductible, it is essentially a government subsidy, which reduces cost-effectiveness.²⁶¹

It is estimated that by implementing a consumer driven health care system, Americans would pay about two-thirds what they pay today for health insurance.²⁶² This is mainly due to the idea that when patients are paying for the health care services on their own, they are much more conscious of cost and will weigh the value of the service against the cost.²⁶³ For example, Vioxx, Celebrex, and Bextra are pain relievers which cost about \$800 more a year than ibuprofen.²⁶⁴ Under a consumer driven system, patients with arthritic pain would weigh the extra benefits received from taking a prescription drug (less pain) with the cost.²⁶⁵

A consumer driven system will also lower costs since patients are twenty

²⁵⁷ *Id.*

²⁵⁸ Knight, *supra* note 255, at D2.

²⁵⁹ Goodman, *supra* note 21, at 1. However, studies suggest that employees do not want these plans since “only [fifteen] percent of employees who were offered health savings account qualified high-deductible plans decided to enroll.” Elise Gould, *Consumer-Driven Health Care is a False Promise*, 3(5) EXECUTIVE COUNS. MAG., Sept./Oct. 2006, available at http://www.epi.org/publications/entry/webfeatures_viewpoints_consumer_driven_healthcare.

²⁶⁰ Goodman, *supra* note 21, at 6.

²⁶¹ Gould, *supra* note 259.

²⁶² Editorial, *U.S. Health Care Reform Should be Consumer-Driven*, D.C. EXAMINER, Nov. 26, 2007, available at http://www.examiner.com/a-1068150-U_S_health_care_reform_should_be_consumer_driven.html.

²⁶³ See Goodman, *supra* note 21, at 2, 4. This creates a “moral hazard” since consumers will “purchase more health services than they would if they were fully aware of the costs.” Joseph Antos et al., *Consumer Choice: Can it Cure the Nation’s Health-Care Ills?*, WALL ST. J., Dec. 13, 2005, at R3, available at <http://online.wsj.com/article/SB113414975523918595.html>. It is argued that “unconstrained patients would attempt to spend the entire . . . GDP on health care.” Goodman, *supra* note 21, at 2. Currently, patients pay only fifteen cents out of every dollar spent on health care out of their own pocket. *Id.* at 5. Thus, “economic incentive is to spend on health care until its value to the patient is only [fifteen] cents on the dollar.” *Id.* However, under a consumer driven system, “patients [are] twice as likely as patients in traditional plans to ask about cost and three times as likely to choose a less expensive treatment option.” *Id.* at 6.

²⁶⁴ Goodman, *supra* note 21, at 4.

²⁶⁵ *Id.*

percent “more likely to follow treatment regimes very carefully.”²⁶⁶ This will drive down costs since under the current system patients pay only fifteen percent of the total cost for care and have less incentive to make sure that they follow the treatment since someone else is paying for the bill.²⁶⁷ This results in increased costs as patients have to repeat treatments because they failed to effectively follow the treatment regimes.²⁶⁸

However, critics claim that the system will result in high premiums for the elderly and ill individuals since they do not have the negotiating clout that businesses have under group plans.²⁶⁹ Chronically ill individuals are extremely vulnerable under this system because their personal costs are extremely high, “but are not large enough to breach the deductible and be covered by insurance.”²⁷⁰ Today, individuals with chronic conditions and costly hospitalizations account for twenty percent of health spenders but over eighty percent of health spending.²⁷¹ Many individuals with high deductible plans may delay receiving care for a condition, resulting in a serious disease which could have been prevented.²⁷² In addition, while consumers are given greater choice, they may “find it difficult to distinguish between necessary and unnecessary care” since they lack the medical knowledge.²⁷³ A consumer driven system requires that the consumers be educated on the quality, price, and effectiveness of products and services.²⁷⁴ However, “markets are shaped by marginal consumers” who are assertive and extremely selective.²⁷⁵ These marginal consumers will force health care providers to create better and cheaper services and products which the rest of the population benefits from.²⁷⁶

D. Employer-Based Health Care System

There is no perfect solution for the United States health care system. Every system has its flaws, thus it is best to reform our current system as opposed to completely changing it. While some, such as Hillary Clinton, advocate for more government involvement as a possible reformation, it is not a system most

²⁶⁶ *Id.* at 6.

²⁶⁷ *See id.*

²⁶⁸ *See id.*

²⁶⁹ Knight, *supra* note 255, at D2.

²⁷⁰ Oxford Analytica, *supra* note 22.

²⁷¹ Gould, *supra* note 259.

²⁷² *Id.*

²⁷³ Oxford Analytica, *supra* note 22.

²⁷⁴ Antos et al., *supra* note 263, at R3.

²⁷⁵ Regina Herzlinger, *Consumer-Driven Health Care: Taming the Health Care Cost Monster*, J. FIN. SERV. PROF'LS, Mar. 2004, available at http://www.manhattan-institute.org/html/_jfsp-consumer.htm.

²⁷⁶ *Id.*

Americans would actually like. Increased government involvement leads to price controls and ultimately a reduction in services provided.²⁷⁷ America is a country built on choice and increased government involvement limits that choice.²⁷⁸

A better solution for America is to open state borders and to allow consumers to purchase health care that is from and regulated in any state. Costs would be lowered “without imposing a large cost on taxpayers and without creating a new government bureaucracy.”²⁷⁹ By opening state borders, there is an increase in competition between the state health care markets, resulting in lower prices.²⁸⁰ For instance, Pennsylvania pays about a third of the cost in New Jersey for the same coverage, regardless of the fact that they share a border.²⁸¹ By opening state borders, residents in New Jersey will be able to obtain the less expensive coverage, thus requiring New Jersey to lower its prices or reduce its mandates in order to be competitive.²⁸²

As stated earlier, states have created almost 1,900 mandated health care benefits that employers must provide to their employees.²⁸³ Small businesses, which employ half the nation’s workforce, are discouraged from providing employee health care since they are subject to state mandates dealing with health insurance coverage.²⁸⁴ It has been estimated that state mandates increased premiums by more than twenty percent in 2007.²⁸⁵ By opening borders, small businesses will be able to shop for lower premiums, and thus more businesses will be able to provide employees with coverage since they will be able to get the lowest premium coverage.²⁸⁶

The United States should also establish more effective tort reform to help lower the cost of health care. As stated earlier, malpractice lawsuits result in increased costs to consumers since physicians are forced to practice defensive medicine as well as purchase medical malpractice insurance.²⁸⁷ Simply reforming

²⁷⁷ AMSA, *supra* note 20.

²⁷⁸ OHSFELDT & SCHNEIDER, *supra* note 7, at 46.

²⁷⁹ Mathews, *supra* note 130, at A18.

²⁸⁰ *Id.*

²⁸¹ *Id.*

²⁸² *See id.*

²⁸³ *Id.*; Whitman, *supra* note 122.

²⁸⁴ SERED & FERNANDOPULLE, *supra* note 98, at 114. The United States provides businesses with the ability to “opt out of the government-regulated health ‘system,’ if it allows them to be more competitive.” Graham, *supra* note 51, at A25. Thus, since small businesses have found that health care costs are unaffordable given the fact that states have implemented the “massive burden of over-regulation on small-group health insurance since the early 1990s,” many are choosing to contract employment without health benefits. *Id.* For instance, small businesses in Massachusetts are required to cover infertility treatment. SERED & FERNANDOPULLE, *supra* note 98, at 114.

²⁸⁵ Whitman, *supra* note 122.

²⁸⁶ *See* Mathews, *supra* note 130, at A18; SERED & FERNANDOPULLE, *supra* note 98, at 114.

²⁸⁷ OHSFELDT & SCHNEIDER, *supra* note 7, at 12; Feigenbaum, *supra* note 71, at 1371; Hartwig & Wilkinson, *supra* note 70, at 3.

tort law could reduce medical care expenditures by 70 billion to 140 billion dollars per year.²⁸⁸ The major part of those savings would be to simply reduce unreasonable awards for non-economic damages, estimated to be between \$60 and \$108 billion dollars a year.²⁸⁹ This would ultimately reduce health care premiums and allow “an additional 2.4 to 4.3 million Americans to obtain insurance.”²⁹⁰

V. CONCLUSION

No matter what health care system the United States enacts, there will always be the uninsured; whether they are illegal immigrants who do not qualify for Medicare or Medicaid,²⁹¹ individuals who can afford health care but simply do not purchase it,²⁹² or individuals who qualify for Medicare or Medicaid and simply do not fill out the application.²⁹³ One only has to look at our current system to see that this is true. While the government says there are forty-seven million “uninsured” Americans, a more real net number is about thirteen million. This is a relatively small number when compared to a total population of over 360 million.²⁹⁴ These facts suggest that the high number of uninsured people in America has little to do with the inefficiencies of the health care system and will likely not drastically change with the implementation of a new system. There is no perfect solution to the United States’ health care problems and it is best to reform the system which is already embedded in American society. An open state border policy, fewer state mandates, and tort reform will solve most of America’s employer based health system problems. And these changes are doable.

²⁸⁸ OHSFELDT & SCHNEIDER, *supra* note 7, at 14.

²⁸⁹ Hartwig & Wilkinson, *supra* note 70, at 6.

²⁹⁰ *Id.*

²⁹¹ Morris & McGann, *supra* note 181.

²⁹² McCaughey, *supra* note 133, at A11.

²⁹³ *Id.*

²⁹⁴ *Id.*; Morris & McGann, *supra* note 181.