



2001

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Recommended Citation

Timothy S. Jost, *Private or Public Approaches to Insuring the Uninsured: Lessons from International Experience with Private Insurance*, 76 N. Y. U. L. Rev. 419 (2001)

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Citation: 76 N.Y.U. L. Rev. 419 2001

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PRIVATE OR PUBLIC APPROACHES TO INSURING THE UNINSURED: LESSONS FROM INTERNATIONAL EXPERIENCE WITH PRIVATE INSURANCE

TIMOTHY STOLTZFUS JOST*

While the United States, virtually alone among developed countries, relies primarily on private health insurance to deliver access to health care services, private health insurance is not unknown elsewhere in the world. In this Article, Timothy Jost surveys the mixed public and private health insurance systems of Australia, Chile, Germany, and the Netherlands, as well as the largely public systems of Canada, France, and the United Kingdom. He shows that countries that place significant reliance on private health insurance also regulate the private insurance market heavily; only where private insurance merely supplements universal public insurance is the private market largely unregulated. Professor Jost concludes from his comparative analysis that market-reliant systems are unlikely to reduce the growing number of Americans who are uninsured, and that the differences between highly regulated private insurance systems and largely public insurance systems are less pronounced than generally assumed. While the United States politically is unlikely to move towards public insurance, he writes, a turn towards greater privatization would tend to worsen, rather than improve, the problem of the uninsured.

INTRODUCTION

There is no more pressing health policy issue facing America today than the problem of the uninsured. In 1999, 42.6 million Americans, almost 15.5% of the population, were covered neither by private nor by public health insurance.¹ It is estimated that as many as 61.4

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¹ Number of Uninsured Drops for First Time in 12 Years, Census Bureau Report Says, Health Care Daily Rep. (BNA), Sept. 29, 2000, WL 9/29/2000 HCD d6.

million Americans could be uninsured by the year 2009 if the economy takes a downturn.² Although being uninsured in America does not mean that one is totally denied access to health care, a large and growing body of research shows that persons who are uninsured get less health care, get it later, and suffer greater mortality and morbidity because of their failure to receive health care in a timely fashion.³

In the recent past a remarkably broad consensus has emerged as to how to address this problem. In March of 1999, Republican Congressman Charles Norwood of Georgia introduced his Affordable Health Care Act,⁴ proposing tax credits and insurance reform to increase access to private health insurance for the uninsured.⁵ Early in June of 1999, a "coalition of researchers spanning the ideological spectrum" endorsed the idea of health care tax credits for the uninsured.⁶ Later that same month, House Majority Leader Richard Armey submitted his Fair Care for the Uninsured Act of 1999⁷ proposing tax credits to make private health insurance more affordable to the uninsured.⁸ In September 1999, Vice President and then-presidential candidate Al Gore proposed a twenty-five percent refundable tax credit to assist employees in purchasing health insurance.⁹ A couple of

² Steven Findlay & Joel Miller, *Nat'l Coalition on Health Care, Down a Dangerous Path: The Erosion of Health Insurance Coverage in the United States* (1999), <http://www.nchc.org/releases/erosion.html>.

³ *Am. Soc'y of Internal Med., Am. Coll. of Physicians, No Health Insurance? It's Enough to Make You Sick—Scientific Research Linking the Lack of Health Coverage to Poor Health* 4 (1999), <http://www.aconline.org/uninsured/lack-contents.htm> (reviewing 124 scientific studies published in past decade); E. Richard Brown, *Access to Health Insurance in the United States*, 46 *Med. Care Rev.* 349, 352-53 (1989) (finding that uninsured have less access to medical care and are less likely to see physician than are insured people); Peter Franks et al., *Health Insurance and Mortality: Evidence from a National Cohort*, 270 *JAMA* 737, 740 (1993) (finding that uninsured's risk of mortality is 1.25 times norm).

⁴ *Affordable Health Care Act of 1999*, H.R. 1136, 106th Cong. (1999).

⁵ *Norwood Offers Proposal to Help Uninsured Through Tax Credits, Affordability Measures*, *Health Care Daily Rep.* (BNA), Mar. 17, 1999 (reporting that Representative Norwood's Affordable Health Care Act would provide refundable tax credit of up to \$3600 per family to increase access to private health insurance), WL 3/17/1999 HCD d6.

⁶ "Consensus Group" Endorses Tax Credits as Key to Covering Uninsured Americans, *Health Care Daily Rep.* (BNA), June 3, 1999, WL 6/3/1999 HCD d3; see also *Health Policy Consensus Group, A Vision for Consumer-Driven Health Care Reform, in Empowering Health Care Consumers Through Tax Reform* 211, 217-18 (Grace-Marie Arnett ed., 1999) [hereinafter *Empowering Consumers*]. The entities from which the individuals in this consensus group were drawn in fact represent primarily the right end of the political spectrum.

⁷ *Fair Care for the Uninsured Act of 1999*, H.R. 2362, 106th Cong. (1999).

⁸ *Armey Introduces Health Care Tax Credit Bill to Subsidize Coverage for Uninsured People*, *Health Care Daily Rep.* (BNA), June 28, 1999 (reporting Representative Armey's proposal of tax credits to help purchase of health insurance), WL 6/28/1999 HCD d6.

⁹ *Candidate Gore Calls for Tax Credit Aimed at Health Care Uninsured*, *Health Care Daily Rep.* (BNA), Sept. 8, 1999 (reporting that presidential candidate Al Gore would

weeks later, then-presidential candidate Senator Bill Bradley came forth with his own health reform proposal: expanding health insurance coverage through tax credits.¹⁰ Five of the eight proposals put forward by health care trade and consumer advocacy associations at a conference on the uninsured in January 2000 included, again, proposals for tax credits.¹¹ Later that month, a bipartisan group of Senate and House members outlined a new health reform plan based on—you guessed it—refundable tax credits.¹² Most recently, two powerful health care interest groups, the American Association of Health Plans (AAHP) and the American Medical Association (AMA), rolled out tax credit proposals.¹³ Even Harry and Louise, the charming couple that helped bring down the Clinton health plan in 1994, have now gone public with a positive message: Expand coverage for the uninsured through changes in the tax code.¹⁴

Though these proposals vary in their details, they all proceed from the assumption that the best way to expand access to health care for the uninsured is to build on our current system of private insurance, which now covers seventy percent of our population, even if the only way this can be accomplished is through increased public subsidies.¹⁵ No observer of American health policy should find this surprising. As Carolyn Tuohy has argued in her brilliant book *Accidental Logics*, the development of health care systems is “path dependent.”¹⁶

introduce twenty-five percent refundable tax credit for people who do not have health insurance through employers), WL 9/8/1999 HCD d6.

¹⁰ Bradley Unveils Proposal That Would Cover All Children, Expand Medicare, Health Care Daily Rep. (BNA), Sept. 29, 1999 (introducing former Senator Bradley's proposal to provide subsidies to families for health care coverage in form of tax credits), WL 9/29/1999 HCD d9.

¹¹ See Robert Wood Johnson Found., Health Coverage 2000: Meeting the Challenge of the Uninsured (comparing various proposals), http://www.rwjf.org/rw_news_and_events/events/shc2000/side-by-side.htm (last visited Feb. 20, 2001).

¹² Bipartisan Group of Lawmakers Outlines Plan for Health Care Tax Credits for Uninsured, Health Care Daily Rep. (BNA), Jan. 27, 2000 (discussing bipartisan proposal to provide up to \$2000 in tax credits for health insurance), WL 1/27/2000 HCD d8.

¹³ AAHP Proposes Medicaid Expansion, Tax Credit to Increase Insurance Coverage, Health Care Daily Rep. (BNA), Mar. 2, 2000 (reporting on AAHP's tax credit proposal), WL 3/2/2000 HCD d11; AMA Delegates Approve Guidelines for Crafting Tax Credits for the Uninsured, Health Care Daily Rep. (BNA), June 14, 2000, WL 6/14/2000 HCD d11.

¹⁴ Richard Lacayo, Health Care: A Litmus Test: In the Primaries, What the Front Runners Say (or Don't Say) About It Says a Lot About Them, Time, Jan. 31, 2000, at 38, 38. Other entities pushing tax credit solutions include the Heritage Foundation. See Grace-Marie Arnett, Rising Costs, Reduced Access: How Regulation Harms Health Consumers and the Uninsured 9 (Heritage Found., Backgrounder No. 1307, 1999).

¹⁵ A comprehensive summary of current proposals is found in Randall Weiss & Mark Garay, Recent Tax Proposals to Increase Health Insurance Coverage (2000).

¹⁶ Carolyn Hughes Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada 6-7* (1999) (introducing notion of recurrence of “path dependence” in dynamics of change in health policy).

The structures that nations develop for providing and paying for health care, though largely the products of historical accidents, take on a powerful logic of their own that is very difficult subsequently to escape or even to change, except perhaps incrementally at the margins.¹⁷ Our system of health care finance has been based on private health insurance since the first half of the last century, and only under highly unusual circumstances, such as the Democratic landslide of 1964, has it been possible even to contemplate expansion of public health care financing programs.¹⁸

Many of these proposals, however, do not simply embrace private insurance, but also articulate a specific vision as to how private insurance markets should be structured. That vision is based on two further beliefs. First, most of the proposals favor highly atomized insurance markets. Their ideal is a market in which every individual chooses his or her own health plan.¹⁹ They abandon the traditional American approach, under which the vast majority of Americans have had group (rather than individual) coverage provided through an employee benefits plan.²⁰ This change is often presented as part of the package of the move from tax deductions to credits but is not a necessary concomitant of such a change. One could have group insurance

¹⁷ See *id.* at 6, 260-62.

¹⁸ See Theodore R. Marmor, *The Politics of Medicare 1-85* (2d ed. 1999); Tuohy, *supra* note 16, at 56-58. By the same token, once the National Health Service (NHS) became embedded in Great Britain, even the Thatcher government was unable to change its fundamentals. *Id.* at 39-41, 63-71.

¹⁹ See, e.g., John C. Goodman & Merrill Matthews, *Reforming the U.S. Health Care System* (Nat'l Ctr. for Policy Analysis, Policy Background No. 149, 1999), www.ncpa.org/bg/bg149/bg149.html; John S. Hoff, *Improving the System for Delivering Subsidies: Cap or Scrap the Exclusion?*, in *Empowering Consumers*, *supra* note 6, at 93; Robert Emmet Moffit, *High Anxiety: Working Families Need Market-Based Health Care Reform*, in *Empowering Consumers*, *supra* note 6, at 35. This also seems to be the ideal for Richard Epstein, who eschews all forms of cross-subsidization. See Richard A. Epstein, *Mortal Peril* 121-27 (1997).

²⁰ See Melissa A. Thomasson, *The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance 1* (Nat'l Bureau of Econ. Research, Working Paper No. 7543, 2000) (tracing history of this phenomenon). These proposals for change are not driven by public opinion, which is highly supportive of the current system of employer-based benefits. In one recent survey, forty-nine percent of adults surveyed supported employers as the main source of coverage, as compared to twenty-three percent who favored direct purchase; further, seventy-three percent of adults with job-based coverage felt that their employers did a "good job" of choosing plans, while only twelve percent felt that their employers did a "bad job." Lisa Duchon et al., *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century 2* (2000). Another recent study found Americans more evenly divided on the choice between employer-based insurance and individual tax credits, but also found that our employer-based health insurance system remains very popular. See Robert J. Blendon et al., *The Uninsured, the Working Uninsured, and the Public*, *Health Aff.*, Nov./Dec. 1999, at 203, 203, 208.

plans paid for by tax credits.²¹ Second, some of the more extreme advocates of reform support not only private insurance markets, but also largely unregulated markets. This position is seen, on the one hand, in extreme libertarians, such as Richard Epstein,²² and on the other hand, in statements made by insurance or health plan industry associations, which generally favor deregulation of the markets in which they sell their products.²³ Though many advocates of the tax credit approach recognize that access to health insurance can only be expanded in regulated markets, most would limit the role of regulation.²⁴

²¹ This is, in fact, one of the major elements of a proposal just recently put forward by Families USA and the Health Insurance Association of America. See Charles N. Kahn III & Ronald F. Pollack, *Building a Consensus for Expanding Health Coverage*, Health Aff., Jan./Feb. 2001, at 40, 45; see also C. Eugene Steuerle & Gordon B.T. Mermin, *A Better Subsidy for Health Insurance?*, in *Empowering Consumers*, supra note 6, at 71 (contemplating continued role for employers to negotiate health plans in tax credit-based system).

²² Epstein, supra note 19, at 52-54, 121-46; see also, Arnett, supra note 14, at 6-7, 9 (advocating consumer choice and moratorium on health insurance regulation); Norman B. Ture & Stephen J. Entin, *Health Care Reform: Why Not Try Real Insurance?*, in *Empowering Consumers*, supra note 6, at 119 (proposing supplantation of government regulation of health care by free market system).

²³ See, e.g., *Key Patients' Protections: Lessons from the Field: Hearing Before the Senate Comm. on Health, Educ., Labor, & Pensions, 106th Cong. (1999)* (statement of Karen M. Ignagni, President and CEO, American Ass'n of Health Plans) (arguing that regulation has "unintended consequence of decreasing quality and increasing costs"), 1999 WL 8085434; William S. Custer, Health Ins. Ass'n of Am., *Health Insurance Coverage and the Uninsured* 4, 16-18 (1998) (finding that regulation reforms have increased number of uninsured Americans); John Berry & Richard White, *An Insurer's Perspective on Reform*, 25 J. Health Pol. Pol'y & L. 205, 209 (2000) (arguing that different forms of regulation encourage adverse selection). Health insurers oppose, in particular, state benefit mandates, which they would like to see preempted by federal law. See Health Ins. Ass'n of Am. (HIAA), *InsureUSA*, at http://www.rvjf.org/rw_news_and_events/eventshe2000/hiaa.htm (last visited Feb. 20, 2001). Insurers generally argue that the presence of regulation increases the cost of insurance, and thus decreases its availability. There seems to be considerable support for this argument, though the extent of the phenomenon is debated. See U.S. Gen. Accounting Office, Rep. No. GAO/HEHS-98-203R, *Private Health Insurance: Impact of Premium Increases on the Number of Covered Individuals Is Uncertain* (1998) (discussing arguments regarding extent to which increases in health insurance costs lead to decreases in number of persons covered).

²⁴ See Stuart M. Butler, *Expanding Health Insurance Through Tax Reform 2* (1999) (proposing neutral tax reform that would grant tax relief to families allowing them to choose their own health plans regardless of source of plans); Alain C. Enthoven, *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care* 78-82, 126-30 (1980) (supporting choice in health care through market system, subject to limited government regulation). For reasons elaborated below, infra text accompanying notes 350-64, tax credits, without some limitations on underwriting or adjustment in the size of credits for risk status, are not capable of extending health insurance to those whose health status is poor, see Mark Merlis, *Public Subsidies and Private Markets: Coverage Expansions in the Current Insurance Environment* 7 (1999) (illustrating that fixed dollar subsidies that would enable lower-risk individuals to obtain health insurance may be insufficient to make coverage affordable for higher-risk individuals who are subject to higher premiums); Linda

All three of these beliefs—the superiority of private insurance markets, the preferability of individual as opposed to group health insurance markets, and the need for (and possibility of) deregulation of insurance markets—are contestable based on comparative research. As every observer of comparative health policy knows, we are the only developed nation on Earth that relies primarily on private health insurance to finance health care, though virtually every other nation on Earth has a private health insurance industry.²⁵ We spend a greater share of our wealth on health care, yet have a higher proportion of our people without assured access to it, than does any other developed nation.²⁶ Indeed, a recent evaluation of the world's health care systems, comparing them on the basis of support for good health, responsiveness to the public's expectations, and fairness of financial contribution, ranked the United States at thirty-seventh.²⁷

Reasonable persons, of course, can argue as to whether the virtues of our market-based health care system—and there are many—justify its high cost and glaring deficiencies.²⁸ Reasonable persons

Blumberg, *Are Tax Credits the Right Track to Take?*, in *Options for Expanding Health Insurance Coverage: A Report on a Policy Roundtable 34, 34-35* (Judith Feder & Sheila Burke eds., 1999) (noting that high-risk uninsureds would be unable to obtain health insurance in unregulated markets if tax credits were too small). Though responsible advocates of tax credits recognize this issue, they often give the problem short shrift in discussions that tend to focus on other implementation issues, such as the relationship between proposed credits and current deductions. See, e.g., Butler, *supra*, at 10 (examining infeasibility of calculating tax credits against withholdings for unemployed people); Mark Pauly, *Extending Health Insurance Through Tax Credits 3* (1999) (discussing interplay between current exclusions and proposed tax credits).

²⁵ See, e.g., Karen Davis, *International Health Policy: Common Problems, Alternative Strategies*, *Health Aff.*, May/June 1999, at 135, 141.

²⁶ For recent data, see Gerard F. Anderson et al., *Health Spending and Outcomes: Trends in OECD Countries, 1960-1998*, *Health Aff.*, May/June 2000, at 150, 151 (noting that in 1998, United States spent \$4270 per capita and fourteen percent of GDP on health care, compared to OECD median of \$2000 per capita and eight percent of GDP); Karen Donelan et al., *The Cost of Health System Change: Public Discontent in Five Nations*, *Health Aff.*, May/June 1999, at 206, 209-10 (noting that fourteen percent of Americans surveyed report that there was time in past twelve months when they needed medical care but could not get it, compared to ten percent of Britons and Canadians surveyed); see also John V. Jacobi, *The Ends of Health Insurance*, 30 *U.C. Davis L. Rev.* 311, 315 n.19 (1997) (citing sources on uniqueness of U.S. health insurance system).

²⁷ World Health Org., *The World Health Report 2000*, at 155 (2000).

²⁸ The American people are well aware of these deficiencies. One public opinion survey, for example, found that Americans are more likely to rate the quality of health care in their community to be fair or poor and to agree with the statement that their health care system involves too much bureaucracy than are Canadians or Germans. Robert J. Blendon et al., *Who Has the Best Health Care System? A Second Look*, *Health Aff.*, Winter 1995, at 220, 223-24. Americans were also much more likely to have problems paying medical bills or to forego care because of cost. *Id.*; see also Karen Donelan et al., *All Payer, Single Payer, Managed Care, No Payer: Patients' Perspectives in Three Nations*, *Health Aff.*, Summer 1996, at 254, 257-62 (analyzing same survey).

certainly can point to the many problems faced by publicly financed systems.²⁹ But what is remarkable about those who argue so passionately for pouring more public money into our highly problematic system of private health insurance is how few of them engage in this discussion. Most seem simply oblivious to (and some profoundly ignorant of) the experience of the rest of the world with respect to health care finance.³⁰ Given the oft-noted reality that we live in an era of globalization, this is remarkable.

Perhaps, however, it is not so remarkable. Most of those who argue for tax credits are focused myopically on the vaunted merits of tax credits versus tax deductions as a vehicle for encouraging expanded insurance coverage, and ignore other alternatives.³¹ Others paint a very grim picture of the health care systems of the rest of the world as failed socialist experiments.³² This is not universally true. Some private insurance advocates, in fact, have considered seriously the relative merits of private versus public insurance systems, and con-

²⁹ See, e.g., Julian Beltrame, *To Ease Crisis in Health Care, Canadians Eye Private Sector*, Wall St. J., Apr. 10, 2000, at B1; Sarah Lyall, *In Britain's Health Service, Sick Itself, Cancer Care Is Dismal*, N.Y. Times, Feb. 10, 2000, at A1.

³⁰ For example, the more than two hundred pages of Epstein's *Mortal Peril* devoted to the issue of access to health care makes only one brief and unsupported negative reference to the Canadian system, and one brief reference to the British system. See Epstein, *supra* note 19, at 48, 78. One of the few tax credit advocates who advert to the comparative question suggests that health care costs are higher in the United States because of our aging population, yet is seemingly oblivious to the fact that we have one of the youngest populations of OECD nations. See Michael Tanner, *What's Wrong with the Present System*, in *Empowering Consumers*, *supra* note 6, at 27. Such ignorance of other countries' health care systems is, of course, not universal. A number of serious scholars who support private health care finance, including, for example, Mark Pauly and Alain Enthoven, are quite familiar with publicly financed systems. See Alain C. Enthoven, *In Pursuit of an Improving National Health Service*, *Health Aff.*, May/June 2000, at 102; Jörg Finsinger, Kornelius Kraft & Mark Pauly, *Some Observations on Greater Competition in the West German Health-Insurance System from a U.S. Perspective*, 7 *Managerial & Decision Econ.* 151 (1986).

³¹ If our only choice were between subsidizing private insurance through tax deductions, on the one hand, and tax credits, on the other, the arguments for the latter approach would be formidable. See, e.g., Jack A. Meyer et al., *Tax Reform to Expand Health Coverage: Administrative Issues and Challenges* 7-10, 23-24 (2000). On the other hand, our system of tax exclusions and deductions has served us reasonably well as a means of extending health insurance coverage, and a system of tax credits may not perform much better. See Jonathan Gruber & Larry Levitt, *Tax Subsidies for Health Insurance: Costs and Benefits*, *Health Aff.*, Jan./Feb. 2000, at 72, 77-78 (finding that tax credits would reduce number of uninsured only slightly).

³² See, e.g., Grace-Marie Arnett, *Introduction and Overview: Empowering Health Care Consumers Through Tax Reform*, in *Empowering Consumers*, *supra* note 6, at xxv, xxvi ("The social welfare programs—including national health insurance—that had proliferated around the world during the twentieth century were bankrupting governments, sending taxes ever higher, and forcing government rationing and other limitations on health services.").

cluded that private systems perform better given the models they apply.³³ This also is not surprising. Public insurance programs are indeed plagued by inefficiencies and shortages that easily could convince the casual observer that private systems are superior. Free market advocates easily can fall prey to the "Nirvana Fallacy" of comparing their models of perfect individual-purchaser-based free markets to the real world failings of public alternatives, or group health insurance markets, or even regulated insurance markets.³⁴

It is not obvious, however, that private systems for financing health care services are indeed superior to public systems.³⁵ It is also far from clear that individual-purchaser-based insurance markets work better than group markets, or that private insurance markets can function without a heavy overlay of regulation. To begin, the whole point of paying for health care services is to make health care available. Any expenditure for administering health insurance systems is deadweight loss, unless it results in better, cheaper, or more accessible or responsive health care services. The direct administrative costs of public systems tend to be quite low.³⁶ Public systems simply collect funds through taxes and pay the money to providers for services pro-

³³ See *Health Care Policy and Politics: Lessons from Four Countries* (Robert B. Helms ed., 1993). Compare Patricia M. Danzon, *Hidden Overhead Costs: Is Canada's System Really Less Expensive?*, *Health Aff.*, Spring 1992, at 21 (concluding that administrative costs really are higher in Canada than in United States), with Morris L. Barer & Robert G. Evans, *Interpreting Canada: Models, Mind-Sets, and Myths*, *Health Aff.*, Spring 1992, at 44 (responding critically to Danzon's article).

³⁴ See Harold Demsetz, *Information and Efficiency: Another Viewpoint*, 12 *J.L. & Econ.* 1, 1-4 (1969) (discussing Nirvana Fallacy). Patricia Danzon's article on the Canadian system is a classic example of this. Indeed, she admits at the outset that she is comparing ideal public monopoly and competitive private models, but drawing on experience from the Canadian system and ignoring the inefficiencies that actually exist in the United States because of tax and regulatory policy. Danzon, *supra* note 33, at 23. In sum, her article compares a worst-case version of the actual Canadian system with an ideal American system. This fact was noted at the time by Canadian economists who critiqued her article. Barer & Evans, *supra* note 33, at 53.

³⁵ Neither is it at all clear that health care services are of higher quality in the United States than in other developed nations. See, e.g., Gerard F. Anderson, *In Search of Value: An International Comparison of Cost, Access, and Outcomes*, *Health Aff.*, Nov./Dec. 1997, at 163, 169-70; Leslie L. Roos et al., *Health and Surgical Outcomes in Canada and the United States*, *Health Aff.*, Summer 1992, at 56, 57.

³⁶ See Timothy Stoltzfus Jost, *The American Difference in Health Care Costs: Is There a Problem? Is Medical Necessity the Solution?*, 43 *St. Louis U. L.J.* 1, 7 (1999) (comparing percentage of premiums used to pay administration costs by private U.S. insurers to significantly lower percentages for public health programs in United States and Germany); Steffie Woolhandler & David U. Himmelstein, *The Deteriorating Administrative Efficiency of the U.S. Health Care System*, 324 *New Eng. J. Med.* 1253, 1253 (1991). But see Randall R. Bovbjerg, *The High Cost of Administration in Health Care: Part of the Problem or Part of the Solution?*, 23 *J.L. Med. & Ethics* 186, 189 (1995) (book review) (offering cautions with respect to making international comparisons of administrative costs).

vided. Public systems in most countries guarantee access for all,³⁷ and also control costs reasonably effectively. They also have available the same mechanisms for assuring quality that are available in private systems.³⁸

The transaction costs of private insurance systems are at the outset much higher than those of public systems, and the administrative costs of individual policies are much higher than those of group policies.³⁹ Private insurers must incur marketing costs (including often substantial sales commissions) and underwriting costs, which are much higher for individual policies than for group policies.⁴⁰ Administrative "loads" can amount to thirty-five to forty percent in the individual market.⁴¹ Commissions for policy sales alone often run in the ten to twenty percent range for initial sales, and around five percent for renewals.⁴² Private insurers are not able to control costs by imposing global budgets and rather must review individual claims or negotiate

³⁷ See Anderson, *supra* note 35, at 167-68 (noting that United States has lowest percentage of coverage of twenty-nine countries surveyed); Donelan et al., *supra* note 26, at 208-09 (noting that United States is only nation surveyed that does not have universal insurance).

³⁸ See Davis, *supra* note 25, at 139-41. Quality is addressed at many levels in countries with national health services such as the United Kingdom's. See Richard B. Saltman, Thinking About Planned Markets and Fixed Budgets, in *Fixing Health Budgets: Experience from Europe and North America* 3, 6-10 (Friedrich Wilhelm Schwartz et al. eds., 1996) (discussing possibility of quality-based planned markets). See generally Judith Allsop & Linda Mulcahy, *Regulating Medical Work, Formal and Informal Controls* (1996) (discussing mechanisms for quality control in British NHS system); *The International Journal for Quality in Health Care* (discussing efforts at quality assurance in health care in various countries).

³⁹ See H.R. Doc. No. 90-757, at 45-46, 51-52 (1989) (explaining that administrative costs, as percentage of total costs, vary inversely with number of people covered under plan); see also Jost, *supra* note 36, at 7-8; George Schieber & Akiko Maeda, *A Curmudgeon's Guide to Financing Health Care in Developing Countries*, in *Innovations in Health Care Financing* 1, 30-31 (George J. Schieber ed., 1997); John F. Sheils et al., *O Canada: Do We Expect Too Much from Its Health System?*, *Health Aff.*, Spring 1992, at 7, 10-12; Woolhandler & Himmelstein, *supra* note 36, at 1256-57.

⁴⁰ These costs may equal as much as forty percent of premiums for small groups, and as little as six percent of premiums for the large group policies. Mark A. Hall, *Reforming Private Health Insurance* 21 (1994); see also Leah Wortham, *The Economics of Insurance Classification: The Sound of One Invisible Hand Clapping*, 47 *Ohio St. L.J.* 835, 863-69 (1986) (discussing insurance transaction costs).

⁴¹ Two recent studies found loading ratios (the percentage of premiums not spent on benefits) to equal seventeen percent for group policies and from thirty-three to forty percent for individual policies. Mark V. Pauly & Allison M. Percy, *Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets*, 25 *J. Health Pol. Pol'y & L.* 9, 18-20 (2000). A third study put the ratio at thirty-four percent for group policies and forty-three percent for individual policies. Mark A. Hall, *The Geography of Health Insurance Regulation*, *Health Aff.*, Mar./Apr. 2000, at 173, 175.

⁴² Deborah J. Chollet & Adele M. Kirk, *Understanding Individual Health Insurance Markets: Structure, Practices, and Products in Ten States* 54-55 (1998).

discounts or risk-sharing agreements with providers at considerable cost.⁴³ Private insurers charge a “risk premium,” beyond the cost of expected loss, for assuming the risk of loss which is transferred from insureds, which, again, is usually much higher for individual policies.⁴⁴ Where individuals or small groups are insured, this risk premium can become quite large (approaching ten percent of premiums), because the risk becomes so uncertain.⁴⁵ Finally, there is the real, though unquantifiable, cost of the anxiety that many Americans suffer either because they do not have private insurance or because they face a realistic possibility of losing it.⁴⁶ If one is going to use public money to pay for private insurance, one must ask: Where is the added value that justifies the inevitable added costs of private insurance?

Advocates of private insurance argue that it truly does offer added value. Private insurance, they contend, can respond creatively, flexibly, and efficiently to consumer demand.⁴⁷ Private systems enable consumers to choose the health plan that best meets their needs

⁴³ See Barer & Evans, *supra* note 33, at 56-57; Timothy Stoltzfus Jost & Sandra J. Tanenbaum, *Selling Cost Containment*, 19 *Am. J.L. & Med.* 95, 107-09 (1993) (comparing global budgetary and micromanagement methods of cost containment). The individual approach to utilization review typical of American insurers also imposes high costs on health care providers and professionals, who constantly must contend with it. See Jost, *supra* note 36, at 7-8, 17. John Sheils, Gary Young, and Robert Rubin argue that global budgeting may not be as successful in the United States as it is in other nations because of our constitutional commitment to due process. Sheils et al., *supra* note 39, at 17-18. A close examination of the role of the courts in our Medicare system, on the other hand, demonstrates that the courts in fact play a minimal role in our largest public health care financing program and have not proved a major impediment to achieving program goals. See Timothy Stoltzfus Jost, *Governing Medicare*, 51 *Admin. L. Rev.* 39, 45-65 (1999) (detailing Supreme Court deference to Health Care Financing Administration in Medicare cases and how this deference guides lower court decisions).

⁴⁴ Hall, *supra* note 40, at 6; Sheils et al., *supra* note 39, at 11 (citing difficulty in predicting covered claims for small group policies as one reason for greater risk/profit factor).

⁴⁵ By contrast, with large groups the risk premium may be as low as one percent. Hall, *supra* note 40, at 9.

⁴⁶ Barer & Evans, *supra* note 33, at 54. Twenty-nine percent of Americans surveyed in a recent survey either were uninsured or had been uninsured (or had a member of their family uninsured) during the preceding three years, while an additional forty-three percent personally knew someone who had gone without coverage. Robert Wood Johnson Found., *Uninsured National Survey, Summary of Findings* (1999), http://164.109.40.27/rw_news_and_events/eventshc2000/bak-new/summary.htm. Twenty-six percent of those surveyed reported that they or a family member had had to postpone receiving medical treatment because of lack of insurance cover. *Id.* The anxiety caused by lack of insurance is widespread. The fact that Americans frequently are required to change health plans because of job changes or because their employer changes coverage leads to difficulties in continuity of care and access to providers and also contributes to anxiety. See Duchon et al., *supra* note 20, at 8 (explaining how reliance on employer-sponsored health plans creates insecurity in coverage).

⁴⁷ See, e.g., Mark V. Pauly, *An Efficient and Equitable Approach to Health Reform, in Empowering Consumers*, *supra* note 6, at 55, 56-57; Pauly & Percy, *supra* note 41, at 9-10.

and budgets rather than paying more for a one-size-fits-all plan.⁴⁸ Privately insured individuals are more or less free from the waiting lists and shortages that plague public systems.⁴⁹ Private systems, it is argued, are better able than public systems to manage the cost and quality of health care;⁵⁰ individual markets are more capable of harnessing the forces of market competition to control the growth of health care costs.⁵¹

These virtues are certainly present in economists' models, but do they exist in the real world? The world provides a great deal of evidence for comparing the performance of public and private health insurance systems. Excepting a handful of lingering hard-line Communist countries, private health insurance exists everywhere.

⁴⁸ Danzon, *supra* note 33, at 27 (concluding that diversity of options in private systems is in response to patient demand); Pauly, *supra* note 47, at 57 (arguing that allowing consumers to find plan that suits their specific needs is most efficient).

⁴⁹ Danzon, *supra* note 33, at 31-32. Arguably, the immediate availability that Americans insist on from their health care system is one of the most important features of that system. See Sherry Glied, *Chronic Condition: Why Health Reform Fails* 93-101 (1997) (discussing importance of considering nonmonetary benefits, such as quick access to local providers, when measuring health care costs); Jost, *supra* note 36, at 8-12 (comparing access to medical services and speed of treatment in United States and Canada). Americans, of course, also experience delays in treatment. The average number of days that patients had to wait to see a specialist, according to one survey, was five in the United States, fourteen in Canada, and four in Germany. Donelan et al., *supra* note 28, at 259. Moreover, waiting times in the United States may be getting worse for some patients. The same survey found that sick, nonelderly persons in limited-choice managed care plans in the United States waited, on average, seventeen days to see a doctor. *Id.* at 263.

⁵⁰ Danzon, *supra* note 33, at 25-26 (arguing that competition creates incentives for insurers to promote risk-averse behavior in insureds and lower administrative costs). Another argument often made by some advocates of private insurance is that risk-based pricing of insurance encourages risk-reducing behavior. See Kenneth S. Abraham, *Distributing Risk: Insurance, Legal Theory, and Public Policy* 77-79 (1986) (arguing that insurance priced below expected cost discourages insureds from taking safety precautions); Epstein, *supra* note 19, at 53-58, 125-26, 132-33 (same); Hall, *supra* note 40, at 29 (describing role of private markets in risk reduction). While the prospect of paying lower premiums may induce employers to offer fitness programs, and even might encourage some insureds to pursue healthier lifestyles, the issue is sharply contested, and Epstein offers no empirical evidence to support what certainly seems to him to be a self-evident proposition. See Robert L. Schwartz, *Making Patients Pay for Their Life-Style Choices*, 4 *Cambridge Q. Healthcare Ethics* 393, 394-95 (1992) (disputing voluntariness of unhealthy lifestyles). Obesity affects 19.7% of American men and 24.7% of American women (predominantly privately insured), compared to 15% of English men and 16.5% of English women, and 1.8% of Japanese men and 2.6% of Japanese women (who are socially insured). Kumudini Mayur, *Obesity: A Growing Problem*, *Futurist*, Oct. 1999, at 14, 14. Tobacco use, on the other hand, is lower among Americans than it is in many other countries. See Barbara Starfield, *Is U.S. Health Really the Best in the World?*, 284 *JAMA* 483, 483 (2000). Many diseases, of course, are caused primarily by genetic or environmental factors that the insured can do little to influence.

⁵¹ See Enthoven, *supra* note 24, at 89-92 (arguing that competition would "solve the problem of health care costs").

While no other country in the world has as high a proportion of the population privately insured as does the United States,⁵² nearly thirty-one percent of the population of Australia has private health insurance,⁵³ and in Chile, where the Constitution guarantees citizens the right to purchase private health insurance, over one-quarter of the population has done so.⁵⁴ In Germany and the Netherlands, only persons whose incomes fall below a specified level must participate in the public insurance program, while the remainder of the population is free to purchase private insurance, or to go without insurance altogether.⁵⁵ In each of these countries, insurance is bought primarily by individuals rather than for employee groups. Sophisticated private insurance concerns compete to insure the wealthy citizens of these countries, who almost never choose to remain uninsured.⁵⁶ Even though universal coverage of most important health care services is available in the United Kingdom, France, and Canada, many persons purchase supplemental insurance to pay for noncovered services and amenities, to obtain access to certain providers, or to avoid waiting lists in the public sector.⁵⁷

If one looks at private insurance markets throughout the world, one striking fact emerges: There is a significant gap between the models of economists and the real world of private insurance. In particular, in countries that rely on private insurance as a primary means of health care finance and where private insurance is sold predominantly

⁵² Arguably, a higher proportion of the population of Switzerland is privately insured. Since late 1994, however, health insurance has been mandatory in Switzerland, and is now denominated social insurance, though it is provided through private companies. Paul J. Donahue, *Federalism and the Financing of Health Care in Canada and Switzerland: Lessons for Health Care Reform in the United States*, 21 *B.C. Int'l & Comp. L. Rev.* 385, 423-24 (1998). Though this Article does not address insurance regulation in Switzerland, many of the features discussed in this Article, such as limitations on premium underwriting and government subsidies, are evident in Switzerland. *Id.* at 423-26.

Some have posited that South Korea has a high proportion of privately insured people, but most experts agree that health insurance in Korea is described best as social insurance. See Seung-Hum Yu & Gerard F. Anderson, *Achieving Universal Health Insurance in Korea: A Model for Other Developing Countries?*, 20 *Health Pol'y* 289, 290 (1992) (discussing history and features of health care in South Korea).

⁵³ Private Health Ins. Admin. Council (PHIAC), *Operations of the Registered Health Benefits Organisations, Annual Report, 1998-99*, at 1 (1999).

⁵⁴ Rubi Valenzuela Magaña, *Superintendencia de Instituciones de Salud Previsional [Superintendency of Health Insurance Institutions] (SISP), An Overview of the Private Health System in Chile* 6 (1998).

⁵⁵ See *infra* text accompanying notes 188-90, 265.

⁵⁶ Insurance is not mandatory in Germany for those whose incomes exceed about \$3200 a month. See *infra* note 189 and accompanying text. However, only about 0.01% of the population is uninsured. Comité Européen des Assurances (CEA), *Health Insurance in Europe* 28 (1997).

⁵⁷ See *infra* text accompanying notes 327-42.

to individuals, insurance is almost without exception heavily regulated, and often also government subsidized.⁵⁸ True free markets for private health insurance are certainly not the norm; indeed, they are quite unusual. Only where private insurance is supplemental, covering nonessential services or duplicating public coverage, can insurance markets that approximate competitive models be found.⁵⁹

The rarity of free markets for private insurance, however, is not the result of an accident. Private health insurance markets are attended by serious and widely recognized market failures, which generally are exacerbated in individual markets and make public regulation almost unavoidable.⁶⁰ The most common forms of regulation, however, introduce other problems, which in turn result in further regulation and often in public subsidies as well. Only when private insurance remains at the fringes of comprehensive public health care finance programs is it likely to remain largely unregulated. Indeed, even in the United States, the most libertarian of developed nations, private health insurance has long been regulated and subsidized, and the current policy initiatives, discussed above,⁶¹ would lead to more regulation and more subsidies.⁶²

If we are to apply a fair comparison, therefore, at least for academic purposes (again, I am not under the illusion that academic analysis here can result in real-world policy changes), we must compare the relative merits of actual, highly regulated and subsidized private insurance systems with public systems. When we do so, we find that many of the proffered virtues of ideally competitive private insurance markets, such as efficiency, flexibility, creativity, and responsiveness to consumer demand, fade from view. Moreover, many of the theoretical and real-world deficiencies of public health care financing programs—their indifference to consumer desires and the inefficiencies attendant on tax financing—are also apparent in real-world private financing programs.⁶³ We also see that the level of regulation is much higher when individual, as opposed to group, policies are involved. Finally, we generally see that private insurance programs pay more for services—not less—than public programs.⁶⁴ When we leave the nirvana of economic models and return to the real world, the superiority

⁵⁸ See *infra* Part II.

⁵⁹ See *infra* Part II.F.

⁶⁰ See *infra* text accompanying notes 347-78.

⁶¹ See *supra* text accompanying notes 4-14.

⁶² The current federal tax subsidy for private health insurance was worth \$11.2 billion in 1998. John Sheils & Paul Hogan, *Cost of Tax-Exempt Health Benefits in 1998*, *Health Aff.*, Mar./Apr. 1999, at 176, 176.

⁶³ See *infra* text accompanying notes 424-29.

⁶⁴ See *infra* text accompanying notes 435-36.

of private to public systems seems much less clear cut; indeed, public programs may come out on top.

The goals of this paper are modest. I will attempt to describe the private insurance regulatory environment of five nations—Australia, Chile, Germany, the Netherlands, and the United States—in which private, often individually purchased, insurance plays a prominent role in health care finance and, much more briefly, of three nations—Canada, France, and the United Kingdom—in which private, largely group insurance plays a more marginal role. I then will examine why the regulatory environment appears as it does. Finally, I will consider how theoretical and empirical comparative analysis ought to proceed in comparing public and private systems in the real world.

I

OPTIONS FOR PAYING FOR HEALTH CARE

Before we commence our comparative exploration of private and public insurance systems, it may be useful first to elucidate the range of options available for paying for health care. Five such options are observable in the world's health care systems: out-of-pocket payment, charitable provision, payroll tax-funded social insurance, general revenue tax-based national health insurance systems, and private insurance. Out-of-pocket direct payment and charitable provision were the earliest approaches historically. Private charity continues to play an important role in funding health services in developing nations, but it is a marginal consideration in developed nations.⁶⁵ Out-of-pocket payments are also a very important means of funding health care services in less developed nations, and they continue to play an important role in most developed countries.⁶⁶ In particular, they remain important for funding consumer cost-sharing obligations and for purchasing nonbasic services not covered by insurance, such as eyeglasses or alternative medicine.⁶⁷ In developed nations, however, es-

⁶⁵ See Schieber & Maeda, *supra* note 39, at 30-31 (pointing out that charitable contributions generally constitute "small portion of total health spending" in industrial countries).

⁶⁶ See George Schieber & Akiko Maeda, *Health Care Financing and Delivery in Developing Countries*, *Health Aff.*, May/June 1999, at 193, 200-03 (noting that as country's per capita income increases, public funding finances larger share of health care services, while private insurance is very limited in poorest countries).

⁶⁷ During 1997, in the United States, for example, out-of-pocket payments funded forty-nine percent of vision products and other medical durables and forty-seven percent of dental care, but only three percent of hospital care and sixteen percent of physicians' services. Bradley R. Braden et al., *National Health Expenditures, 1997*, 20 *Health Care Financing Rev.* 83, 116 (1998) (tabulating data on types of health expenditures and sources of funds).

sential, high-cost services normally are funded by private or public insurance rather than by out-of-pocket payments.⁶⁸

It is obvious why health insurance has become so common. In any given year, the burden of health care expenditures is extraordinarily concentrated on a small number of persons.⁶⁹ Though large health care expenditures are borne disproportionately by the elderly and the chronically ill, even the young and healthy are at risk of suffering accidents or diseases that easily could overwhelm their financial capacity.⁷⁰ Only the very wealthy, or the very poor, can afford to self-insure for sickness and accident without risking financial disaster.⁷¹ The purchase of health insurance is, therefore, a rational response to generally unpredictable risk.⁷²

Reliance on health insurance, however, goes beyond levels that would seem rational. Many Americans, for example, purchase insurance for routine expenditures, such as optical care or preventive dental care, that are more or less predictable and easily could be managed through savings.⁷³ This phenomenon may be in part explained in the United States by the tax subsidy afforded employed persons with health insurance, which makes it cheaper to cover these expenses with before-tax dollars through insurance than with after-tax dollars out-of-pocket.⁷⁴ This, however, does not wholly explain the phenomenon. Medicare recipients overwhelmingly insure themselves against the

⁶⁸ See *id.* (showing that, in 1997, private and public health insurance together paid eighty-two percent of cost of physical services and ninety-two percent of cost of hospital care).

⁶⁹ See Anne K. Gauthier et al., *Risk Selection in the Health Care Market: A Workshop Overview*, 32 *Inquiry* 14, 15 (1995) (noting that more than thirty-five percent of subscribers submit no claims in given month, while less than five percent of subscribers account for vast majority of claims).

⁷⁰ Mark A. Hall, *Making Medical Spending Decisions: The Law of Ethics and Economics of Rating Mechanisms* 29 (1997).

⁷¹ The wealthy because they can afford to, the very poor because they have nothing to lose.

⁷² See Hall, *supra* note 40, at 6-8 (explaining how insurance allows subscribers to avoid bearing full brunt of loss, to reduce risk in aggregate, and to take advantage of economies of scale); Wortham, *supra* note 40, at 843 (stating that insurance can provide such societal benefits as stability and psychological security and can produce overall social gain).

⁷³ See Schieber & Maeda, *supra* note 39, at 12 (asserting that "many individuals want to be insured against small predictable losses").

⁷⁴ Hall, *supra* note 40, at 25 (citing "implicit tax subsidy for employer-paid health expenses" as reason that "the costs of predictable health needs are less than what employees would have to pay from after-tax wages"); Mark V. Pauly, *Taxation, Health Insurance, and Market Failure in the Medical Economy*, 24 *J. Econ. Literature* 629, 638 (1986) (explaining that tax subsidy renders it "cheaper (after taxes) to pay one's medical care bills via insurance than to pay them directly"). Pauly cites studies to establish that "the tax subsidy *is* known to matter to the choice of group insurance," *id.* at 646, and alludes to the normative proposition that this subsidy "has warped the choice process" so as to result in excessive purchase of insurance, *id.* at 629.

cost-sharing obligations imposed by Medicare, even though they receive no tax benefits from doing so. The tendency to overinsure may have as much to do with consumer and provider culture and preferences as with tax subsidies.⁷⁵ Whatever the reason, however, in most of the developed world, most people are insured through public or private systems that afford a high level of insurance coverage.

Individual risk aversity and preference for health insurance, moreover, are not the only factors explaining the prevalence of health insurance throughout the world. In most nations, the ideal of social solidarity also plays a significant role.⁷⁶ Insurance is not merely a means through which individuals shield themselves against the risk of incurring health care expenditures, but is also the means through which societies afford their citizens who lack financial resources a measure of security and basic opportunity to participate in society.⁷⁷ To achieve this ideal of social solidarity, all but the least developed nations have established some form of public health insurance.⁷⁸

Two basic approaches have been devised for providing public insurance: social insurance and tax-based insurance programs.⁷⁹ The social insurance approach to health care finance originated in Bismarck's Germany in the 1880s and continues today in the sickness funds of Central Europe, Asia, and Latin America and in the Medicare program in the United States.⁸⁰ Social insurance programs

⁷⁵ E-mail from Randall Bovbjerg, Principal Research Associate, Urban Institute, to Timothy Stoltzfus Jost, Professor of Law, Ohio State University (June 13, 2000) (on file with the *New York University Law Review*).

⁷⁶ Schieber & Maeda, *supra* note 39, at 10-11 (asserting that "governments often provide access to health services for people who cannot afford them" because "almost all societies view access to health care as a basic human right"); Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 *J. Health Pol. Pol'y & L.* 287, 290-92 (1993) (arguing that medical care is financed through social insurance because of "solidarity principle," namely, "that medical care should be distributed according to medical need").

⁷⁷ See Donald W. Light, *The Practice and Ethics of Risk-Rated Health Insurance*, 267 *JAMA* 2503, 2507-08 (1992) (discussing morally fair underwriting); Stone, *supra* note 76, at 290-92 (discussing solidarity principle).

⁷⁸ World Health Org., *supra* note 27, at 192-95.

⁷⁹ Laurene A. Graig, *Health of Nations: An International Perspective on U.S. Health Care Reform* 3-4 (3d ed. 1999); see also Richard B. Saltman & Josep Figueras, *European Health Care Reform: Analysis of Current Strategies* 115-39 (1997) (discussing funding of health services in Europe).

⁸⁰ See Jörgen Marrée & Peter P. Groenewegen, *Back to Bismarck: Eastern European Health Care Systems in Transition* 6, 12-13 (1997) (reporting that former Czechoslovakia, Hungary, and to some extent Poland were among first countries to introduce Bismarckian social insurance and recently have reintroduced it); Bengt Jönsson & Philip Musgrove, *Government Financing of Health Care, in Innovations in Health Care Financing*, *supra* note 39, at 41, 46-51 (discussing existence of social insurance approach in various countries).

also are emerging in the former Communist nations of Eastern Europe.⁸¹

Social insurance programs collect from their insureds a payroll tax—an employee contribution—which is withheld from the insureds' income or is paid by their employers.⁸² Social insurance funds spend this money to cover the cost of health care received by these insureds and also insure against the risks of unemployment, retirement, occupational injury or disease, and disability.⁸³ In some nations these funds are administered by the government; in many they are administered by quasi-public entities that are occupationally, religiously, or politically based.⁸⁴ In a few nations, an attempt is made to establish trust funds to cover future medical expenses of contributors.⁸⁵ Most social insurance programs, however, are funded on a pay-as-you-go basis. Because social insurance programs are tied to earmarked, wage-based "contributions," they do not always guarantee universal coverage.⁸⁶

While social insurance programs began in the nineteenth century as attempts to forestall the growth of socialism, tax-based national health insurance programs are predominantly the creations of twentieth-century socialist governments.⁸⁷ Tax-based insurance programs are funded through general revenue taxes.⁸⁸ They are administered by government entities.⁸⁹ They usually cover the entire population, regardless of occupation (though in some nations they are means-

⁸¹ Marrée & Groenewegen, *supra* note 80, at 12-13 (describing post-1989 reintroduction of social insurance in Eastern Europe); Saltman & Figueras, *supra* note 79, at 123-27 (detailing characteristics of social insurance programs emerging in Eastern European nations).

⁸² Jönsson & Musgrove, *supra* note 80, at 46-47 (indicating that social insurance is financed through payroll taxes, paid by workers or employers). Both methods of financing are economically identical.

⁸³ In fact, social insurance programs initially focused on wage replacement and only later and gradually came to focus on covering the costs of medical treatment, because wage losses were usually much greater than health care costs. Paul Starr, *The Social Transformation of American Medicine* 238, 245 (1982) (reporting that health insurance was aimed originally only at compensating for wage losses occasioned by illness and that such losses were two to four times greater than health care costs for individual workers).

⁸⁴ Jönsson & Musgrove, *supra* note 80, at 47 (noting that social insurance programs sometimes are administered by independent bodies).

⁸⁵ This is true of the Hospital Insurance portion of the U.S. Medicare program. See 42 U.S.C.A. § 1395i (1992 & Supp. 2000) (establishing Federal Hospital Insurance Trust Fund); see also 26 U.S.C. §§ 1401(b), 3101(b), 3111(b) (1994) (setting tax rates for trust fund contributions).

⁸⁶ See Richard A. Knox, *Germany: One Nation with Health Care for All* 54-62 (1993) (describing gaps in coverage in Germany).

⁸⁷ See Starr, *supra* note 83, at 238-39.

⁸⁸ See Jönsson & Musgrove, *supra* note 80, at 46.

⁸⁹ *Id.* at 47.

tested). The archetypal tax-based insurance program, the British National Health Service (NHS), established by the Labour government which came to power following World War II, purchases hospital care from public hospitals and primary care services from private general practitioners.⁹⁰ Tax-based insurance programs also exist in the Scandinavian countries, Spain, Portugal, and Italy, and in one form or another, in many developing nations.⁹¹ Our own Medicaid program bears many of the hallmarks of a tax-based insurance program described above.

Though both social insurance and tax-based insurance programs rely on public funding of health care services, neither approach is necessarily tied to public provision of services. Some national health service programs, such as those found in Sweden, provide health care services predominantly through the program's own salaried professionals.⁹² In the British, Canadian, and Danish national health services, on the other hand, general practitioners are independent professionals who cooperate with the health service as independent contractors, not employees.⁹³ In most national health service systems, hospitals are publicly owned.⁹⁴ Hospitals in social insurance countries often are publicly owned, though some countries, such as the Netherlands, have a large proportion of private nonprofit or religious hospitals.⁹⁵

Tax-based programs coexist with social insurance programs in some developing countries, with wealthier workers employed in the formal economy enrolled in social insurance programs, while other citizens, who do not receive regular wages, obtain health care through

⁹⁰ See Donald Light & Annabelle May, *Britain's Health System: From Welfare State to Managed Markets* 14-15 (1993) (describing British system).

⁹¹ See Marrée & Groenewegen, *supra* note 80, at 8, 11-12.

⁹² Stefan Håkansson & Sara Nordling, *The Health System of Sweden*, in *Health Care and Reform in Industrialized Countries* 191, 198-99 (Marshall W. Raffel ed., 1997) [hereinafter *Industrialized Countries*].

⁹³ Peter R. Hatcher, *The Health System of the United Kingdom*, in *Industrialized Countries*, *supra* note 92, at 227, 242-43; Allan Krasnik & Signild Vallgård, *The Health System of Denmark*, in *Industrialized Countries*, *supra* note 92, at 29, 31-32; Peggy Leatt & A. Paul Williams, *The Health System of Canada*, in *Industrialized Countries*, *supra* note 92, at 1, 8-12.

⁹⁴ Hatcher, *supra* note 93, at 229 (noting that in United Kingdom, many hospitals are self-governing trusts, but are still public institutions); Krasnik & Vallgård, *supra* note 93, at 33 (describing Danish hospital system); Leatt & Williams, *supra* note 93, at 12 (noting that in Canada, some hospitals are owned by religious institutions).

⁹⁵ J.A.M. (Hans) Maarse, *The Health System of the Netherlands*, in *Industrialized Countries*, *supra* note 92, at 135, 141. In Germany, about half of the hospital beds are publicly owned, and the remainder are in religious or private hospitals. Wolfgang Greiner & J.-Matthias Graf v.d. Schulenburg, *The Health System of Germany*, in *Industrialized Countries*, *supra* note 92, at 77, 88.

public hospitals and clinics.⁹⁶ Most countries with social insurance programs make allowance for persons who are not participating in the workforce by publicly subsidizing the purchase of social insurance, or by establishing a separate system.⁹⁷ Finally, many countries have a completely separate program for public employees and members of the military, as does the United States.⁹⁸

In virtually every nation on Earth, various private health care financing arrangements coexist with public health care financing. The earliest private health care financing schemes were those operated by guilds, clubs, lodges, or other nonprofit fraternal organizations.⁹⁹ These organizations provided their members with medical services, often through the means of contract doctors or clinics, and usually as an adjunct to provision of sick or disability pay, which was much more important to their members in the early years.¹⁰⁰ In the United States, provider-sponsored nonprofit plans played a pivotal role in the development of private health insurance in the middle of the last century.¹⁰¹ Private health care finance is still provided in many nations through

⁹⁶ See Deborah J. Chollet & Maureen Lewis, *Private Insurance: Principles and Practice, in Innovations in Health Care Financing*, supra note 39, at 77, 106-09 (examining roles, characteristics, and extent of private health insurance coverage and main alternatives in various countries).

⁹⁷ See, e.g., Ass'n of Dutch Health Insurers, *Health and Health Care in the Netherlands 3* (1999) (noting that social insurance includes recipients of social security); Knox, supra note 86, at 58-59 (explaining that Germany subsidizes purchase of insurance).

⁹⁸ In the United States, for example, the Federal Employees Health Benefits program covers federal employees. Comm. on Employer-Based Health Servs., Inst. of Med., *Employment and Health Benefits: A Connection at Risk 73* (Marilyn J. Field & Harold T. Shapiro eds., 1993) [hereinafter IOM]. The Department of Defense and CHAMPUS cover members of the military and their dependents. Barry Furrow et al., *Health Law: Cases, Materials and Problems 838* (3d ed. 1997).

⁹⁹ IOM, supra note 98, at 51 (discussing early voluntary initiatives); Edwin J. Faulkner, *Accident-and-Health Insurance 15-16* (1940) (discussing Friendly Societies and early health insurance in the United States); David G. Green, *Working-Class Patients and the Medical Establishment: Self-Help in Britain from the Mid-Nineteenth Century to 1948*, at 8-14 (1985) (discussing work clubs, provident dispensaries, medical aid companies, doctors' clubs, public medical services, and Friendly Society schemes); Almont Lindsey, *Socialized Medicine in England and Wales: The National Health Service 1948-61*, at 5-6 (1962) (same); Gordon McLachlan, *A History of the Nuffield Provincial Trust 352-53* (1992) (same); Starr, supra note 83, at 239-40 (discussing various schemes in England and Germany).

¹⁰⁰ IOM, supra note 98, at 51-53; Starr, supra note 83, at 206-09. As with social insurance in the early years, wage loss replacement was often a more important benefit of these programs than was coverage of medical costs. *Id.* at 245, 258.

¹⁰¹ See Odin W. Anderson, *Blue Cross Since 1929: Accountability and the Public Trust 29-44* (1975) (tracing development of Blue Cross in 1930s); IOM, supra note 98, at 66-70 (recounting development of Blue Cross and Blue Shield); Herman Miles Somers & Anne Ramsay Somers, *Doctors, Patients, and Health Insurance: The Organization and Financing of Medical Care 291-95, 317-22* (1961) (same); Starr, supra note 83, at 295-310 (same).

mutual or nonprofit insurance organizations, epitomized in the United States by the Blue Cross and Blue Shield plans.¹⁰²

Employers and unions or other worker organizations also played an early role in providing or paying for health care for employees.¹⁰³ Again, health care in the early years often was provided through contract doctors or clinics.¹⁰⁴ At the present time, however, virtually all employee benefit plans (either self-insured or administered by private insurers) pay independent providers or managed care organizations directly for health care services or indemnify their beneficiaries for services the beneficiaries purchase.¹⁰⁵ Employee benefit plans generally are provided in the United States through Employee Retirement Income Security Act (ERISA) plans and are common in many other countries as well.

Over time, private commercial insurers, which had long provided life and casualty insurance, became interested in health coverage as well. Although commercial medical insurance appeared as early as the nineteenth century, many commercial insurers regarded the costs of medical treatment to be uninsurable until well into the twentieth century. It was thought that the risk of ill health was too difficult to predict and the problem of moral hazard too significant to justify health insurance as a commercial venture.¹⁰⁶ Once Blue Cross and employment-related organizations created successful insurance programs, however, commercial insurers also entered the market.¹⁰⁷ Though for the first several decades of its existence commercial insurance meant indemnity insurance, today it generally means managed care: schemes in which the payer plays a role in managing the in-

¹⁰² Blue Cross and Blue Shield plans had 67.6 million members in the United States in 1996. HIAA, *Source Book of Health Insurance Data, 1999-2000*, at 39 (1999) (providing breakdown of health insurers by type and year).

¹⁰³ IOM, *supra* note 98, at 54-55 ("In the early part of [the twentieth] century, company medical services could be one component of 'welfare capitalism,' a range of housing, education, social assistance, and other programs intended to socialize workers, bind them to their employer, and discourage unions."); Somers & Somers, *supra* note 101, at 229-31 ("The majority of health and welfare plans were set up by employers without direct participation by organized labor."); Starr, *supra* note 83, at 200-06, 241 (discussing company plans). A key factor in the expansion of these plans was the recognition of the nontaxability of employer-paid premiums for these plans. See Melissa A. Thomasson, *The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance* (Nat'l Bureau of Econ. Research, Working Paper No. 7543, 2000), available at <http://www.nber.org/papers/w7543.pdf>.

¹⁰⁴ IOM, *supra* note 98, at 65-66; Starr, *supra* note 83, at 200-06.

¹⁰⁵ See HIAA, *supra* note 102, at 13-24 (discussing types of health insurance currently available); Starr, *supra* note 83, at 291-95 (same).

¹⁰⁶ Starr, *supra* note 83, at 294-95.

¹⁰⁷ J.F. Follmann, Jr., *Medical Care and Health Insurance: A Study in Social Progress* 112-13 (1963); Starr, *supra* note 83, at 331-32.

sured's care, perhaps even providing care directly itself through health maintenance organization arrangements.¹⁰⁸

Only in the United States has private health insurance in its various forms become the dominant form of payment for health care.¹⁰⁹ Even in the United States, it is only dominant in terms of the proportion of the population covered—not in terms of the proportion of medical expenses paid.¹¹⁰ In other nations private health insurance coexists with public insurance programs, serving one of two functions.

First, in some nations—most often those with social insurance programs—private insurance is available as an alternative to social insurance, usually for those not obligated by law to purchase social insurance.¹¹¹ In Germany, for example, only persons earning less than 6450 DM (\$3200) a year are subject to mandatory enrollment in the social insurance funds.¹¹² Persons earning more than this amount in general can choose to be insured either through the social insurance funds or through private health insurance funds.¹¹³ In Chile, all persons are required to pay seven percent of their wages toward the purchase of health insurance, but all can choose either to use these funds to obtain social insurance coverage or to purchase private health insurance if they can afford it.¹¹⁴

Second, in many nations—predominantly those with tax-based insurance programs—private health insurance is used to supplement public insurance schemes.¹¹⁵ In several countries, for example, private insurance covers health care products and services not insured by public insurance, such as optical or dental care in several Canadian prov-

¹⁰⁸ Though HMO-type arrangements are classified for some purposes as prepayment arrangements rather than insurance (i.e., they look more like a computer service plan than like a life insurance policy), they do involve the payment of premiums, the transfer of risk, and payment for services, and thus will be classified as insurance for our purposes.

¹⁰⁹ William A. Glaser, *Health Insurance in Practice: International Variations in Financing, Benefits, and Problems* 6-7 (1991).

¹¹⁰ In 1997, seventy percent of the American population was covered by private health insurance, and twenty-six percent was covered by public programs, whereas private health insurance covered 32.6% of national health expenditures compared to 46.7% covered by public programs in 1996. HIAA, *supra* note 102, at 11, 92.

¹¹¹ Glaser, *supra* note 109, at 65-68 (1991) (noting variations between countries).

¹¹² Andreas Besche, *Das Nebeneinander von GKV und PKV im Spiegel der Gesundheitspolitik* [The Coexistence of Social Health Insurance and Private Health Insurance in the Light of Health Policy], Presentation at the Herbsttagung der Arbeitskreises "Vertretervereinigung der deutschen Assecurance" [Fall Conference of the Working Party of the Association of German Underwriting Representatives] (Oct. 25, 1999) (transcript on file with the *New York University Law Review*).

¹¹³ See *infra* text accompanying notes 189-91.

¹¹⁴ See *infra* text accompanying notes 133-46.

¹¹⁵ Glaser, *supra* note 109, at 77-81.

inces,¹¹⁶ pharmaceuticals in the United States for Medicare beneficiaries,¹¹⁷ or certain ancillary services in Australia.¹¹⁸ In other nations, such as the United Kingdom or Australia, private insurance is purchased by persons who in fact are fully insured by social insurance or tax-based insurance schemes to provide double coverage, in order to assure prompter or more convenient access to health care, more control over choice of provider, or access to better quality health care.¹¹⁹ Private health insurance serves, therefore, as a safety valve for public systems with limited budgets. Some authorities distinguish analytically between supplemental insurance that covers cost-sharing obligations and noncovered services and supplemental insurance that provides double coverage.¹²⁰ As our concern is primarily with regulation of access to insurance, this distinction is unnecessary, as neither form of supplemental insurance is regulated extensively.

A general summary of approaches to health care finance, however, cannot capture the richness and variety of health care finance as it exists in individual nations. We turn now to several country case studies, before returning to a more generalized analysis.

II COUNTRY CASE STUDIES

A. *Chile*¹²¹

As just noted, one approach to the accommodation of public and private health care finance is for the two systems to be offered as alternatives. In other words, part of the population is publicly insured, another part privately insured. This model is being promoted by government policy in a number of South American countries, most nota-

¹¹⁶ Colleen M. Flood, *The Structure and Dynamics of Canada's Health Care System*, in *Canadian Health Law and Policy* 5, 29 (Jocelyn Downie & Timothy Caulfield eds., 1999).

¹¹⁷ See Barry R. Furrow et al., *Health Law* § 9-8 (2d ed. 2000) (discussing U.S. Medigap coverage).

¹¹⁸ See *infra* text accompanying notes 231-33.

¹¹⁹ Chollet & Lewis, *supra* note 96, at 77, 79 (discussing role of private insurance); Glaser, *supra* note 109, at 78-80 (discussing private insurance in United Kingdom).

¹²⁰ See Jürgen Wasem, *Regulating Private Health Insurance Markets*, Presentation at the Four Country Conference on Health Care Reforms and Health Care Policies in the United States, Canada, Germany and the Netherlands, Amsterdam-Rotterdam, Neth. 79, 81-82 (Feb. 23-25, 1995) (unpublished manuscript, on file with the *New York University Law Review*).

¹²¹ For a fuller explanation of regulation of private health insurance in Chile, see generally Timothy Stoltzfus Jost, *Managed Care Regulation: Can We Learn from Others? The Chilean Experience*, 31 *U. Mich. J.L. Reform* 863 (1999), from which much of the following material is drawn.

bly Chile, Argentina, Brazil, Uruguay, and Colombia.¹²² It has the longest tradition in Chile, the only nation in the world (as far as I know) whose constitution guarantees its residents a right to purchase private health insurance. Article 19, Section 9 of the 1980 Chilean Constitution, dealing with the "Right to Health Protection," provides: "Each person shall have the right to choose the health system, whether State or private, that he wishes to join."¹²³

This right is by no means merely theoretical. Currently 3.8 million persons, about twenty-six percent of the Chilean population, and thirty-two percent of the workforce, are privately insured by thirty-three Chilean private health insurance companies (Instituciones de Salud Previsional or ISAPREs).¹²⁴ Most of these persons are insured under individual policies, though some of the smaller ISAPREs are "closed" ISAPREs that insure only a single employer or industry, and some members of open ISAPREs are insured as part of an employee group.¹²⁵ In 1995, forty-two percent of all Chilean health expenditures (totaling U.S. \$2.65 billion) came from the private sector.¹²⁶

Chile has long been a leader in Latin America, and indeed in the world, in public health care provision. As early as the nineteenth century, it established public health institutions to address the problem of communicable diseases.¹²⁷ In the 1920s, it established a social insurance system, covering workers and their families.¹²⁸ In the 1950s, it also created a National Health Service (SNS), resembling the British

¹²² Chollet & Lewis, *supra* note 96, at 96-97, 106-09; see also André Cezar Medici et al., *Managed Care and Managed Competition in Latin America and the Caribbean*, in *Innovations in Health Care Financing*, *supra* note 39, at 215-29 (examining four basic systems found in Latin America and Caribbean: health care providers financed out-of-pocket, private health insurance financed by prepaid contributions, social insurance systems financed by mandated employer and employee contributions, and publicly delivered health care).

¹²³ Raúl Bertelsen Repetto, Chile, in *The Right to Health in the Americas: A Comparative Constitutional Study* 166, 172 (Hernán L. Fuenzalida-Puelma & Susan Scholle Connor eds., 1989).

¹²⁴ Valenzuela Magaña, *supra* note 54, at 6, 9.

¹²⁵ See *infra* text accompanying notes 153-55.

¹²⁶ SISP, Chilean Health Statistics (1997) (unpublished manuscript data supplied by SISP to author, on file with the *New York University Law Review*).

¹²⁷ Jorge Jimenez de la Jara & Thomas J. Bossert, *Chile's Health Sector Reform: Lessons from Four Reform Periods*, in *Health Sector Reform in Developing Countries: Making Health Development Sustainable* 199, 202 (Peter Berman ed., 1995) (describing nineteenth-century health insurance institutions that focused on preventing spread of smallpox and cholera).

¹²⁸ *Id.* The Servicio Médico Nacional de Empleados [National Medical Service of Employees] (SERMENA) was organized under a 1968 statute as a separate legal entity to provide social insurance for white-collar employees. Mercedes Cifuentes, *Health Care*, in *Private Solutions to Public Problems* 53, 62 (Cristián Larroulet ed., 1993) (describing SERMENA's Free Choice system under which beneficiaries may choose from medical professionals registered with SERMENA).

NHS, which used social security payroll taxes and general tax revenues to finance a system of public hospitals and clinics, as well as to provide basic public health services.¹²⁹

The Pinochet military government of the 1970s, heavily influenced by the free-market ideology of the University of Chicago, implemented a free-market model for the financing of health care.¹³⁰ This system did not replace the public system, however, as the Pinochet government's dedication to libertarian ideals was accompanied by a commitment to improving health care for the very poor and to improving preventive and primary care generally.¹³¹ Rather, the Pinochet government combined the social insurance and national health service systems, at the same time separating the public purchaser and provider functions within the public system.¹³² More importantly for our purposes, the Pinochet government also created a separate private insurance system, administered through the ISAPRES.

Under the current Chilean system, all employees, self-employed persons who contribute to the social security pension system, and indigents are covered by the public system, the National Health Fund (FONASA), unless they elect to purchase private insurance coverage.¹³³ All FONASA beneficiaries can choose either to receive services in public facilities (for which they must pay copayments ranging from zero to fifty percent according to income) or to purchase vouchers that allow them to receive services through FONASA's network of private preferred providers.¹³⁴ FONASA is financed by payroll taxes

¹²⁹ Jimenez & Bossert, *supra* note 127, at 203; see also Cifuentes, *supra* note 128, at 62 (describing birth of public health care system through Servicio Nacional de Salud [National Health Service] (SNS) and preponderance of State's role for financing and administering health care). The SNS was established by statute in 1952. *Id.*

¹³⁰ Jimenez & Bossert, *supra* note 127, at 207-08 (describing how team of market-oriented technocrats adopted market-based economic policy and addressed social policy by reinforcing basic safety net for poorest population).

¹³¹ *Id.* at 208. Included within the Pinochet policy was a commitment to prioritizing care of mothers, children, and high-risk groups. Cifuentes, *supra* note 128, at 66.

¹³² Brian Cartin, Chile: The Effectiveness of the Reform, in *Do Options Exist? The Reform of Pension and Health Care Systems in Latin America 205, 207-08* (Marfa Amparo Cruz-Saco & Carmelo Mesa-Lago eds., 1998); World Bank, Chile: The Adult Health Policy Challenge 3-4 (1995). The Sistema Nacional de Servicios de Salud [National System of Health Services] was created by statute in 1979. Cifuentes, *supra* note 128, at 69.

¹³³ Valenzuela Magaña, *supra* note 54, at 1-2.

¹³⁴ World Bank, *supra* note 132, at 5. The right to obtain health care from private preferred providers, previously available only to white-collar workers under SERMENA, was extended to all beneficiaries of the Fondo Nacional de Salud [National Health Fund] (FONASA) by statute in 1979. Cifuentes, *supra* note 128, at 69. The statutory provision for subsidies and classification of copayments was established in 1985. *Id.* at 71. Private establishments participating in the preferred provider arrangement are classified into three levels based on cost, but reimbursement amounts are established based on the lowest cost

(currently set at seven percent of income), general revenue funds, fees for the sale of vouchers, and fees from the sale of health care services.¹³⁵ Though the public sector remains subject to criticisms for waste and inefficiency,¹³⁶ and suffers from shortages and waiting lists,¹³⁷ its beneficiaries are relatively satisfied with the services they receive.¹³⁸

Alternatively, Chileans may choose to obtain health care coverage from the ISAPREs, which are private health insurance companies. Most are owned by small groups of investors, though two are public corporations and one is a cooperative.¹³⁹ Twenty-one of the currently operational ISAPREs are open to any applicants, while fourteen smaller ISAPREs are closed.¹⁴⁰ The vast majority of ISAPRE members, 3.7 of 3.9 million, are members of open ISAPREs.¹⁴¹ The market is highly concentrated, with three ISAPREs containing over sixty percent of the open ISAPRE beneficiaries, and four more containing an additional twenty-four percent.¹⁴² Most ISAPREs function as

level. *Id.* at 71-72. Beneficiaries desiring higher cost, and possibly higher quality services, pay the difference out of pocket. *Id.*

¹³⁵ Payroll taxes and general revenue taxes each account for about forty percent of FONASA income. World Bank, *supra* note 132, at 5.

¹³⁶ Some 1800 of the 4400 new personnel positions created in the health sector in the early 1990s went to administrative personnel, who now consume thirty-five percent of the health sector's total expenditures. Cartin, *supra* note 132, at 218.

¹³⁷ Claudia Villalobos, *El Enfermo Crónico [The Chronically Ill]*, *La Epoca*, May 17, 1998, at 1.

¹³⁸ In a 1995 beneficiary satisfaction survey, sixty-eight percent of affiliates of the Instituciones de Salud Previsional (ISAPREs) preferred their own system, while twenty-three percent were inclined to FONASA; sixty-six percent of FONASA beneficiaries favored their own system, while twenty-nine percent valued the ISAPRE system more. Ricardo Bitrán & Francisco Xavier Almarza, *Las Instituciones de Salud Previsional (ISAPREs) en Chile [The Health Insurance Institutions (ISAPREs) in Chile]* 56 (1996).

¹³⁹ Interview with Francisco Quesney Langlois, Medical Director, Banmedica, in Santiago, Chile (June 24, 1998) (interview notes on file with the *New York University Law Review*). Two ISAPREs, Aetna and Cigna, are subsidiaries of U.S. insurance companies. Karen Stocker et al., *The Exportation of Managed Care to Latin America*, 340 *New Eng. J. Med.* 1131, 1133 (1999). The largest ISAPRE, Consalud, was originated by the Construction Industry Council as part of its welfare efforts to serve construction workers, and is nonprofit. Interview with Nicolás Estarck Aguilera, Director of Systems and Technologies, Consalud, in Santiago, Chile (June 16, 1998). It is different from the more entrepreneurial ISAPREs in important respects, which will be explored below.

¹⁴⁰ Cartin, *supra* note 132, at 210 (explaining that open-type ISAPRE "accepts any insured able to pay the costs (premium) associated with membership, whereas the closed type is tied to one or more companies or industries and provides services only to their employees").

¹⁴¹ SISP, *Boletín Estadístico [Statistical Bulletin]* 35 tbl.2.1.9 (1997) (giving ISAPRE members by insurer for 1997).

¹⁴² *Id.*

traditional indemnity insurers.¹⁴³ A few of the ISAPREs, however, for some time have provided as well as paid for health care, while other ISAPREs have long had their own preferred provider arrangements.¹⁴⁴

Any employee, pensioner, or other person who can find an ISAPRE willing to sell him or her a policy may purchase an ISAPRE policy, paid for with the seven percent health insurance payroll tax supplemented by an out-of-pocket payment for any additional premium that may be necessary.¹⁴⁵ ISAPREs are marketed aggressively by in-house sales agents, who are paid on a commission basis.¹⁴⁶ A person who purchases insurance from an ISAPRE is no longer covered by FONASA—he or she moves from the public to the private sector of health care finance.

The way in which ISAPRE insurance is purchased contributes to a bizarre multiplicity of health care plans. A health plan is a particular policy covering a particular configuration of services, coinsurance, and caps, marketed by a particular ISAPRE. Though it is difficult to

¹⁴³ In fact, patients seeking care usually first secure a voucher from their insurer by paying the copayment and then take the voucher to the provider, who bills the insurer for the service based on the voucher. The system thus functions quite differently from traditional indemnity insurance in the United States, under which the patient paid the provider first, then sought indemnity from the insurer. See Interview with Francisco Quesney Langlois, *supra* note 139.

¹⁴⁴ See Jost, *supra* note 121, at 875-77. But Chile has a strong ideology and tradition of free choice of provider, and ISAPREs have been reluctant to place very strict limits on choice. Interview with Eduardo Urrutia Hewstone, General Manager, and Lee Kortmansky, Chief of Program Administration, Clínica Davila, in Santiago, Chile (June 24, 1998).

¹⁴⁵ Law 18,933, arts. 29-30 (Chile 1990). A person who chooses to be insured by an ISAPRE must pay seven percent of his employment income as the insurance premium up to a ceiling of 4.2 UF a month (equivalent to U.S. \$113 in November 2000). Valenzuela Magaña, *supra* note 54, at 4. (The UF is a unit of measure adjusted automatically for inflation on a monthly basis. It is widely used in Chile for financial transactions and thus is commonly understood.) Though U.S. \$113 is a modest sum, considering the cost of health insurance, it is a significant amount given that the average income of a member of an open ISAPRE was U.S. \$696 monthly in 1997. *Id.* at 24 tbl.6. Persons insured by ISAPREs may supplement the seven percent, and often pay an additional two to three percent voluntarily if the seven percent does not cover all desired benefits. An employer may also supplement the seven percent with an additional amount of up to two percent for poorer workers and claim a tax credit for the contribution, resulting in a modest, though symbolically important, public subsidy for the ISAPRE system. The two percent subsidy when added to the seven percent premium may not exceed 1 UF (about U.S. \$27.10 in November of 2000) for the insured plus 0.5 UF (U.S. \$13.50) for each dependent, so only persons of very modest income are eligible for the subsidy. This subsidy makes up about 2.6% of ISAPRE revenues. SISP, *supra* note 126.

¹⁴⁶ The commission structure usually takes into account the value of the policy, the length of time the insured remains with the ISAPREs, and the track record of the insured for paying premiums. Sales agents therefore face an incentive to sign up stable applicants with relatively high incomes. Interview with Francisco Quesney Langlois, *supra* note 139.

ascertain the number of health plans that exist within the ISAPRE system, it is unquestionably enormous. Persons within the Superintendency estimate that 10,000 plans exist, with 1000 or so available at any one time, but individuals affiliated with particular ISAPREs estimate that some individual ISAPREs independently may have thousands of plans.¹⁴⁷

This great number of plans exists primarily for two reasons. First, it allows exquisite price discrimination. The statutory seven percent premium is a continuous variable, since the level of wages varies continuously. Each ISAPRE thus must offer a large number of plans so that at any premium, corresponding to seven percent of any given wage level, a variety of choices are available.¹⁴⁸ Second, the multiplicity of plans facilitates a peculiar form of indirect experience rating that represents the ISAPREs' response to the legal prohibition against direct experience rating. The law requires that ISAPREs raise premiums across the board for an entire plan if they want to raise rates at all and prohibits raising premiums for individuals who require expensive medical care. It is widely believed that ISAPREs do in fact raise premiums, sometimes dramatically, for plans with which they have a negative experience, but then create new plans that closely resemble the old plan and offer them to persons who had had a favorable claims experience under the old plan. Thus high-cost insureds pay more or drop the plan, while less costly insureds move to new, lower-cost plans, permitting indirect experience rating but also adding to the multiplicity of plans.

ISAPRE advocates assert that the multiplicity of plans signifies healthy competition and promotes consumer choice. Skeptics, however, believe that the multiplicity of plans makes true comparison among insurers difficult, if not impossible.¹⁴⁹ This is particularly true because coverage limitations are often expressed in terms of internal insurance company schedules that are difficult to locate and understand.¹⁵⁰ The fact that health insurance is sold only by agents of particular companies, rather than by independent agents marketing a variety of policies, makes comparison even more difficult.

¹⁴⁷ Interview with Gonzalo Simón, Development Director, Vida Tres, in Santiago, Chile (June 19, 1998) (interview notes on file with the *New York University Law Review*).

¹⁴⁸ One expert estimated that if the premium were allowed to vary from 6.5% to 7.5%, eighty percent of the plans would disappear. Interview with Francisco Quesney Langlois, *supra* note 139.

¹⁴⁹ Mathias Kifmann, Chile: Private Health Insurance in Chile: Basic or Complementary Insurance for Outpatient Services?, 51 *Int'l Soc. Sec. Rev.* 137, 143 (1998).

¹⁵⁰ Interview with Fernando Riveros Vidal, Chief, Audit Department, SISP, in Santiago, Chile (June 22, 1998) (interview notes on file with the *New York University Law Review*).

ISAPREs have relatively high operating costs, which are smaller for larger ISAPREs and have diminished over time. Between 1985 and 1995, the percentage of ISAPRE revenues actually returned to beneficiaries in the form of medical reimbursements and sick leave increased from 59.5 percent to 71.5 percent.¹⁵¹ In 1997, 18.9 percent of ISAPREs' revenues were spent on sales and administrative expenses.¹⁵²

Though most ISAPRE policies are purchased by individuals, thirty-five to forty percent are negotiated as collective policies covering a firm's employees as a group.¹⁵³ Collective policies tend to offer more favorable coverage for employees for several reasons: The proportion of the premium devoted to sales and underwriting costs is lower, higher income employees subsidize lower income employees (though there are often several benefit levels within collective plans for different levels of employees), and collective policy negotiators tend to drive a harder bargain.¹⁵⁴ Some ISAPREs are unenthusiastic about collective policies, however, because the freedom of movement guaranteed to beneficiaries allows higher income employees to opt out of collective plans, undermining the underwriting assumptions on which the plans were based.¹⁵⁵

ISAPRE policies are commonly subject to significant coinsurance obligations, though ISAPREs do offer full coverage policies to those willing to pay the price. A study of seventy-five percent of open ISAPRE members showed the majority had an average copayment of thirty percent, though a small percentage of those insureds with high costs of care pay almost fifty percent.¹⁵⁶ More importantly, coverage is almost always subject to caps, both globally and service-by-service.¹⁵⁷ Historically these caps have not been expressed in readily understandable terms such as cash equivalent, but rather by reference to a separate company list of general coverage specifications, which is not readily available.

ISAPREs not only cover medical care; they also pay for sick leave, which in fact accounts for twenty to twenty-two percent of the

¹⁵¹ Bitrán & Almarza, *supra* note 138, at 43.

¹⁵² SISP, *supra* note 126.

¹⁵³ Bitrán & Almarza, *supra* note 139, at 34.

¹⁵⁴ Interview with María Eugenia Salazar C., Health Director, Probenefits, in Santiago, Chile (June 16, 1998) (interview notes on file with author).

¹⁵⁵ Interview with Francisco Quesney Langlois, *supra* note 139.

¹⁵⁶ Bitrán & Almarza, *supra* note 138, at 31-32. By law, copayments cannot exceed seventy-five percent. *Id.*

¹⁵⁷ Kifmann, *supra* note 149, at 144.

ISAPRES' claims-related expenses.¹⁵⁸ ISAPRES must pay sick leave if a doctor certifies an insured to be unable to work.¹⁵⁹ Until 1990 the ISAPRES also were responsible for maternity leave, to which a pregnant woman is entitled from forty-two days before the birth until eighty-four days after.¹⁶⁰ Even apart from pregnancy leaves, however, working women request sick leave twice as often as do men, contributing to the preference of ISAPRES for insuring men rather than women.¹⁶¹

ISAPRES in fact have no obligation to accept particular applicants for insurance, and can refuse to insure persons who are likely to incur high medical expenses. They also may vary premiums freely based on age, sex, and plan coverage for those applicants whom they insure.¹⁶²

ISAPRE coverage is skewed, not surprisingly, towards the wealthier members of society. The average monthly wage of ISAPRE members in 1997 was about U.S. \$700, while the average wage of FONASA beneficiaries (excluding indigents) was U.S. \$250.¹⁶³ Over thirty-three percent of ISAPRE members earn more than U.S. \$830 a month, and over sixty-three percent more than U.S. \$400.¹⁶⁴ This is not surprising, as the Chilean system in particular was designed to reserve the publicly subsidized public health system for the less fortunate. Indeed, the remarkable thing about the ISAPRE system is that it extends so far down into the population and covers people of such modest means. Over one-third of ISAPRE members earn less than U.S. \$400 a month, which means that their seven percent premiums equal less than U.S. \$28 a month, unless they are supplemented by the employer or employee.¹⁶⁵

Coverage also is skewed toward young, healthy males. ISAPRE coverage drops dramatically upon retirement. Only 9.8% of ISAPRE

¹⁵⁸ Valenzuela Magaña, *supra* note 54, at 17. For 1996 the figure was nineteen percent. Nat'l Ass'n of Pre-Paid Health Ins. Plans, *ISAPRES: The Private Health Sector in Chile 23* (1996).

¹⁵⁹ Law 18,933, art. 37 (Chile 1990). The insurance companies have medical controllers who attempt to identify and deny unnecessary or excessive sick leaves. About three percent of the leaves are rejected. Bitrán & Almarza, *supra* note 138, at 40. Beneficiaries whose applications are denied or modified may appeal to a supervisory body, the Comisión de Medicina Preventiva e Invalidez [Preventive Medicine and Disability Commission], where they usually win. Interview with Francisco Quesney Langlois, *supra* note 139.

¹⁶⁰ Valenzuela Magaña, *supra* note 54, at 17 n.10.

¹⁶¹ *Id.* at 17.

¹⁶² Law 18,933, art. 33.

¹⁶³ SISF, *supra* note 126; see also *supra* note 145.

¹⁶⁴ SISF, *supra* note 126.

¹⁶⁵ *Id.*

members are fifty-five or over, and only 2.7% are sixty-five or over.¹⁶⁶ Some ISAPREs will not accept applicants who are over a certain age, and all charge higher premiums to the elderly.¹⁶⁷ As noted above, women of childbearing age also have a difficult time securing ISAPRE coverage in their own right—sixty-nine percent of ISAPRE primary insured individuals are men.¹⁶⁸ Women are much more likely to be insured as dependents of insureds, because dependents cannot receive sick leave, but in the prime childbearing years (between twenty and thirty-five) only about thirty-one percent of total ISAPRE beneficiaries, including primary insureds and dependents, are women.¹⁶⁹ Once women reach the age of thirty-five, they are as likely to be insured by ISAPREs as are men.¹⁷⁰

Though ISAPREs have considerable control over whom they accept as insureds, they nevertheless are subject to regulation. Once a person has been insured by an ISAPRE for one year, the ISAPRE cannot terminate the insured unless he or she has breached the terms of the insurance policy, though the insured can leave an ISAPRE at any time with at least one month's notice.¹⁷¹ Further, as has been noted already, an ISAPRE may not raise the rates that it charges any single insured member. If an ISAPRE wishes to increase premiums, it cannot raise one member's rates above rates given new members at that time and must give two months' notice of the increase.¹⁷²

ISAPREs are required to pay something for each of the services covered by FONASA, and under recent regulations also must cover these services at least to the extent that they would be covered under FONASA.¹⁷³ ISAPREs may exclude only a short list of services or conditions, such as cosmetic surgery for the purposes of beautification (not of repair of malformation), nursing care at home or in institutions, or services required because of war or criminal conduct.¹⁷⁴ Re-

¹⁶⁶ SISP, *supra* note 141, at 33 tbl.2.1.7. Since only 7.2% of the Chilean population is over sixty-five years of age, see World Bank, Report No. 19940, Chile Health Insurance Issues: Old Age and Catastrophic Health Costs 27 (2000), <http://www.worldbank.org>, these figures are not quite as skewed as they appear.

¹⁶⁷ Bitrán & Almarza, *supra* note 138, at 70-72 (stating that elderly are charged 2 to 4.5 times rate of young person).

¹⁶⁸ SISP, *supra* note 141, tbs.2.1.7, 2.1.8.

¹⁶⁹ *Id.*

¹⁷⁰ Superintendencia de ISAPREs [Superintendency of ISAPREs], Series Estadísticas Anuales: Sistema ISAPRE 1981-1998 [Annual Statistical Series: ISAPRE System 1981-1998] 56 tbs.2.7.5, 2.7.6 (1998).

¹⁷¹ Law 18,933, art. 38 (Chile 1990); SISP, Resolución Exenta No. 2500 § 5.3 (1997) (modifying SISP, Circular No. 36 (1997)), <http://www.sisp.cl/intecset.htm>.

¹⁷² Law 18,933, art. 38.

¹⁷³ SISP, Circular No. 36, §1.3, <http://www.sisp.cl/intecset.htm>.

¹⁷⁴ Law 18,933, art. 33-bis.; SISP, Resolución Exenta No. 2263 § 5.1 (1997), <http://www.sisp.cl/intecset.htm>.

cent legislation makes ISAPREs responsible, at least initially, for expenses attendant to emergency treatment of their members. ISAPREs may impose waiting periods only for pregnancy and preexisting conditions.¹⁷⁵ Under recently issued regulations, preexisting conditions must be covered fully after eighteen months.¹⁷⁶

ISAPREs also are subsidized by the government in several different ways. To begin, the ubiquity of caps for most services and of overall caps makes ISAPRE insurance coverage of limited value for catastrophic conditions, though ISAPREs also do make catastrophic policies available for a price.¹⁷⁷ ISAPRE members who experience health care catastrophes, therefore, often must return to the public system for care. Indeed, FONASA does not know precisely whom it covers, and it is widely believed that ISAPRE members routinely receive services in SNS hospitals at FONASA expense once their ISAPRE caps are exceeded, even though this technically is not permitted except in emergencies.¹⁷⁸ Indeed, one analyst has argued persuasively that private insurance in Chile operates much like private

¹⁷⁵ Law 18,933, art. 33(f); SISP, Resolución Exenta No. 2263 § 5.2.1. Treatment related to a nonreported preexisting condition must be covered unless the last medical treatment for the condition took place within the preceding five years and the insured knowingly concealed the existence of the condition. Law 18,933, art. 33-bis. Costs associated with pregnancy only need be covered proportionately to the amount of time remaining in the pregnancy at the time of admission to the ISAPRE; for example, a woman becoming insured with three months remaining in her pregnancy would be covered for one-third of her maternity costs. *Id.* arts. 33(f), 33-bis.

¹⁷⁶ SISP, Resolución Exenta No. 2263 § 5.2.1. The regulation only applies to disclosed preexisting illnesses. Concealed preexisting conditions need not be covered until five years have elapsed. *Id.* § 5.2.3.

¹⁷⁷ Bitrán & Almarza, *supra* note 138, at 65 (noting limitations on ISAPRE catastrophic conditions coverage). Catastrophic policies are issued by life as well as health insurance companies. Catastrophic policies often exclude certain diseases or coverage of the elderly. *Id.*; see also Uri Wainer K., *Hacia una mayor equidad en la salud: El caso de las ISAPREs* [Towards Greater Health Equality: The Case of the ISAPREs] 29-32 (1997) (citing studies finding that small but significant number of ISAPRE beneficiaries encounter uncovered medical expenses that are catastrophic relative to their income, which is particularly likely to occur with persons who have low-coverage plans and seek care from high-cost hospitals).

¹⁷⁸ Bitrán & Almarza, *supra* note 138, at 67 (explaining incentives and interaction between ISAPRE and FONASA); Osvaldo Larrañaga, *Eficiencia y equidad en el sistema de salud chileno* [Efficiency and Equity in the Chilean Health System] 27 (n.d.) (noting that public system's lack of control mechanisms promotes this situation); Interview with Giorgio Solimano, President, CORSAPS, in Santiago, Chile (June 19, 1998) (interview notes on file with the *New York University Law Review*). FONASA is trying to establish a comprehensive list of its beneficiaries, but currently can identify only ninety to ninety-five percent of them. FONASA, however, is supposed to get lists from the ISAPREs of their beneficiaries, and public hospitals are in the process of developing systems of certification that would require them to verify insurance status at time of admission. Where hospitals discover that a patient is a member of an ISAPRE, they are supposed to bill the ISAPRE and the patient for their respective obligations for the cost of the care. Interview with Rony

insurance in other countries that have national health services—as a supplement to, rather than a substitute for, the public coverage.¹⁷⁹

Second, the state bears the cost of maternity leave, immunization, and other public health programs for ISAPRE as well as FONASA beneficiaries.¹⁸⁰ Finally, ISAPRE premiums and disbursements are exempt from taxation and, additionally, up to two percent of employer contributions to ISAPREs above the seven percent premium can be exempt from taxation for low income insureds, a benefit not available to FONASA members.¹⁸¹

In fairness, it must be noted that the ISAPREs also subsidize the public sector, though the subsidies are less obvious. First, many professionals who work in the public sector also provide care on a fee-for-service basis to ISAPRE beneficiaries. Many of these professionals make the bulk of their income in the private sector, and deliver care for much lower compensation in the public sector. In fact, the ISAPREs have made a significant contribution to the development of a private health infrastructure in Chile, by freeing up public health facilities to treat public beneficiaries.¹⁸² Second, some believe that the reported higher rates of physician visits by ISAPRE members compared to publicly insured patients may be due in part to fraudulent receipt of ISAPRE benefits by persons who are in fact publicly insured.¹⁸³ Controls over the receipt of ISAPRE-financed services appear not to be very effective. The fact that cross-subsidies flow in both directions, however, further demonstrates the gulf that separates the ISAPRE system from the free market ideal.

In sum, though the Chilean market for private insurance comes quite close to approximating the free market ideal at the point of initial purchase, private health insurance is regulated more closely at the point of renewal, and an extensive system of public subsidies distorts the insurance market.

B. Germany

Though Germany has the world's oldest modern social insurance system, dating back to the 1880s, its tradition of private health insur-

Lenz Alcayaga, Director of FONASA, in Santiago, Chile (June 24, 1998) (interview notes on file with author).

¹⁷⁹ Kifmann, *supra* note 149.

¹⁸⁰ Larrañaga, *supra* note 178, at 26.

¹⁸¹ *Id.*

¹⁸² The percentage of total hospital beds in private hospitals grew from ten percent in 1981 to twenty-five percent in 1996. Valenzuela Magaña, *supra* note 54, at 32 tbl.18.

¹⁸³ See Interview with Marcel Maira Carlini, Vice President, and Eduardo Hoyos Lombardi, Director of Health, Consalud, in Santiago, Chile (June 16, 1998) (interview notes on file with author).

ance dates back much further, to the medieval guilds and, later, friendly societies.¹⁸⁴ A founding principle of Germany's social insurance scheme was that it would cover only those who required social protection—originally manual laborers—and that the rest of the population would be covered by private insurance.¹⁸⁵ During the century following the founding of the social insurance system, however, the proportion of the population socially insured expanded steadily, as more and more vocational and demographic groups were assimilated into the social insurance scheme.¹⁸⁶ The boundary between the private system (the *Privat Krankenversicherung* (PKV)) and the social health insurance system (the *Gesetzliche Krankenversicherung* (GKV)) has been relatively stable since the 1970s, when the last major occupational group—agricultural workers—was brought within the social insurance system.¹⁸⁷

Today, about 7.2 million Germans are covered by comprehensive private PKV insurance, compared to about 50.9 million who belong to the public GKV system.¹⁸⁸ Three major groups are covered by the PKV: the self-employed, civil servants, and employees whose income exceeds a certain level, set for the year 2000 at 6450 DM per month in the West (about \$3200), and 5325 DM in the East.¹⁸⁹ Employees whose income exceeds the compulsory insurance level can opt for private insurance, but if they do so they are largely precluded from returning thereafter to the GKV.¹⁹⁰ Approximately 6.2 million persons who could be insured privately because of their income voluntarily choose public insurance instead.¹⁹¹ Because PKV premiums are underwritten based on risk status, while GKV rates are based strictly on

¹⁸⁴ Peter Bach et al., *Private Krankenversicherung: MB/KK- und MB/KT-Kommentar* [Private Health Insurance: Commentary on the MB/KK and the MB/KT] 67 (2d ed. 1993). The MB/KK are the regulations governing private health insurance in Germany.

¹⁸⁵ CEA, *supra* note 56, at 29.

¹⁸⁶ Bach et al., *supra* note 184, at 67-75.

¹⁸⁷ *Id.* at 71.

¹⁸⁸ Verband der privaten Krankenversicherung [Private Insurance Association], *Private Health Insurance: Facts and Figures 1998/99*, at 9, 11 (1999) [hereinafter *Facts and Figures*]. Another 7.6 million persons who are insured publicly also purchase private supplemental insurance to cover services not covered by public insurance, such as better hospital accommodation, supplemental dental care, foreign travel health coverage, or supplemental loss of income insurance. *Id.* at 16-20.

¹⁸⁹ Besche, *supra* note 112, at 19; *Private Health Insurance*, in *Gesellschaft für Versicherungswissenschaft und -gestaltung* [Society for the Study and Design of Insurance] & King's Fund, *British-German Workshop on Health Policy* 86, 93 (1999) (comments of Andreas Besche).

¹⁹⁰ Besche, *supra* note 112, at 16-18. Employees pay half the premium for private insurance if the employer would have been responsible for paying under the statutory insurance system. Graig, *supra* note 79, at 55.

¹⁹¹ *Facts and Figures*, *supra* note 188, at 9.

a percentage of income that does not vary with age, sex, or even number of dependents, those who are less healthy or have large families often find the GKV to be the better deal.¹⁹²

Privately insured individuals in Germany can choose the benefit package best suited to their needs from a wide variety of benefit combinations.¹⁹³ Insureds also may opt between policies that provide full indemnification and those imposing high cost-sharing obligations. PKV premiums are written on a level lifetime basis; that is, premiums are set for life at the time of application, taking into account the age, gender, and health status of the applicant, with the goal of accumulating sufficient reserves while the insured is young to cover anticipated greater health care expenses in old age.¹⁹⁴ Though premiums are in theory not supposed to be increased in later life, they are in fact adjusted from time to time to account for health care inflation.¹⁹⁵ Returns on accumulated lifetime reserves exceeding a certain level, however, are applied to reducing premium costs in later life.¹⁹⁶ Sizeable premium rebates also are offered to those who do not submit claims over a period of time.¹⁹⁷

While on the surface the market for private insurance in Germany resembles the competitive ideal, the PKV in fact is regulated heavily. The general policy conditions of health insurance policies must be approved by the state before use.¹⁹⁸ Waiting periods may last only three months before coverage begins, or eight months for certain kinds of care such as maternity care, psychotherapy, or orthodontics, and newborns of insureds must be covered immediately, as must persons who transfer from the social insurance funds.¹⁹⁹ Insureds must

¹⁹² See Private Health Insurance, *supra* note 189, at 94-95 (comments of Andreas Besche) (providing calculations for private health insurance (PKV) and public health insurance (GKV) premiums).

¹⁹³ CEA, *supra* note 56, at 30.

¹⁹⁴ See § 8a MB/KK (F.R.G.), reprinted in Peter Bach et al., *Private Krankenversicherung: MB/KK- und MB/KT-Kommentar* [Private Health Insurance: Commentary on the MB/KK and the MB/KT] 289 (2d ed. 1993).

¹⁹⁵ Elliot K. Wicks, *German Health Care: Financing, Administration, and Coverage* 30 (1992) (explaining intentions behind basic rate design of PKV).

¹⁹⁶ § 12a VAG (F.R.G.). The VAG (*Versicherungsaufsichtsgesetz* or Insurance Oversight Code) is the statute governing insurance in general in Germany and is available in English translation at <http://www.iuscomp.org/gla/statutes/VAG.htm>. These rebates amounted to nearly DM 777 million in 1998. *Facts and Figures*, *supra* note 188, at 41.

¹⁹⁷ These rebates amounted to DM 764 million in 1998. *Facts and Figures*, *supra* note 188, at 40.

¹⁹⁸ CEA, *supra* note 56, at 29.

¹⁹⁹ §§ 2(2), 3 MB/KK, reprinted in Peter Bach et al., *Private Krankenversicherung: MB/KK- und MB/KT-Kommentar* 122-23, 176-77 (2d ed. 1993).

be guaranteed free choice of doctor and hospital.²⁰⁰ The Law on Compulsory Long-Term Care Insurance of 1995 requires all privately insured individuals to carry long-term-care insurance, the premiums, terms, and conditions of which are highly regulated.²⁰¹

Private insurance plans operate on an indemnity basis for professional services. Health care professionals are limited by law with respect to how much they can charge, but charges to privately insured individuals are much higher than the payments professionals receive from the public insurance program.²⁰² Private insurers do not negotiate directly with professionals for lower charges.

Private insurance funds forego strict risk-based underwriting principles with respect to certain insureds. Civil servants, who account for about half of privately insureds, are accepted regardless of medical risk, though surcharges of up to 100% are charged to high-risk applicants, and private insurers share among themselves the disproportionate risks encountered because of such insureds.²⁰³ Insurers do not cancel insureds once accepted, and charge a fixed rate for children.²⁰⁴

Increasingly, the government has begun to obligate the PKV to take on lower-income insureds, thus relieving the GKV of the financial burden of insuring these persons. These lower-income insureds are then cross-subsidized by private insureds. The recently adopted Health Reform 2000 statute, for example, prohibits those who are over fifty-five from returning from the PKV to the GKV when their income drops.²⁰⁵ The statute also expands the coverage of the "Standard Tarif," a special low-cost private insurance premium pegged to public insurance premium levels, to cover lower-income insureds over the age of fifty-five.²⁰⁶ The standard tariff also is extended to civil servants in certain circumstances without risk adjustment.²⁰⁷ The 2000

²⁰⁰ § 4 MB/KK, reprinted in Peter Bach et al., *Private Krankenversicherung: MB/KK- und MB/KT-Kommentar* 180-81 (2d ed. 1993).

²⁰¹ CEA, *supra* note 56, at 30-31.

²⁰² Wicks, *supra* note 195, at 31.

²⁰³ *Id.* at 28.

²⁰⁴ *Id.* at 30.

²⁰⁵ Besche, *supra* note 112, at 17.

²⁰⁶ *Id.* The Standard Tarif was introduced in 1994 to cover persons over the age of sixty-five with limited means. § 257 SGB (F.R.G.). Chapter V of the SGB (Socialgesetzbuch or Social Insurance Code) governs the German social health insurance program.

²⁰⁷ Press Release, Verband der Privaten Krankenversicherung [Private Insurance Association], *Auswirkungen der GKV-Gesundheitsreform 2000 und der Änderung des Pflegeversicherungsgesetzes auf die Privatversicherten* [Implications of the Social Insurance Health Reform of 2000 and the Change in the Nursing Care Insurance Law for the Privately Insured] (Dec. 20, 1999), at <http://www.pkv.de/presse/P91220.htm>.

Reform law further imposes a ten percent surcharge on younger insureds to alleviate the premium costs experienced by older insureds.²⁰⁸ In sum, though an active market for private insurance exists in Germany, private insurance premiums and contract provisions are set increasingly not by the market, but rather by public regulation, at least for some private insureds.

C. *Australia*

Australia also has a comparatively high level of health insurance coverage. About 30.5% of the Australian population is covered by private health insurance,²⁰⁹ and about eleven percent of health care expenditures are provided by private health insurance.²¹⁰ Most private insurance companies are nonprofit, and most insurance is sold on an individual basis, though group policies do exist.²¹¹

Public health insurance is quite recent in Australia: The current Medicare program dates only from 1983.²¹² From the 1950s until the 1970s, the government subsidized the purchase of private health insurance.²¹³ A public health insurance program (Medibank) was created in 1975 by a Labour government, but when the Liberal-National (conservative) government regained power later that year, it turned away from public finance, offering subsidies for those who would opt out of the public program for private insurance and imposing tax penalties on those who chose not to.²¹⁴ To assure universal availability of private insurance, the conservative coalition government also created a government-sponsored private insurance company—Medibank Private—which continues to be the largest private insurer in Australia.²¹⁵ The return of a Labour government in 1983 led to the reinstatement

²⁰⁸ Besche, *supra* note 112, at 18.

²⁰⁹ PHIAC, *supra* note 53, at 1.

²¹⁰ Commonwealth Dep't of Health and Aged Care, *Private Health Insurance 5* (Occasional Papers: New Series No. 4, 1999) [hereinafter *Private Health Insurance* (Austl.)].

²¹¹ See Indus. Comm'n, *Private Health Insurance 53* (Report No. 57, 1997), <http://www.pc.gov.au/ic/inquiry/57privatehealth/finalreport/>.

²¹² George R. Palmer & Stephanie D. Short, *Health Care and Public Policy: An Australian Analysis 58* (1994) (discussing historical background of health insurance in Australia).

²¹³ This government scheme is known as the "Earle Page scheme." *Id.* at 55. Under this scheme, pensioners received fully subsidized hospital and medical care, while others received subsidies for purchasing private insurance. Richard de Abreu Lourenco et al., *The Australian Health Care System 10-11* (Ctr. for Health Econ. Research & Evaluation, Discussion Paper 38, 1999) (discussing historical background of health insurance in Australia).

²¹⁴ Palmer & Short, *supra* note 212, at 56-58 (recounting establishment of Medibank and subsequent return to voluntary insurance).

²¹⁵ Indus. Comm'n, *supra* note 211, at 103-06 (discussing Medibank Private and noting that it is largest private health fund in Australia).

of a public insurance program, renamed Medicare, which now seems to enjoy almost universal political acceptance.

Medicare covers hospital care (delivered through public hospitals provided through the states and funded by Commonwealth and state funds), physician care (paid for by the Commonwealth program on an assignment or indemnification basis), and pharmaceutical benefits.²¹⁶ Medicare is financed by a 1.4% levy on taxable income and by general revenue funds.²¹⁷

Though the proportion of the population covered by private insurance has dropped steadily since the introduction of Medicare, private health insurance remains very important in Australia.²¹⁸ Although everyone in Australia is covered by Medicare, and, therefore, private insurance is in a sense supplemental insurance offering "double cover,"²¹⁹ private insurance in Australia also can be considered as an alternative to social insurance, both because it offers access to a health care system separate from that covered by the public system, and because government incentives and penalties directed towards encouraging private insurance cover effectively treat it as an alternative system.²²⁰

There are two primary forms of private insurance coverage: hospital and ancillary cover.²²¹ Hospital insurance covers private hospital stays or private patient stays in public hospitals.²²² In recent years there has been a strong trend towards provision in private hospitals.²²³ Hospital insurance pays for the cost of the hospital stay itself, subject

²¹⁶ Lourenco et al., *supra* note 213, at 7-8, 15-23 (providing overview of funding of Medicare and benefits provided).

²¹⁷ *Id.* at 18. Nursing home, community care, and mental health care are also covered by federal, state, and local programs. *Id.* at 50-56.

²¹⁸ The proportion of the population covered by private insurance dropped from 50% when Medicare was created in 1983-84 to 30.5% in June 1999. During 1999 it increased slightly. PHIAC, *supra* note 53, at 1. In the mid-1960s, under the Page plan, as much as seventy percent of the population had subsidized private insurance, but this level dropped, in part because low-risk insureds grew weary of subsidizing high-risk insureds. Lourenco et al., *supra* note 213, at 10-13.

²¹⁹ See Wasem, *supra* note 120, at 82.

²²⁰ See *infra* notes 253-57.

²²¹ As of June 30, 1999, 5.793 million Australians had hospital cover, of whom 4.423 million had ancillary cover as well, while 1.626 million had ancillary cover only. PHIAC, *supra* note 53, at 116.

²²² Australia had 312 private hospitals serving 1.875 million discharged patients in 1998-99, as compared to 726 public hospitals serving 3.839 million patients. Commonwealth Dep't of Health & Aged Care, Australia: Selected Health Care Delivery and Financing Statistics—September 2000, tbl.1, at <http://www.health.gov.au/haf/ozhealth/ozhstats.htm>. Private hospitals tend to be smaller, however, and treat simpler cases, though there are certainly private hospitals that rival public hospitals in size and complexity of care. See Lourenco et al., *supra* note 213, at 39-40.

²²³ See PHIAC, *supra* note 53, at 46.

to whatever cost-sharing obligations are imposed by the policy, and, in many cases, dependent on whether or not the fund has an agreement with the particular hospital.²²⁴ It also covers part of the fee of private doctors for in-hospital care that is not covered by Medicare.²²⁵

Many doctors who provide services to private patients in private hospitals also balance bill above and beyond the insurance payment—a practice forbidden with respect to those who enter hospitals as public patients.²²⁶ Thus, a patient with private insurance may end up paying far more if admitted as a private rather than a public patient.²²⁷ Private insurance plans are not permitted to pay for physician care out of the hospital.

Since 1995, the government has attempted to get insurers to enter into preferred provider agreements with hospitals and hospital-based physicians in order to limit or eliminate balance billing (making possible “no or known gap policies”)²²⁸ and to institute simplified billing arrangements so that insureds will understand their obligations better.²²⁹ These moves have been resisted by organized medicine and are proceeding slowly.²³⁰ Balance billing (gap obligations) remain an important and intractable issue.²³¹

Ancillary cover pays for many services not covered by Medicare, such as optometrist services and glasses, speech therapy, hearing aids, ambulance services, physiotherapy, chiropractors, and most forms of

²²⁴ Doing the Health Insurance Tango—Your Guide to the Right Steps, Choice, Aug. 1998, at 16, 18-21 [hereinafter Health Insurance Tango].

²²⁵ If a patient is admitted as a public patient, Medicare covers the doctor's charges in full. If the patient is private, Medicare pays seventy-five percent of a scheduled fee, and private insurance pays the remaining twenty-five percent. *Id.* at 18. Doctors are permitted to balance bill private patients, however, and many do. During 1994-95, for example, anesthesiologists charged \$172.6 million, only \$140.9 million of which was covered by insurance. J.S. Deeble, Submission to the Inquiry into the Health Legislation (Private Health Insurance Reform) Amendment Act 1995, at 12 (1996). A private patient, therefore, may end up facing a hefty bill even after private insurance pays for a service that would be free to a public patient.

²²⁶ See Gwen Gray, “No Gaps” Health Insurance: A Gain for Consumers or a Windfall for Specialists?, 22 *Austl. Health Rev.* 18, 22-23 (1999).

²²⁷ Physician services in hospitals for public patients are covered fully by Medicare, and balance billing is prohibited. See Jane Hall, Incremental Change in the Australian Health Care System, *Health Aff.*, May/June 1999, at 99-101.

²²⁸ See Gray, *supra* note 226, at 23-24.

²²⁹ Private Health Insurance (Austl.), *supra* note 210, at vi.

²³⁰ The government's preferred provider agreement policy has been branded as leading to “U.S.-style managed care,” which seems to be all one word, and which, it is assumed, everyone knows from watching American television and movies is not what is wanted in Australia. See, e.g., Rob Hodge, Is MBF's New Tendering Scheme Good for the Health System? It's U.S.-Style Managed Care, *Austl. Med.*, Oct. 4, 1999, at 12; Sally Nathan, Managed Care or Managed Scare?, *Consuming Interest*, Spring 1997, at 12.

²³¹ See Gray, *supra* note 226, at 22-25 (providing overview of recent political struggles over gap insurance).

dental care.²³² Ancillary cover is commonly purchased as an adjunct to hospital cover, but many persons purchase it as a free-standing product.²³³

As in many other countries, private hospital insurance in Australia permits those who purchase it to jump the queues found in the public system, and to receive care more conveniently and in more comfortable surroundings.²³⁴ Not surprisingly, private insurance pays for a significant majority of hospital admissions for knee procedures and for scope and lens procedures in Australia, while it pays for only a small proportion of admissions for pulmonary or cardiac problems.²³⁵

Private insurance in Australia is heavily regulated. Health insurers must be registered with the government and are monitored carefully for solvency by the Private Health Insurance Administration Council.²³⁶ Policies and premiums, and changes in policies and premiums, must be filed with the Department of Health and Aged Care, which may disapprove them.²³⁷ Complaints against private health insurers are investigated by a Private Health Insurance Ombudsman.²³⁸

Private insurance in Australia for the last half-century has been community rated by law: That is, the same rate must be charged to all applicants in the community, varied only by whether the insured unit is an individual, couple, or family.²³⁹ This obviously makes health insurance very attractive to those who are worried about their health. Insurers are quite concerned about "hit-and-run" purchasers, who obtain coverage only until they have had their baby or gotten their knee replacement.²⁴⁰ In fact, however, though insureds tend to be older,²⁴¹

²³² Private Health Insurance (Austl.), *supra* note 210, at 11.

²³³ PHIAC, *supra* note 53, at 38.

²³⁴ Deeble, *supra* note 225, at 4; Hall, *supra* note 227, at 101.

²³⁵ Private Health Insurance (Austl.), *supra* note 210, at 41.

²³⁶ Indus. Comm'n, *supra* note 211, at 50-52; PHIAC, *supra* note 53, at 5.

²³⁷ Indus. Comm'n, *supra* note 211, at 73-76.

²³⁸ See Private Health Ins. Ombudsman, *Who We Are* (n.d.) (explaining in brochure ombudsman's services and philosophy), available at <http://www.phio.org.au/mission.htm> (last visited Feb. 21, 2001).

²³⁹ See Hall, *supra* note 227, at 99.

²⁴⁰ Indus. Comm'n, *supra* note 211, at 173-74.

²⁴¹ Approximately forty-four percent of persons aged thirty-five to fifty-four, and forty percent of those aged fifty-five to seventy-four, were privately insured in 1995, as compared to twenty-seven percent of those aged twenty-five to thirty-four, and twenty-one percent of those aged fifteen to twenty-four. Private Health Insurance (Austl.), *supra* note 210, at 13. Insurance coverage has stayed more or less constant for persons over sixty-five over the past decade, while it has continued to drop steadily for persons under sixty-five. PHIAC, *supra* note 53, at 22.

they are also generally in good health,²⁴² and, not surprisingly, wealthier than average.²⁴³ The problem of adverse selection is controlled to some extent by waiting periods that the funds are permitted to impose—two months for coverage generally and twelve months for pre-existing conditions and maternity coverage.²⁴⁴ Longer waiting periods also are imposed for some kinds of treatment, such as in vitro fertilization or bone marrow transplants.²⁴⁵

The incentives that insurers face for cream skimming—picking off the better risks and discouraging high-risk insureds²⁴⁶—also are reduced through the existence of a complex government-sponsored reinsurance scheme.²⁴⁷ In brief, funds are transferred through the scheme to insurers with disproportionately high proportions of patients who are over sixty-five or who have remained in hospital for more than thirty-five days, from insurers whose insureds are under-represented in these categories.²⁴⁸ Well over half of the benefits paid by insurers are for persons in these categories and thus subject to the reinsurance scheme.²⁴⁹ While this may ameliorate the problem experienced by insureds, it makes insurance even less attractive to low-risk insureds, who, according to one estimate, pay seventy percent more for health insurance than is justified given their potential use of health services.²⁵⁰ Insurers attempt to alter their benefits to make their policies less attractive to high-risk insureds (for example, by excluding coverage for hip replacements) or to make them more attractive to low-risk insureds (by offering, for example, discounts on athletic

²⁴² Persons who rate their health as excellent are more likely to be insured privately than those who rate it as poor, but the probability of having private insurance rises with the number of chronic conditions. *Indus. Comm'n*, *supra* note 211, at 188-89.

²⁴³ Seventy percent of the wealthiest quintile of families had private insurance, as compared to twenty percent of the poorest quintile. *Id.* at 172.

²⁴⁴ The funds enforce the preexisting conditions clauses remorselessly, and many of the complaints to the Health Insurance Ombudsman concern preexisting-condition disputes. Interview with Matthew Blackmore, Executive Director, Consumers Health Forum, in Canberra, Austl. (Oct. 15, 1999).

²⁴⁵ *Health Insurance: Fate or Fortune?*, *Choice*, Nov. 1999, at 24, 30-31.

²⁴⁶ See Wynand P.M.M. van de Ven et al., *Access to Coverage for High-Risks in a Competitive Individual Health Insurance Market: Via Premium Rate Restrictions or Risk-Adjusted Premium Subsidies?*, 19 *J. Health Econ.* 311, 316 (2000) (defining cream skimming). "Cream skimming" is the term of choice for this practice in Australia and also is used elsewhere. In the United States, the practice is sometimes called "cherry picking," while in Germany it is called "raisin picking."

²⁴⁷ See *id.* at 322-38.

²⁴⁸ This risk adjustment scheme will be modified under recently adopted legislation to increase incentives for insurers to limit the costs imposed by these insureds. *PHIAC*, *supra* note 53, at 18 (discussing modifications).

²⁴⁹ In 1998-99, insurers paid Austl. \$1.483 billion in ordinary benefits and Austl. \$1.582 billion in reinsurance account benefits. *PHIAC*, *supra* note 53, at 44.

²⁵⁰ *Deeble*, *supra* note 225, at 9.

shoes).²⁵¹ Policies also vary widely in terms of deductibles and co-insurance and are priced accordingly in an attempt to correlate more closely price and risk.²⁵²

As noted already, private health insurance enrollment has declined steadily since the establishment of Medicare. The current government, however, is committed strongly to stopping or reversing this trend. To this end it has adopted a number of initiatives. First, under a recent law, thirty percent of the cost of private health insurance is covered by the government.²⁵³ This represents an Austl. \$1.5 billion (approximately U.S. \$900 million) subsidy for private health insurance in 2000-01, compared to total Commonwealth Medicare expenditures of about Austl. \$12.1 billion (approximately U.S. \$7.3 billion) in 1996-97.²⁵⁴ Second, individuals with an income in excess of Austl. \$50,000 (about U.S. \$30,000), or families with an income above Austl. \$100,000 (about U.S. \$60,000), must purchase private health insurance or face a one percent additional tax on their income.²⁵⁵ Third, Australia recently has adopted a lifetime health cover premium scheme that will require persons who purchase health insurance after July 1, 2000 to pay an additional two percent over the base premium for each year after they turn thirty years old that they delay seeking cover.²⁵⁶ This incremental premium is subject to a ceiling of seventy percent above base premium. This scheme, it is hoped, will encourage Australians to seek cover at an earlier age. To date, however, these carrots and sticks seem to be having a minuscule effect on increasing private insurance coverage in Australia and come at a very high cost to the government.²⁵⁷

²⁵¹ See *Indus. Comm'n*, supra note 211, at 141-42 (discussing ways insurers compete for low-risk customers). Funds have been able to exclude coverage of particular conditions since 1995, but such exclusion is becoming increasingly common. Funds are required only to cover psychiatric, rehabilitative, and palliative care and otherwise can exclude services. See *PHIAC*, supra note 53, at 35.

²⁵² See *Health Insurance Tango*, supra note 224, at 24-31 (comparing private insurance prices and copayments for various Australian states and territories).

²⁵³ *Private Health Insurance (Austl.)*, supra note 210, at v.

²⁵⁴ *Id.* at 10. The government expects reduced public spending of over Austl. \$400 million because of increased private coverage.

²⁵⁵ *Id.* at 12.

²⁵⁶ See *Commonwealth Dep't of Health & Aged Care, Facts About Lifetime Health Cover 1 (1999)* (explaining Lifetime Health Cover program).

²⁵⁷ See, e.g., *Austl. Consumers' Ass'n, Briefing Paper: In Response to the Coalition's Proposed 30% Rebate for Private Health Insurance 1-10 (1998)* (arguing that income remains best predictor of private health insurance coverage and calling for government reforms that would encourage providers to control costs and increase range of choices); Philip M. Clarke, *The Effect of the 30% Private Health Insurance Rebate on the Purchasing Behaviour and Intentions of the Australian Population*, 22 *Austl. Health Rev.* 7, 13-16 (arguing that premium changes have small effect on purchasing behavior at high cost); Jane

In sum, Australia represents a market where private insurance is regulated and cross-subsidized heavily, but also continues to retain a large (though shrinking) consumer base and government support.

D. The Netherlands

Writing about the Dutch health care system from a distance is a somewhat risky enterprise because it changes so often. In the late 1980s, the Netherlands, with great fanfare and international publicity, embraced managed competition by adopting the Dekker proposal to promote competition between public and private health plans.²⁵⁸ This plan was modified somewhat after a change of government in 1989, and even more significantly by a subsequent government that took office in 1994.²⁵⁹ Private health insurance has long played an important role in the Dutch health care system. The Dekker plan foresaw abolishing the distinction between social insurance and private health insurance funds in a managed competition environment. Despite the fact that a number of private insurers now are paired corporately with social insurance funds, private insurance continues to enjoy an existence quite separate from the social insurance funds.²⁶⁰

The current Dutch health insurance system is divided into three layers or compartments. First and most basically, there is the Exceptional Medical Expense scheme (created by the *Algemene Wet Bijzondere Ziektekosten* (AWBZ)) in which the entire population is enrolled.²⁶¹ This social insurance program covers long-term care, mental care, care for the handicapped, and home care—essentially long-term and catastrophic care that is not readily insurable through private insurance.²⁶² The second compartment covers basic medical

Hall et al., *Whither Private Health Insurance?*, 21 *Austl. & N.Z. J. Pub. Health* 119, 120 (1997) (arguing that offering financial incentives will affect only some potential insureds and does not address fundamental problems with insurance market); Ian McAuley, *Private Health Insurance: Redefining the Issues*, *Austl. Rationalist*, Spring 1998, at 8, 8-15 (1998) (finding that incentives greatly benefited those who already had private insurance while failing to win over those without it, and arguing that government's efforts to promote private insurance may be misplaced).

²⁵⁸ Frederik T. Schut & Herbert E.G.M. Hermans, *Managed Competition in the Netherlands and Its Lessons for Canada*, 20 *Dalhousie L.J.* 437, 444-46 (1997) (explaining two major components of Dekker proposal: guaranteeing universal access to basic health care and creating incentives for insurers and providers to increase efficiency).

²⁵⁹ *Id.* at 444-45; see also Frederik T. Schut, *Health Care Reforms in the Netherlands: Miracle or Mirage?*, 18 *J. Pub. Health Med.* 278, 280 (1996).

²⁶⁰ Frederik T. Schut & Eddy K.A. van Doorslaer, *Towards a Reinforced Agency Role of Health Insurers in Belgium and the Netherlands*, 48 *Health Pol'y* 47, 57 (1999).

²⁶¹ Association Internationale de la Mutualité [International Insurance Association] (AIM), *Health Protection Systems Today: Structures and Trends in 15 Countries* 134 (1999).

²⁶² *Id.*

care, including, for example, medical and surgical treatment, obstetric care, hospital care, dental care for children, pharmaceuticals, rehabilitation care, ambulance transport, and speech therapy.²⁶³ About sixty-three percent of the population receives payment for this care through obligatory insurance with the sickness funds.²⁶⁴ An additional six percent—certain kinds of civil servants—receive this care through special public insurance programs.²⁶⁵ The rest of the population, about thirty-one percent, consisting primarily of salaried workers with an income above a certain level,²⁶⁶ the self-employed, and retired persons previously privately insured, are privately insured for these services.²⁶⁷ Private health insurance accounts for fifteen percent of total Dutch health care spending.²⁶⁸ Though those eligible for private insurance are not compelled to purchase it, virtually all do, and generally as individuals rather than as members of employment-related groups. Finally, the third compartment of supplementary or additional medical care—such as dental care for adults, private rooms, and alternative medicine—is insured through insurance plans purchased through the social or private insurance funds, which are completely optional.²⁶⁹

The supplementary or additional medical care insurance (the third layer) is sold on a risk-adjusted basis and essentially is unregulated.²⁷⁰ Second-level, basic health insurance is also sold by private insurers in somewhat less competitive markets.²⁷¹ Insurers are generally free to accept or decline applicants and can and do adjust premiums for risk, particularly age.²⁷² Insurance plans offer a variety of coverages and cost-sharing arrangements.²⁷³ The fact that catastrophic care is covered by the AWBZ, of course, also makes adverse selection, or “cream skimming,” much less of a problem with respect to the private insurance market.²⁷⁴

²⁶³ *Id.* at 138-39.

²⁶⁴ *Id.* at 137.

²⁶⁵ *Id.*

²⁶⁶ For 1999, this level of income was 64,300 guilders a year (about U.S. \$28,000) or more. *Id.* at 135.

²⁶⁷ *Id.* at 137.

²⁶⁸ *Id.* at 135.

²⁶⁹ *Id.* at 139.

²⁷⁰ Note, however, that insurers must meet solvency requirements.

²⁷¹ AIM, *supra* note 261, at 145.

²⁷² See van de Ven et al., *supra* note 246, at 311, 317 (arguing that in unregulated competitive market insurers will risk-adjust premiums, and citing findings of premium differentiation in Netherlands and United States). Despite this, Dutch private insurers do not charge fully risk-related premiums. Kieke G.H. Okma, *Health Care, Health Policies, and Health Reforms in the Netherlands 12-13* (2000).

²⁷³ CEA, *supra* note 56, at 65.

²⁷⁴ See Wynand P.M.M. van de Ven & Frederik T. Schut, *Should Catastrophic Risks Be Included in a Regulated Competitive Health Insurance Market?*, 39 *Soc. Sci. Med.* 1459,

Nevertheless, basic health insurance is subject to a certain level of market regulation, which seems to be increasing steadily in intrusiveness.²⁷⁵ Under the Health Insurance Access Act (*Wet op de toegang tot ziektekostenverzekeringen (WTZ)*), insurers must offer a standard package policy (providing cover comparable to that provided by the social insurance funds) to certain statutorily qualified persons who apply within four months of meeting eligibility criteria.²⁷⁶ The coverage and cost-sharing arrangements provided under the standard package policy are determined by government regulation.²⁷⁷ Among those eligible for the standard package are: (1) persons who are required to leave the social insurance program; (2) persons who were uninsured and did not know or reasonably could not be expected to know that they presented above-average risks; (3) persons moving to the Netherlands previously insured elsewhere; and (4) persons over the age of sixty-five who previously had some other form of private insurance.²⁷⁸ Since 1991, privately insured persons who pay more than the maximum standard policy premium for their age group also may opt for the standard policy, as may privately insured students since 1992.²⁷⁹ About fourteen percent of private insureds have the standard package policy.²⁸⁰

Premiums for the standard policy are currently set at about 2880 guilders (approximately U.S. \$1490) annually for adults, or 2650 guilders (approximately U.S. \$1610) annually for senior citizens.²⁸¹ These premiums do not cover the full cost of insuring these groups, so private insurers must cross-subsidize. All insurers must participate in a risk-sharing reinsurance pool and collect a solidarity contribution from all other insureds, which is shared through the pool.²⁸² Private insureds also are required to contribute to a second solidarity pool (the MOOZ) to subsidize the social insurance funds in which elderly members are overrepresented.²⁸³ The government also has had plans for some time to transform private insurance into something more

1465-66, 1470-71 (1994) (arguing for different regulatory regime for catastrophic risks because of greater profit incentives for cream skimming when catastrophic risks are insured, which results in loss of access, efficiency, and social welfare).

²⁷⁵ See Okma, *supra* note 272, at 8-9 (discussing reasons for this regulation).

²⁷⁶ AIM, *supra* note 261, at 144; Ministry of Health, Welfare & Sport, *Health Insurance in the Netherlands* 35-36 (4th ed. 1998).

²⁷⁷ Ministry of Health, Welfare & Sport, *supra* note 276, at 36-38.

²⁷⁸ *Id.* at 35.

²⁷⁹ *Id.* at 36.

²⁸⁰ AIM, *supra* note 261, at 144.

²⁸¹ *Id.*

²⁸² *Id.*

²⁸³ See *id.* at 136. Solidarity contributions for 1999 were set at 237.6 guilders for privately insured individuals aged twenty to sixty-four. *Id.*

closely resembling social insurance by instituting open enrollment requirements, rate banding, and a risk pooling scheme, though no movement is being made to implement these reforms at present.²⁸⁴ In sum, though private insurance is sold in private markets, they are markets characterized, as elsewhere in the world, by increasing government intervention and mandated cross-subsidization.

E. The United States

Other developed nations have a different concept of social equity than that which has evolved in the United States. It is not surprising that nations that embrace a solidarity principle are reluctant to let markets alone determine access to health care, or even to allow unregulated markets for private insurance covering basic health care services. When, however, we examine private insurance regulation in the United States, at least as it affects individual and small group policies, we see much the same phenomenon that we observe in other nations: health insurance sold in heavily regulated, tax-subsidized markets.

In the American federal system, the regulation of insurance, including health insurance, has been the task of the states.²⁸⁵ The states have long required that health insurers be licensed, and they have regulated health insurers with respect to solvency and policy provisions.²⁸⁶ Increasingly in recent years, however, the states have regulated insurance-rating and underwriting practices as well.²⁸⁷ Though most private health insurance in the United States is provided through employee benefits plans, where the reach of state regulation is limited federally by ERISA,²⁸⁸ state insurance regulation is saved from ERISA preemption,²⁸⁹ and ERISA has not had the deregulatory impact here that it has had in other areas of benefits regulation.²⁹⁰

²⁸⁴ Schut & Hermans, *supra* note 258, at 451-52 (discussing long-term aim of "a complete convergence of sickness funds and private health insurers").

²⁸⁵ This allocation of responsibility was confirmed by the McCarran-Ferguson Act of 1945, which presumed the absence of federal insurance regulation. 15 U.S.C. §§ 1011-1015 (1994).

²⁸⁶ See O.D. Dickerson, *Health Insurance* 435-52 (1959) (discussing provisions and administration of state regulation and efforts toward national uniformity).

²⁸⁷ In the early years of health insurance, regulators eschewed rate regulation because there were a wide variety of contract forms, little cooperation among insurers, and generally competitive rates. Edwin J. Faulkner, *Health Insurance* 497 (1960).

²⁸⁸ Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001-1461 (1994 & Supp. IV 1998); see also Furrow et al., *supra* note 117, §§ 8-3 to -5 (discussing ERISA preemption).

²⁸⁹ See 29 U.S.C. § 1144(a), (b)(2)(A) (1994); Furrow et al., *supra* note 117, § 8-3(b).

²⁹⁰ Self-insured plans, however, are exempt even from state insurance regulation. 29 U.S.C. § 1144(b)(2)(B).

Health insurance in the United States for much of the past century has been sold predominantly to employment-related groups.²⁹¹ With respect to individuals and small groups, risk-based underwriting and experience rating have long been the norm.²⁹² This has resulted in some individuals and small groups finding insurance to be very, and sometimes even prohibitively, expensive.²⁹³ Persons who are self-employed or employed by small businesses are far less likely to be insured than are those employed by large businesses. Only about half of employers with fewer than 200 employees offer health insurance benefits, while nearly all employers with more than 200 do so.²⁹⁴

In hopes of making health insurance more affordable to small businesses and the self-employed, nearly every state has adopted small-group and individual market reforms during the past decade.²⁹⁵ Many of these reforms are now mandated under the 1996 federal Health Insurance Portability and Accountability Act (HIPAA). HIPAA amended ERISA, the Public Health Services Act, and the Internal Revenue Code, to improve, among other things, the portability and continuity of health insurance coverage in the group and individual markets.²⁹⁶ HIPAA has four main consequences. First, it limits

²⁹¹ Somers & Somers, *supra* note 101, at 228-46 (describing origins and development of health insurance plans in industrial relations context). A recent study found that only about 6.6% of individuals under the age of sixty-five in the United States relied on individual coverage as their primary means of insurance. This amounts to only about twenty percent of the potential market, i.e. of those who are not otherwise insured. Pauly & Percy, *supra* note 41, at 11, 14.

²⁹² Blue Cross plans in their early years followed community rating principles, offering the same premium to all applicants. Somers & Somers, *supra* note 101, at 309-10. From the outset, however, commercial insurers used experience rating and risk underwriting. Dickerson, *supra* note 286, at 329-55; Somers & Somers, *supra* note 101, at 274-76, 309-10.

²⁹³ This generally translates into lower-wage workers having worse access to and having to pay more for insurance. Only forty-three percent of workers earning less than \$7 per hour were offered job-based benefits, compared to ninety-three percent of workers earning more than \$15 per hour, while the average monthly employee contribution for low-cost health insurance for workers earning less than \$7 per hour was \$130, compared to \$84 a month for workers earning more than \$15 per hour. Peter J. Cunningham et al., *Who Declines Employer-Sponsored Health Insurance and Is Uninsured?* 2-3 (Ctr. for Studying Health System Change, Issue Brief No. 22, 1999), <http://www.hschange.org/CONTENTS/46/46.pdf>.

²⁹⁴ See Paul B. Ginsburg et al., *Tracking Small-Firm Coverage, 1989-1996*, Health Aff., Jan./Feb. 1998, at 167.

²⁹⁵ Esther Hing & Gail A. Jensen, *Health Insurance Portability and Accountability Act of 1996: Lessons from the States*, 37 *Med. Care* 692, 693-95 (1999); Gail A. Jensen & Michael A. Morrissey, *Small Group Reform and Insurance Provision by Small Firms, 1989-1995*, 36 *Inquiry* 176, 176 (1999).

²⁹⁶ 29 U.S.C. § 1181 (Supp. IV 1998); 42 U.S.C. § 300gg-41 (Supp. IV 1998); see also Jack A. Rovner, *Federal Regulation Comes to Private Health Care Financing: The Group Health Insurance Provisions of the Health Insurance Portability and Accountability Act of 1996*, 7 *Annals Health L.* 183, 184-87 (1998) (describing portability and renewal guarantees as new federal baseline).

the extent to which health plans may impose preexisting-conditions limitations.²⁹⁷ Second, it prohibits discrimination by group health plans against individual participants and beneficiaries based on health status.²⁹⁸ Third, it requires insurers who market insurance in the small group market (to employers with two to fifty employees) to guarantee coverage and renewability to small employers who seek coverage.²⁹⁹ Fourth, it requires insurers who sell individual insurance policies to make them available to certain individuals who had been covered previously by group policies.³⁰⁰

Though all states are now obligated to implement the requirements of HIPAA (or have HIPAA requirements directly imposed through federal regulation),³⁰¹ many states enforced similar provisions before its adoption with respect to small group markets.³⁰² Thirty-eight states had guaranteed issue and forty-three had guaranteed renewal requirements in small group markets before HIPAA.³⁰³ Forty-five states had imposed restrictions on preexisting conditions clauses before HIPAA.³⁰⁴ Indeed, a number of states currently go beyond HIPAA in limiting preexisting conditions clauses, including three states that outlaw them altogether in small group markets and ten additional states that impose stricter limits than does HIPAA.³⁰⁵

Though HIPAA does not address insurance premiums, many states do, at least in small group markets.³⁰⁶ Thirty-five states impose

²⁹⁷ 29 U.S.C. § 1181(a); 42 U.S.C. § 300gg-41(a); see also Colleen E. Medill, *HIPAA and Its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?*, 65 *Tenn. L. Rev.* 485, 497-99 (1998) (stating that “key to HIPAA’s coverage portability is the reduction of the period of . . . coverage exclusion by the participant’s prior creditable coverage”).

²⁹⁸ 29 U.S.C. § 1182(a)-(b).

²⁹⁹ 42 U.S.C. § 300gg-11(a)(1).

³⁰⁰ *Id.* § 300gg-41(a)(1).

³⁰¹ See Furrow et al., *supra* note 117, § 9-7.

³⁰² Some states also did not take steps immediately to implement HIPAA’s requirements, resulting in federal enforcement in those states. See U.S. Gen. Accounting Office, *Rep. No. GAO/HEHS-98-67, Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators 18-21* (1998), available at <http://www.gpo.gov/>.

³⁰³ Gail A. Jensen & Michael A. Morrissey, *Mandated Benefit Laws and Employer-Sponsored Health Insurance 4* (1999).

³⁰⁴ *Id.*

³⁰⁵ Blue Cross/Blue Shield, *State Legislative Health Care and Insurance Issues, 1998 Survey of Plans* (1999).

³⁰⁶ Mark A. Hall, *The Competitive Impact of Small Group Health Insurance Reform Laws*, 32 *U. Mich. J.L. Reform* 685, 693 (1999) [hereinafter Hall, *Competitive Impact*] (noting that while HIPAA did not impose rate restrictions, many states have done so); Mark A. Hall, *The Structure and Enforcement of Health Insurance Rating Reforms*, 37 *Inquiry* (forthcoming Winter 2000/2001) [hereinafter, Hall, *Rating Reforms*] (manuscript at 5, on file with the *New York University Law Review*) (describing states’ rate restrictions).

rating bands, limiting premiums charged to small groups to a band range of two-to-one for experience, health status, or duration of coverage, as recommended by the National Association of Insurance Commissioners.³⁰⁷ The trend seems to be toward tighter rating bands. Six states impose tighter rating bands,³⁰⁸ while seventeen states require community rating insofar as they prohibit rating based on experience, health status, or duration of coverage.³⁰⁹ New York, one of the most restrictive states, even limits variance of premiums based on age. Most states also limit durational rating (churning) by limiting how much an insurer can increase a particular subscriber's rates at the time of renewal relative to the insurer's average increases.³¹⁰ Every state, however, permits rates to vary based on the richness of benefit coverage, size of insured unit, and geographic location.³¹¹ Ten states also have adopted mandatory reinsurance pools, and twenty have voluntary reinsurance pools, assuring that insurers that end up carrying high-risk groups can spread some of their risks to insurers with more favorable risk experience.³¹²

States also have been active in regulating individual health insurance markets. The most common individual market reform is guaranteed renewal, required by HIPAA but adopted by twenty-one states before HIPAA.³¹³ Thirty-one states have adopted restrictions on pre-existing conditions limitations covering persons beyond those who must be covered under HIPAA. Among other individual market reforms adopted by the states are restrictions on the use of experience, health status, or duration for setting premiums (eight states); prohibitions against the use of experience, health status, or duration of coverage in underwriting (eleven states); provision for voluntary or mandatory participation in reinsurance pools (nine states); and desig-

³⁰⁷ Blue Cross/Blue Shield, *State Legislative Health Care and Insurance Issues, 1999 Survey of Plans* (2000).

³⁰⁸ *Id.*

³⁰⁹ *Id.*

³¹⁰ Hall, *Rating Reforms*, *supra* note 306 (manuscript at 14); see also *infra* note 362 (explaining churning). Hall notes that some states apply these limits only within rating blocks, allowing insurers to raise rates at different levels for different policies. This apparently has encouraged insurers to act just like their counterparts responding to similar restrictions in Chile: They simply tinker with the benefits, issue a new policy, and raise rates. Hall, *Rating Reforms*, *supra* note 306 (manuscript at 15). Some states have attempted to address this problem by limiting the ability of insurers to manipulate policy forms. *Id.* (manuscript at 16). Adjustment of policies for benefit differences remains an intractable problem, however. *Id.* (manuscript at 22-24) (describing states' strategies to prevent adjustment of policies for benefit differences).

³¹¹ Blue Cross/Blue Shield, *supra* note 305.

³¹² *Id.*

³¹³ *Id.*

nation of minimum loss ratios, or the percentage of premiums that must be paid out in claims (nine states).³¹⁴

HIPAA mandates health plan coverage for all individuals who lose group coverage, regardless of health status or claims experience, if the individual has had at least eighteen months of prior continuous coverage without a lapse of sixty-three or more days since the most recent group coverage.³¹⁵ Relatively few individuals fit this precise description and qualify for this benefit.³¹⁶ Moreover, states may opt out of this requirement by providing an acceptable alternative mechanism. In fact, as of December 1998, only thirteen states were complying with the HIPAA-guaranteed issue alternative, while the remaining states relied on another alternative.³¹⁷ Twenty-five states provided coverage through high-risk insurance pools,³¹⁸ mostly funded through premiums and assessments on insurers, which charge premiums of up to between 125% and 250% of the average premium for individual coverage³¹⁹ and impose high cost-sharing requirements and relatively low annual and lifetime maximums.³²⁰

In the end, these state regulatory requirements seem to have had a limited positive, and perhaps even a negative, impact on the extent of insurance coverage in small group markets.³²¹ The requirements probably have had a quite negative impact on the extent of insurance coverage in individual markets, though the reforms probably have helped some individuals and firms that otherwise might not have been able to secure insurance.³²² HIPAA probably has had an even less

³¹⁴ *Id.*

³¹⁵ 42 U.S.C. § 300gg-41(b) (Supp. IV 1998).

³¹⁶ Chollet & Kirk, *supra* note 42, at 16 (noting that narrowness of HIPAA eligibility categories means that few individuals will qualify).

³¹⁷ *Id.* at 15-17 (noting that even of those thirteen states requiring all insurers participating in individual market to guarantee issue of one or more products to all applicants, only four states require guaranteed issue of all products).

³¹⁸ See Sally C. Stearns et al., *The Structure and Experience of State Risk Pools: 1988-1994*, 54 *Med. Care Res. & Rev.* 223, 223-24 (1997).

³¹⁹ See *id.* at 228.

³²⁰ See *id.* at 227.

³²¹ See Hing & Jensen, *supra* note 295, at 70 (noting that states' small group reforms had mixed results).

³²² See generally Jensen & Morrissey, *supra* note 295 (noting that states' reforms had limited impact on extent of coverage and that individual coverage has declined despite reforms); Leigh Page, *Insurance Reform Effect: Coverage Drop*, *Am. Med. News*, Sept. 21, 1998, at 5 (noting that states' reforms have caused net decline in individual and small group coverage according to two recent studies); see also Stephen Zuckerman & Shruti Rajan, *An Alternative Approach to Measuring the Effect of Insurance Market Reforms*, 36 *Inquiry* 44, 53-54 (1999) (arguing that small group reforms may have forestalled further deterioration in small group markets, though they have not increased insurance coverage, but individual market reforms have been accompanied by increased uninsurance). On the other hand, research sponsored by the Heritage Foundation found a dramatic increase in

beneficial effect.³²³ On the other hand, the disastrous effects that some predicted the reforms might have on insurers have not materialized either.³²⁴ Insurers have remained in business in virtually all states, even those that have adopted rigorous reforms.³²⁵

Even in the United States, therefore, we see that pure competitive markets for health insurance are not tolerated where they really would make a difference, in the small group and individual markets. Since large groups essentially community rate at the group level,³²⁶ and HIPAA forbids differential premiums or coverage denials on the basis of health status within groups, pure risk-based competitive markets for health insurance are almost as rare in the United States as they are elsewhere in the world.

F. Alternative Approaches to Private Insurance: Canada, the United Kingdom, and France

A high and escalating level of government involvement in health insurance markets is not, however, unavoidable. Something more closely approximating the competitive ideal of private health insurance markets exists in a number of nations.

In Canada, for example, where basic health care services are covered by the federal/provincial basic health insurance scheme and several provinces proscribe the purchase of private insurance to cover

uninsured rates in states with the strictest insurance regulation. See Melinda L. Schriver & Grace-Marie Arnett, *Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations 1* (Heritage Found., Background No. 1211, 1998). These findings were to some extent contradicted by an Urban Institute Study reviewing the same data. See Page, *supra*, at 5. Finally, for the argument that state reforms have been largely ineffective in expanding coverage, see Frank A. Sloan & Christopher J. Conover, *Effects of State Reforms on Health Insurance Coverage of Adults*, 35 *Inquiry* 280, 289 (1998).

³²³ See Geri Aston, *Insurance Reform Law Falls Short*, *Am. Med. News*, Sept. 14, 1998, at 1 (noting that HIPAA has not achieved results anticipated by legislators).

³²⁴ Hall, *Competitive Impact*, *supra* note 306, at 699 (noting that small group insurance markets have remained stable following reform). This has been less true in individual markets, though with the exception of Kentucky and Washington, states adopting individual market reforms have been able to maintain relatively healthy markets. See Adele M. Kirk, *Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts*, 25 *J. Health Pol. Pol'y & L.* 133, 139-40, 151-53 (2000) (describing decline in Washington and Kentucky individual insurance markets following reform); Len M. Nichols, *State Regulation: What Have We Learned So Far?*, 25 *J. Health Pol. Pol'y & L.* 175, 194 (2000) (noting that while reforms did not cause market collapse, neither did they decrease dramatically numbers of uninsured).

³²⁵ Kentucky is the only state in which individual markets collapsed after the adoption of reforms, though the situation in Kentucky was in many respects unique. See Kirk, *supra* note 324, at 147-58 (describing Kentucky reform experience).

³²⁶ Everyone in the group pays the same premium for the same coverage, regardless of health status. See Thomas R. Oliver, *Dynamics Without Change: The New Generation*, 25 *J. Health Pol. Pol'y & L.* 225, 227 (2000).

services covered by the public program, nearly fifteen million persons have private health insurance, almost exclusively for services not covered by the public program, such as private hospital rooms, vision and dental care, hearing aids, chiropractors, and prescription drugs.³²⁷ These health plans usually are provided by employers, though employees often are required to contribute to the premiums.³²⁸ Private health insurance is government-subsidized to the extent that employers can exclude from their income their contributions to employee health benefit plans, and employees are not taxed on these benefits.³²⁹ Private insurance rates, however, are not regulated, except insofar as provincial civil rights laws prohibit discrimination on the basis of age, sex, or handicap that is not bona fide and reasonable.³³⁰ The percentage of health care expenses in Canada covered by the private sector has been growing in recent years, in part because the government is defining more and more services as nonessential or not "medically necessary," and thus not covered,³³¹ and because of the growing cost of medications, most of which are covered by private insurance.³³²

³²⁷ Graig, *supra* note 79, at 137-38; Flood, *supra* note 116, at 29. At the end of 1998, 14.889 million Canadians had extended health insurance, and 7.547 million had dental insurance. Private health insurance plays a similar role in Japan. See Graig, *supra* note 79, at 99 (noting that individuals cannot opt out of Japan's national insurance program, but private insurance covers benefits not included in national program).

³²⁸ Graig, *supra* note 79, at 138.

³²⁹ *Id.*; see also Flood, *supra* note 116, at 30 (noting that private insurance is subsidized through tax deductions).

³³⁰ Flood, *supra* note 116, at 30. In fact, only a very small percentage of applicants are denied coverage as uninsurable (two percent according to one report from Quebec), but higher-risk applicants are charged higher rates. See Can. Life & Health Ins. Ass'n, *The Place of the Private Sector in the Health Care Field* § 1.1.2 (1999) [hereinafter *Can. Life & Health Ins. Ass'n, Place of the Private Sector*], http://www.clhia.ca/submissions/quebec/priv_pq_doc.html. Health insurers are regulated by the federal Office of Superintendent of Financial Institutions for solvency and fiscal responsibility. See Can. Life & Health Ins. Ass'n, *Canada's Life and Health Insurance Industry: The Regulatory Environment* 3 (1997), http://www.clhia.ca/submissions/sub3_d.htm.

³³¹ See Joan M. Gilmour, *Creeping Privatization in the Health Care System: Implications for Women as the State Re-Draws Its Role* 18-20 (Apr. 13, 2000) (unpublished manuscript, on file with the *New York University Law Review*) (noting that economic concerns have driven Canadian government to deem more services not "medically necessary").

³³² Ted Schrecker, *Private Health Care for Canada: North of the Border, an Idea Whose Time Shouldn't Come?*, 26 *J. Law, Med., & Ethics* 138, 140 (1998) (describing growing private spending on health expenses); Can. Life & Health Ins. Ass'n, *Place of the Private Sector*, *supra* note 330, § 1.3.2 (arguing that increased private spending is driven in part by increasing cost of medications). In 1997, Quebec established a Drug Insurance Plan, which might indicate a move away from essentially unregulated insurance markets. Under this plan, residents of Quebec are required to carry insurance for pharmaceuticals, which is covered either by a public plan or by private plans. A risk pool has been established among participating group plans to share the risk of high-cost cases. See Can. Life & Health Ins. Ass'n, *Submission Concerning the Report on the Evaluation of the General*

Similarly, private health insurance covers twelve to thirteen percent of the population in the United Kingdom, where it largely serves the function of allowing insureds to queue jump, but also allows insureds to choose their hospital or surgeon.³³³ About sixty percent of private medical insurance coverage in the United Kingdom is provided by employers, but employer-paid premiums are taxable to employees.³³⁴ Though the Thatcher government established tax subsidies for some who purchased private insurance,³³⁵ these were abolished when Labour returned to power.

In the United Kingdom, insurers are free to risk underwrite as long as they do not discriminate against the disabled.³³⁶ An investigation of the private health insurance industry by the Office of Fair Trading in the late 1990s resulted only in tepid recommendations that insurers should come up with a more transparent means of communicating the content of insurance coverage through the use of "core term products," either discontinue or explain better to potential purchasers the use of "moratorium underwriting" (insurance sold without underwriting but with long preexisting conditions clauses), and warn initial purchasers that premiums are likely to increase in the future at rates substantially in excess of inflation.³³⁷ These recommendations are being implemented partially by the insurance industry, and further government regulatory action apparently is not being contemplated.³³⁸

Finally, about eighty-five percent of French families have private insurance purchased from either a commercial insurer or a *Mutuelle* (descendants of the guild funds).³³⁹ Private insurance now covers about twelve percent of national health expenditures, much of which consists of cost-sharing obligations imposed under the public insur-

Drug Insurance Plan §§ 1.1 to .2 (2000), http://www.clhia.ca/submissions/med_pq/med_en_f.html.

³³³ Graig, *supra* note 79, at 163. Indeed, some insurance contracts only cover services if the NHS waiting lists are of a certain duration. See *Private Health Insurance*, *supra* note 189, at 86-89 (comments of William Laing).

³³⁴ Graig, *supra* note 79, at 164.

³³⁵ See Rob Baggott, *Health and Health Care in Britain 153* (1994) (describing policies of Conservative government to expand private health insurance coverage).

³³⁶ Insurers, however, may exclude only psychiatric care, cosmetic surgery, and treatment of chronic diseases. *Private Health Insurance*, *supra* note 189, at 87 (comments of William Laing).

³³⁷ Office of Fair Trading (U.K.), *Health Insurance: A Second Report by the Office of Fair Trading 5-6* (1998), <http://www.oft.gov.uk/html/rsearch/reports/oft230.htm>.

³³⁸ See *id.* at 10-11.

³³⁹ E-mail from Sophie Bancet, General Counsel's Office, La *Mutuelle Générale des PTT*, to Timothy Stoltzfus Jost, Professor, Ohio State University (Apr. 19, 2000) (on file with the *New York University Law Review*).

ance plan.³⁴⁰ About sixty percent of private insurance is purchased through groups, forty percent by individuals.³⁴¹ Private insurance is offered on an indemnification basis and effectively insures against the cost-sharing obligations imposed on patients under the national social insurance scheme, as well as for expenses not covered (such as the extra charge for a private room).³⁴²

French insurers are generally free to risk-underwrite and to decline applications for insurance based on risk.³⁴³ They are subject to some limits, however. Insurers may exclude preexisting conditions if the condition has been referred to expressly as excluded by the policy and the insurer proves that it was preexisting at the time the contract issued, but otherwise are limited in their ability to exclude coverage for preexisting conditions to those excluded from coverage by the national social security system.³⁴⁴ If insurers choose to insure a group, they must insure all members of the group.³⁴⁵ After two years of coverage, an insurer cannot refuse to renew an insured or raise premiums based solely on medical condition.³⁴⁶ Thus private insurance is regulated more heavily in France than in Canada or the United Kingdom, though initial underwriting is subject to few regulatory constraints.

Though the health care systems of these three nations are quite different, the function of private insurance within them is quite similar. In each of these countries, private insurance is provided predominantly through employment-related group contracts primarily as a fringe benefit and less often is purchased in individual markets, though individual markets exist in all three countries. Further, in each country private insurance plays merely a supplementary role, covering frills and amenities not covered by comprehensive insurance schemes.

³⁴⁰ Joseph White, *Competing Solutions: American Health Care Proposals and International Experience* 105-06 (1995).

³⁴¹ E-mail from Sophie Bancet to Timothy Stoltzfus Jost, *supra* note 339.

³⁴² CEA, *supra* note 56, at 43-44.

³⁴³ *Id.* at 44 (contrasting statutory health insurance, in which contributions are fixed without reference to risks, with private health insurance, in which insureds' contributions depend on nature and extent of risks); E-mail from Sophie Bancet, General Counsel's Office, La Mutuelle Générale des PTT, to Timothy Stoltzfus Jost, Professor of Law, Ohio State University (Apr. 20, 2000) (on file with the *New York University Law Review*).

³⁴⁴ *Protection sociale complémentaire* [Complementary Social Protection], in *Dictionnaire Permanent Assurances* [Permanent Insurance Dictionary] 3557, 3588 (1997) (explaining French law requiring coverage of preexisting conditions); see also *id.* at 3595 (explaining conditions under which preexisting conditions may be excluded).

³⁴⁵ *Id.* at 3588.

³⁴⁶ *Id.* at 3595-96.

III THE ANALYTIC BASIS OF HEALTH INSURANCE REGULATION

From these case studies we see that, even in the United States, private health insurance is highly regulated and often government subsidized wherever it is relied upon as a primary means for purchasing essential health care services for a significant portion of a nation's population. Insurance also seems to be more highly regulated and subsidized where individual, as compared to group, policies predominate. What explains the pervasiveness of private insurance regulation in these examples?

To begin, when an insured purchases insurance, she pays money up front in exchange for the insurer's promise to pay a contingent claim if and when it eventuates in the future. Both the future capacity and the willingness of the insurer to pay when a claim is presented are important to the insured. Both problems are addressed by regulation. The problem of capacity to pay is dealt with almost everywhere through licensing, capitalization, and reserve requirements, as well as by periodic reporting and financial examinations.³⁴⁷ The problem of unfair claims practices (of unwillingness to pay) traditionally has been addressed by the courts (applying the doctrines of *contra proferentem*, reasonable expectations, and bad faith to compel insurers to pay wrongly denied claims),³⁴⁸ and by regulators through the specification or prohibition of contract clauses and regulation of claims practices.³⁴⁹

Our concern here, however, is not with solvency and claims practices regulation, but rather with regulation of underwriting of premiums and of contract limitations and exclusions. In the first five case studies just reviewed, this form of regulation seems quite common, though its intensity and prevalence varies from country to country. Chile, Germany, Australia, the Netherlands, and the United States all attempt to use private insurance to cover the primary health care

³⁴⁷ U.S. Gen. Accounting Office, Rep. No. HRD-94-26, Health Insurance Regulation: Wide Variation in State's Authority, Oversight, and Resources 8-10 (1993) (discussing shortcomings in current state oversight of insurance company solvency); Peter M. Lencsis, Insurance Regulation in the United States: An Overview for Business and Government 25-51 (1997) (addressing licensing of insurers, insurers' assets, reserves, and investments, and annual statements and periodic examinations); Chollet & Lewis, *supra* note 96, at 87-89 (discussing standards for insurer entry and exit).

³⁴⁸ See Abraham, *supra* note 50, at 101-32 (exploring these doctrines); Tom Baker, Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages, 72 *Tex. L. Rev.* 1395 (1994) (analyzing bad faith breach of contract doctrine).

³⁴⁹ See Dickerson, *supra* note 286, at 440-43; Faulkner, *supra* note 287, at 485-96; Chollet & Lewis, *supra* note 96, at 89-90.

needs of important segments of their population. For reasons that are intuitively obvious and have long been understood, however, private health insurance purchased by private parties in unregulated and unsubsidized markets is simply incapable of covering whole populations.

In competitive insurance markets, no single insurer can choose to offer the same price to all purchasers of insurance (i.e., to “community rate” voluntarily).³⁵⁰ Any insurer that tried to do so obviously would have to charge a rate high enough to break even—that is, a rate high enough to cover the costs anticipated from extraordinarily expensive cases as well as the cost of a much higher number of more moderately expensive services. The distribution of health care costs over a population in any given year, however, is extraordinarily skewed. The most expensive one percent of the insured population accounts for thirty percent of all medical care costs, while the least expensive fifty percent are responsible for only three percent of costs.³⁵¹ Thus, for an insurer dedicated to community rating to cover the costs it will face from extraordinarily expensive insureds, it will have to charge hefty premiums to many insureds who in fact will incur no insured expenses over the course of the year, many of whom will not anticipate any health care expenses at the outset.

Faced with sizeable premiums and little anticipation of need for insurance, some low-risk insureds undoubtedly will decline insurance coverage, choosing to self-insure (unless the purchase of insurance is mandated)³⁵² and perhaps spending more on prevention. High-risk insureds, on the other hand, will find community-rated insurance very attractive.³⁵³ In other words, insurers will be at risk for “adverse selection” (the preferential election to insure by high-risk individuals).³⁵⁴

³⁵⁰ The classic demonstration of this is found in Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q.J. Econ. 629 (1976).

³⁵¹ Marc L. Berk & Alan C. Monheit, *The Concentration of Health Expenditures: An Update, Health Aff.*, Winter 1992, at 145, 146 ex.1; see also Gauthier et al., *supra* note 69, at 15, 17 (finding that thirty-five percent of insureds do not submit claim in any given month, and five percent account for vast majority of claims). One large University of California plan discovered that 227 individuals accounted for forty-two percent of reimbursable hospital costs during the 1982-83 contract year, while in another University health plan, 0.04% of Blue Cross enrollees accounted for 21% of reimbursements. IOM, *supra* note 98, at 178-79 (discussing impact on health plan costs of small group of individuals who require high level of care).

³⁵² Jacobi, *supra* note 26, at 387-88 (arguing that social policy should favor programs that result in inclusion of everyone).

³⁵³ Hall, *supra* note 40, at 11.

³⁵⁴ See *id.* (defining “adverse selection”); Wortham, *supra* note 40, at 844 (“Insurers fear adverse selection because it means that the group of people who actually purchase a particular insurance coverage will not have the same characteristics as the group on whose past

If, however, as would be expected in competitive markets, at least one insurer offers insurance at a lower price, low-risk insureds will abandon the high-cost insurer and flock to the new entrant.³⁵⁵ But high-risk insureds will do so as well, seriously threatening the viability of the lower-cost insurer. The lower-cost insurer may try to discourage some high-risk insureds by offering a less generous product, for example, a product subject to lower caps or higher cost sharing, or covering fewer services.³⁵⁶ If the lower cost insurer succeeds, however, high-risk insureds discouraged from moving to the low-cost insurer will remain with the higher-cost, higher-coverage insurer, which will now need to raise its premiums to cover the ever more expensive population it has retained.³⁵⁷ As it does so, however, its policies will become even less attractive to those low-risk insureds who had remained loyal to it. An insurer who community rates voluntarily, in the end, will slip into the insurance "death spiral," as it is left with an ever less favorable risk pool and must charge ever higher rates.³⁵⁸ High-option plans will be driven out of the market by adverse selection.³⁵⁹ In short, a stable "pooling equilibrium," in which every insured remains in a common pool paying the same amount for insurance is not possible in competitive health insurance markets.³⁶⁰

losses premiums were calculated."). Adverse selection may occur either when insurers are unable to identify high-risk applicants or when rate regulation limits their ability to respond, by acting on their identification of such applicants. Van de Ven et al., *supra* note 246, at 316. There is considerable evidence of the existence of adverse selection when health plans are required to accept all eligible applicants at a fixed price, as in the federal COBRA continuation coverage program, or where, as in the Federal Employees Health Benefits program or the California Public Employees Retirement System, beneficiaries can choose between high and low benefit option plans. Hall, *supra* note 40, at 40-41.

³⁵⁵ Rothschild & Stiglitz, *supra* note 350, at 636.

³⁵⁶ Mark V. Pauly, *Is Cream-Skimming a Problem for the Competitive Medical Market?*, 3 *J. Health Econ.* 88, 92 (1984).

³⁵⁷ Jacobi, *supra* note 26, at 388-89.

³⁵⁸ *Id.* at 389. Insureds anticipating increased use of medical care, such as maternity care, conversely may switch from low- to high-benefit plans. See James C. Robinson et al., *Health Plan Switching in Anticipation of Increased Medical Care Utilization*, 31 *Med. Care* 43 (1993) (using data from patients expecting increased need for maternity care to support hypothesis that individuals switch health plans in anticipation of changing medical care needs).

³⁵⁹ See generally M. Susan Marquis, *Adverse Selection with a Multiple Choice Among Health Insurance Plans: A Simulation Analysis*, 11 *J. Health Econ.* 129 (1992) (demonstrating this through simulation based on Rand Health Insurance experiment).

³⁶⁰ Rothschild & Stiglitz, *supra* note 350, at 634-37 (discussing equilibrium in market with combination of high-risk and low-risk individuals). This phenomenon may be a greater problem in theory than in practice. There is some evidence that individual insureds are in fact willing to pay premiums in excess of the actuarially accurate marginal cost of coverage for that individual, particularly if the alternative is doing without insurance. Jacobi, *supra* note 26, at 389-91.

If however, at least one insurer risk underwrites or “experience rates,”³⁶¹ offering higher rates for higher-risk applicants and lower rates for lower-risk applicants, the market will sort itself out into a “separation equilibrium.”³⁶² Low-risk insureds will leave high-cost, one-rate-fits-all insurance plans for lower-cost alternatives calibrated to their level of risk.³⁶³ Community-rated plans will be forced to move to risk underwriting or be priced out of the market. This is precisely what happened in the United States during the middle of the last century, as Blue Cross plans, many of which originally were community rated, lost the low-risk end of their business to experience-rated commercial insurers, who offered more attractive rates, and eventually adopted experience rating themselves.³⁶⁴

Low-risk insureds, however, may not only find community-rated plans a bad deal, but they simply may be unable to afford them.³⁶⁵ Low-risk insureds in the United States are often young persons who have just entered the job market, and many may not yet have even a permanent or fulltime job.³⁶⁶ One-size-fits-all insurance rates set high

³⁶¹ To “experience rate” is to offer rates to groups or to individuals based on experience with health care costs. Furrow et al., *supra* note 98, at 463.

³⁶² See Pauly, *supra* note 356, at 90 (giving formula for equilibrium annual premiums when prices are set tailored to risk). Another underwriting strategy used by insurers to control risk is durational underwriting, or “churning”: offering very low premiums to low-risk groups, and then raising premiums by 50% to 100% (or even refusing to renew) a year or two later as the effectiveness of the initial screening wears off and the group’s risk profile regresses to the mean. See Hall, *Competitive Impact*, *supra* note 306, at 688. A perfect separation equilibrium, in which every insured pays his or her own projected costs, is not possible because the administrative costs involved in achieving such a result would be prohibitive for the insurer. IOM, *supra* note 98, at 169.

³⁶³ Neoclassical economic theory would argue that the separation equilibrium in this situation is the efficient result. See Wortham, *supra* note 40, at 858-59 (summarizing neoclassical economic theory arguments).

³⁶⁴ Hall, *supra* note 40, at 14; see also Abraham, *supra* note 50, at 72-73 (discussing advantages of experience rating); Joseph P. Newhouse, *Patients at Risk: Health Reform and Risk Adjustment*, *Health Aff.*, Spring 1994, at 132, 133-34 (using history of Blue Cross as evidence of importance of risk selection).

³⁶⁵ See Deborah L. Rogal & Anne K. Gauthier, *Introduction: The Evolution of the Individual Insurance Market*, 25 *J. Health Pol. Pol’y & L.* 3, 7 (2000). One study found that cost was cited sixty-four percent of the time as the main reason persons remained uninsured in the United States. Karen Donelan et al., *Whatever Happened to the Health Insurance Crisis in the United States?*, 276 *JAMA* 1346, 1348 (1996).

³⁶⁶ See Cunningham et al., *supra* note 293, at 2-3 (noting strong correlation between low hourly wage and likelihood of being uninsured); Findlay & Miller, *supra* note 460, at 7-8 (noting that many young and nontraditional workers are often uninsured); Henry S. Farber & Helen Levy, *Recent Trends in Employer-Sponsored Health Insurance Coverage: Are Bad Jobs Getting Worse?*, 19 *J. Health Econ.* 93, 95 (2000) (noting that new and part-time workers are less likely to be covered by insurance). This is one of the arguments most often made against the cross-subsidy aspect of group insurance coverage. See Hoff, *supra* note 19, at 103 (pointing out that young workers, who subsidize insurance for old and sick under group insurance, often earn less than old and sick workers do); Ture & Entin, *supra*

enough to cover the expenses of all insureds simply may be too high to fit into their budgets.³⁶⁷ In fact, in the four years following the adoption by New York of required community rating in the individual market in 1993, individual enrollment dropped by at least thirty-eight percent and possibly by as much as fifty percent.³⁶⁸ During the same four years, one major New York insurer reported that the average age of its individual indemnity pool increased by 11.5 years.³⁶⁹ Community rating, when applied to small groups, decreases both insurance offer and purchase rates by five percentage points because of loss of low-risk firms and insureds, even though it also increases accessibility for high-risk firms and individuals.³⁷⁰

However, when plans underwrite based on individual, or even small group, risk and experience, they may charge premiums that high-risk individuals and groups find simply unaffordable, or plans simply may refuse to sell to some high-risk individuals when they are not required legally to do so.³⁷¹ Insurers in the United States that sell in the individual market often exclude or limit coverage for maternity care, mental health, substance abuse treatment, or HIV-related expenses; charge high deductibles and coinsurance amounts; and impose

note 22, at 125 (arguing for free-market pricing and providing assistance only to those for whom premiums constitute hardship).

³⁶⁷ See Pauly & Percy, *supra* note 41, at 21. One hoped-for effect of tax credit proposals is that subsidies would make insurance rates, based on rating restrictions, more attractive to low-risk insureds. See Merlis, *supra* note 24, at 8-9 (comparing subsidies without simultaneous rate reform, which will result in increased likelihood of low-risk insureds obtaining coverage, with subsidies and simultaneous rate reform, which will have smaller—though still positive—effect on low-risk coverage).

³⁶⁸ Mark A. Hall, An Evaluation of New York's Reform Law, 25 *J. Health Pol. Pol'y & L.* 71, 72, 76 (2000) (discussing effect of insurance market reform on individual enrollment). Small group enrollment, on the other hand, increased after the reforms were adopted. *Id.* at 77, 79.

³⁶⁹ *Id.* at 87. Other major insurers also reported that their average number of claims for individuals, hospital days per thousand insured, and prevalence of AIDS and cirrhosis among insureds were far higher in the New York individual market than in the group market. *Id.*

³⁷⁰ Joan L. Buchanan & M. Susan Marquis, Who Gains and Who Loses with Community Rating for Small Business?, 36 *Inquiry* 30, 38, 40-41 (1999).

³⁷¹ Chollet & Kirk, *supra* note 42, at 48; see also Hall, *Competitive Impact*, *supra* note 306, at 688 (explaining practice of "ridering out," whereby insurers exclude certain conditions or decline to cover high-risk patients). An Office of Technology Assessment found that eight percent of individual insurance applicants in 1987-88 were rejected outright, thirteen percent were insured with exclusion waivers, five percent were charged higher premiums, and two percent were subjected to both exclusion waivers and higher premiums. Stone, *supra* note 76, at 307. On the other hand, a recent study of the individual insurance market finds that, while persons who self-report fair or poor, as opposed to good or excellent, health status are less likely to have individual coverage, the difference is modest. Pauly & Percy, *supra* note 41, at 15, 17.

lengthy preexisting condition exclusions where permitted to do so.³⁷² They charge rates as much as 50% to 200% higher than their standard rates for conditions such as obesity, tobacco use, and hypertension, and may deny coverage for a history of angina, stroke, or rheumatoid arthritis.³⁷³ Insurers compelled under HIPAA to offer individual insurance policies to individuals who lost group insurance charged rates up to 600% above standard rates.³⁷⁴ Many individuals or employers therefore have had to pass up health insurance simply because of its cost.³⁷⁵ Regardless of whether plans are community-rated or experience-rated, therefore, some individuals will not be able to find coverage at an affordable price.³⁷⁶

Moreover, insurers have means other than risk underwriting to control adverse selection. Preexisting condition exclusions or coverage waiting periods make insurance plans less appealing to high-cost insureds.³⁷⁷ Caps on coverage (either lifetime, enrollment period, or condition-specific coverage caps) likewise can discourage those in ill health from purchasing insurance.³⁷⁸ These devices, sometimes referred to as "postclaims underwriting," discourage adverse selection, but also limit the risks faced by insurers when it occurs.³⁷⁹ Finally, benefit packages can be designed to include or exclude benefits or providers of particular interest to low- or high-risk groups.³⁸⁰

Ample evidence also can be found of risk segmentation, favorable selection, and the use of devices such as exclusions and caps to limit risk in loosely regulated health insurance markets outside the United States. As noted above, in Chile the elderly and disabled are

³⁷² See Chollet & Kirk, *supra* note 42, at 38-43 (summarizing these practices).

³⁷³ *Id.* at 49-51.

³⁷⁴ U.S. Gen. Accounting Office, *supra* note 302, at 8.

³⁷⁵ See Duchon et al., *supra* note 20, at 4-5 (noting that fourteen percent of employees declined to participate in job-based plans, and nearly half of those cited cost as reason); Findlay & Miller, *supra* note 460, at 5-6 (noting that six million fewer people took health care from their employers in 1996 than in 1987 despite increase in number of small businesses offering coverage); Richard Kronick & Todd Gilmer, *Explaining the Decline in Health Insurance Coverage, 1979-1995*, *Health Aff.*, Mar./Apr. 1999, at 30, 45 ("More workers were uninsured in 1995 than in 1979 because rising health care expenditures made insurance unaffordable for a growing number of workers."); see also Jensen & Morrissey, *supra* note 295, at 184 (stating that ninety percent of small employers identified cost of coverage as reason why they were not offering insurance to their employees).

³⁷⁶ A recent study of New Jersey's Individual Health Coverage Program found minimal evidence of adverse selection, but noted that this might result from the fact that premiums offered under the plan were high and not affordable to many high-risk insureds. Katherine Swartz & Deborah W. Garnick, *Can Adverse Selection Be Avoided in a Market for Individual Health Insurance?*, 56 *Med. Care Res. & Rev.* 373, 386 (1999).

³⁷⁷ IOM, *supra* note 98, at 173; Chollet & Lewis, *supra* note 96, at 83-84.

³⁷⁸ Chollet & Lewis, *supra* note 96, at 83-84.

³⁷⁹ Hall, *supra* note 40, at 19.

³⁸⁰ IOM, *supra* note 98, at 173-74.

largely excluded from private insurance, women wage-earners are discriminated against, and caps and preexisting condition exclusions are common (to the extent that they are permitted).³⁸¹ It also appears that even though insurance coverage through friendly societies was quite common in pre-NHS Britain, women, the very poor, and those at high risk for needing medical care, had difficulty securing coverage.³⁸²

The exclusionary effects of risk-underwritten private insurance are mitigated to a considerable degree when insurance is sold to employment-related groups.³⁸³ Employment-related groups, especially large groups, are able to spread risk broadly, making insurance more affordable to higher-risk individuals. In effect, they community rate at the group level rather than the insurer level.³⁸⁴ As only persons healthy enough to work and their dependents are included in such groups, the risk exposure faced by an insurer or self-insured employer who insures a group is controlled to some extent.³⁸⁵ If the employer covers most of the cost of the insurance itself as a business expense, moreover, low-risk employees may not be aware of the extent to which they are subsidizing their higher-risk coworkers. Where employment-related insurance is tax subsidized, as it long has been in the United States, insureds may be troubled even less by cross-subsidization.³⁸⁶ Historically, therefore, group health insurance in the United States, the United Kingdom, France, Canada, and other countries has had the effect of making private insurance more available.

³⁸¹ See *supra* Part II.A.

³⁸² The most thorough study of this topic is found in Green, *supra* note 99. Though Green's main argument is that socialized medicine was a mistake in Britain, and that Britain instead should have relied on the growth of private coverage through the friendly societies, he does admit that coverage was far from universal prior to 1948 and that these groups in particular faced difficulties obtaining coverage. *Id.* at 100-06.

³⁸³ Indeed, some of the tax credit proposals would require employers to continue to offer insurance plans to their employees, recognizing the important role of employers as facilitators in health insurance markets. See Steuerle & Mermin, *supra* note 21, at 85-86.

³⁸⁴ The early pioneers of employment-related group health insurance in the United States understood this and supported group-based insurance because of it. See IOM, *supra* note 98, at 67 (noting that use of employee group model was key to managing risk pool).

³⁸⁵ Although some plans still cover retirees, this coverage is usually secondary to Medicare; thus, risk exposure is somewhat controlled.

³⁸⁶ See Alan C. Monheit et al., *How Are Net Health Insurance Benefits Distributed in the Employment-Related Insurance Market?*, 32 *Inquiry* 379, 389 (1995). According to one study, individuals who are eligible for tax-subsidized, employment-based coverage are twenty-four times more likely to have health insurance than those who must buy it as individuals. Tanner, *supra* note 30, at 32. One potential problem of moving to individual tax credits, however, is that it would break down the community cross-subsidization aspects of group coverage, as low-risk individuals would leave groups for cheaper individual coverage and high-risk individuals would be pushed out of plans to lower the costs of group coverage. Merlis, *supra* note 24, at 12-14.

Because unregulated private health insurance markets leave high-risk individuals with very costly, often simply unaffordable, premiums, or apply other terms and conditions, such as lengthy preexisting condition exclusions, that make affordable insurance of little value, nations that rely on individual private insurance policies for providing primary cover to portions of their populations almost inevitably regulate (usually quite extensively) and often subsidize private insurance markets to mitigate these results.³⁸⁷ In other words, they conscript private insurance to serve the public goal of equitable access.

Regulation in some nations begins with attempts to require community rating, or at least to limit the extent of risk underwriting and experience rating.³⁸⁸ This is the case in Australia, and to a lesser extent Germany, the United States, and the Netherlands.³⁸⁹ Most countries also restrict or prohibit insurers from canceling or refusing to renew insurance for individuals or groups as they become higher risk with time or in fact incur substantial expenses. This is the case in Chile, Australia, the United States, and Germany.³⁹⁰ In many places, rating restrictions grow more complex over time, as insurers adjust to them and figure out ways to avoid them.³⁹¹

Simply requiring that all insurance purchasers be offered the same rates (subject usually to adjustment for size of insured unit—individual, couple, family—and perhaps for age or gender) will not suffice, however, to assure access to insurance.³⁹² As noted above, by excluding preexisting conditions for long periods of time, barring coverage for high-cost or chronic conditions, or imposing low maximum

³⁸⁷ See Nichols, *supra* note 324, at 180-81. Risk-based underwriting and other insurer practices aimed at countering adverse selection have other deleterious effects that also encourage public regulation. First, the possibility of adverse selection may discourage plans from offering benefits that might attract high-risk insureds, thus leaving these persons without important coverage. Second, insureds may fail to submit claims to insurers for fear that doing so will result in increased rates or in loss of coverage. IOM, *supra* note 98, at 182.

³⁸⁸ Van de Ven et al., *supra* note 246, at 312-13.

³⁸⁹ See *supra* text accompanying notes 194 (Germany), 239 (Australia), 271-74 (Netherlands), 307-12 (United States).

³⁹⁰ See *supra* text accompanying notes 171-72 (Chile), 203-04 (Germany), 239 (Australia), 315 (United States).

³⁹¹ Professor Hall, an astute observer of insurance regulation in the United States, concludes: "Competitive insurance markets are inherently complex, so more complex reforms are fitting. However, complex reforms require careful monitoring to eliminate all of the possible avenues for circumvention. . . . Avoiding . . . larger-scale problems requires careful construction of the rules and diligent monitoring of their implementation." Hall, *Rating Reforms*, *supra* note 306 (manuscript at 30).

³⁹² Moreover, it also can be one factor which leads to withdrawal of insurers from the highly regulated market, leaving a less competitive environment. See Hall, *Competitive Impact*, *supra* note 306, at 699-703 (detailing impact of small group reforms on competitiveness in New York market).

coverage limitations (including disease-specific caps), insurers can defeat the whole purpose of government efforts to extend coverage to high-risk individuals.³⁹³ Private insurance coverage effectively will be denied to high-risk persons unless the use of these limitations is restricted, or perhaps even outlawed. Most nations in which private insurance plays an important role, therefore, including Chile, France, the United States, and Australia, place limits on the extent to which insurers can impose these clauses and restrictions.³⁹⁴

Insurers denied the use of these obvious restraints on coverage, however, can resort to still more subtle devices to skim the cream from markets and to avoid high-risk insureds. Insurers compelled to community rate can expect one-third of their insureds to be unprofitable, with the maximum predictable loss exceeding eight times overall average per capita expenditures.³⁹⁵ This creates significant incentives for cream skimming through whatever avenues are open. Some private insurers in Australia, required to sell policies on a community-rated basis, reportedly opened offices on the upper floors of buildings without elevators to limit accessibility by those in frail health.

Insurers may shape their benefit packages to include health club dues or discounts on running shoes, or to exclude long-term care or mental health care, in an effort to encourage low-risk and discourage high-risk applicants.³⁹⁶ They may refuse to pay commissions to agents who sell certain types of insurance or who sell insurance to certain types of customers, and may encourage "field underwriting," where agents simply do not sell insurance to certain potential consumers.³⁹⁷ If reforms grandfather in existing policies, insurers may close their existing products to new entrants and offer new products with less favorable benefits.³⁹⁸ Other insurers may attempt to skim cream through selective advertising, providing poor service to high-risk individuals, sharing risk with contracting providers to give the providers

³⁹³ See Nichols, *supra* note 324, at 180-81.

³⁹⁴ See *supra* text accompanying notes 175-76 (Chile), 244-45 (Australia), 296 (United States), 304, (same), 344 (France).

³⁹⁵ Van de Ven et al., *supra* note 246, at 331.

³⁹⁶ Alexander K. Feldvebel & David Sky, *A Regulator's Perspective on Other States' Experiences*, 25 *J. Health Pol. Pol'y & L.* 197, 202 (2000) (describing how benefit design achieves resegregation). Professor Hall refers to these practices as "gerrymandered benefit packages." Hall, *Competitive Impact*, *supra* note 306, at 694.

³⁹⁷ Mark A. Hall, *The Role of Independent Agents in the Success of Health Insurance Market Reforms*, 78 *Milbank Q.* 23, 35-43 (2000) (concluding that while field underwriting is widespread, no evidence exists that it is undermining core reform laws); see also Kirk, *supra* note 324, at 170 (noting that risk segmentation is "something akin to a physical law in insurance," as reformed markets resegment if permitted).

³⁹⁸ Deborah J. Chollett, *Consumers, Insurers, and Market Behavior*, 25 *J. Health Pol. Pol'y & L.* 27, 38 (2000).

an incentive to cream skim, or simply bribing high-risk insureds to leave the plan.³⁹⁹ In the United States, one widely used strategy for avoiding individual and small group reforms is to establish “association plans” which purport to be group plans, free from the constraints of individual market reforms, but which can be used to cream skim from the regulated individual market.⁴⁰⁰

Insurers may not need even to take actions aimed at excluding particular individuals: Simply limiting choice of provider may be sufficient to exclude individuals who are currently high users of medical care because they may be reluctant to sever current ties with particular providers.⁴⁰¹ One industry source quoted by Mark Hall candidly stated that regulators “can’t hold a candle” to the abilities of insurers to promote risk selection.⁴⁰² Resources committed to cream skimming, however, result in a welfare loss for society, as cream skimming simply shifts risk to other parties, often to those least able to bear it, rather than providing a benefit to society.⁴⁰³

Regulators may address the problem of subtle forms of cream skimming by attempting to alter the incentives faced by insurers. One approach is for regulators to use reinsurance or high-risk pool schemes to make higher-risk insureds more attractive to insurers and, conversely, to make cream skimming less attractive.⁴⁰⁴ Reinsurance or high-risk pool schemes indeed may be necessary to keep insurers with too many high-risk insureds from leaving the market alto-

³⁹⁹ Hall, *Competitive Impact*, supra note 306, at 694; van de Ven et al., supra note 246, at 321.

⁴⁰⁰ See Berry & White, supra note 23, at 209 (noting adverse selection results where there is regulated individual coverage and unregulated association coverage); Hall, supra note 41, at 181 (finding that associations “offer an attractive, cheaper option for younger, healthier small groups”); Kirk, supra note 324, at 154 (finding “considerable potential for adverse selection against the community-rated portion of the market”).

⁴⁰¹ See Fred J. Hellinger, *Selection Bias in HMOs and PPOs: A Review of the Evidence*, 32 *Inquiry* 135, 141 (1995).

⁴⁰² Hall, *Competitive Impact*, supra note 306, at 722 (describing impact of small group health insurance market reforms in 1990s on market competition).

⁴⁰³ See van de Ven et al., supra note 246, at 320 (demonstrating impact of cream skimming by inefficient insurers). It is always possible, however, that insurers will react to underwriting limitations by trying to manage costs rather than risk. A reasonably vigorous market for individual health insurance continued to exist in New York after the imposition of very restrictive underwriting reforms because insurers switched to managed care plans, reducing the costs of their products. See Chollet, supra note 398, at 42; Hall, *Competitive Impact*, supra note 306, at 707-09.

⁴⁰⁴ See van de Ven et al., supra note 246, at 326-28 (evaluating various means of preventing cream skimming). For descriptions of the operation of reinsurance in the American context, see Hall, *Rating Reforms*, supra note 306 (manuscript at 44-47). Some advocates of tax credit or voucher proposals for subsidizing private insurance would adjust the amount of the voucher or credit for risk to make it of value to high-risk individuals. See Hoff, supra note 19, at 102-07.

gether.⁴⁰⁵ The Australian and the Dutch WZT reallocation pools are good examples of this. Alternatively, premiums paid to insurers can be risk adjusted through some kind of prepayment pooling mechanisms.⁴⁰⁶ Risk pooling in various forms is used in public and private insurance systems in Colombia, Ireland, Germany, Switzerland, the Czech Republic, Israel, the Netherlands, in the United States Medicare+Choice program, and in a number of states of the United States.⁴⁰⁷ Operation of these pools, however, requires extensive and intrusive government involvement in private health insurance markets.⁴⁰⁸ There is also always the possibility that insurers may be able to predict risk better than the risk adjustment mechanism and use this information to cream skim low-risk patients or to dump high-risk patients.⁴⁰⁹

Finally, as community rating and risk adjustment make the purchase of insurance less and less attractive to the young and healthy, a number of nations have chosen to subsidize the purchase of private insurance to make it more affordable to those who otherwise might not purchase it. Absent sizable subsidies, individual insurance

⁴⁰⁵ The individual health insurance market in the United States is characterized by a large number of small-volume insurers whose existence is very tenuous if they are compelled to take on high-risk insureds. See Chollet, *supra* note 398, at 40 (highlighting differences between individual and group markets).

⁴⁰⁶ See Jacobi, *supra* note 26, at 393-400 (summarizing concept of risk adjustment); Joseph P. Newhouse, *Risk Adjustment: Where Are We Now?*, 35 *Inquiry* 122, 123 (1998) (discussing arguments for risk-adjustment and current state of risk-adjustment technology). Some advocates of tax credits propose risk adjusting tax credits to obviate the need for rating restrictions. See Mark Pauly, *Extending Health Insurance Through Insurance Credits, in Options for Expanding Health Insurance Coverage*, *supra* note 24, at 32, 33 (describing credits as nonintrusive means of reducing uninsured population). Another approach simply would be to tie the amount of tax credits to the premium actually paid, though this approach would pose obvious cost control problems. See Meyer et al., *supra* note 31, at 30-31 (analyzing administrative burdens presented by common proposals for tax reform).

⁴⁰⁷ See Ashley Files & Margaret Murray, *German Risk Structure Compensation*, 32 *Inquiry* 300, 304 (1995) (discussing German risk-sharing requirements); van de Ven et al., *supra* note 246, at 328 (discussing use of various subsidy-premium schemes). See generally Daniel L. Dunn, *Applications of Health Risk Adjustment: What Can Be Learned from Experience to Date?*, 35 *Inquiry* 132 (1998) (describing current applications of risk adjustment in United States); Katherine Swartz & Deborah W. Garnick, *Lessons from New Jersey*, 25 *J. Health Pol. Pol'y & L.* 45 (2000) (describing operation of one relatively successful effort at establishing risk sharing program as part of individual market reforms).

⁴⁰⁸ Risk adjustment schemes also are applied in public programs that contract with managed care organizations in the United States (such as the Medicare+Choice program) and are also necessary to avoid risk selection where large employer group plans or purchasing cooperatives offer individual enrollees a choice of plans to avoid cherry picking. See Gauthier et al., *supra* note 69, at 17 (summarizing problem of risk selection and discussing potential consequences on certain populations and viability of health plans).

⁴⁰⁹ Newhouse, *supra* note 406, at 125.

remains unaffordable to many.⁴¹⁰ As noted above, Australia recently adopted a policy of reimbursing privately insured individuals thirty percent of their health insurance premiums.⁴¹¹ Chileans may take the seven percent payroll tax that otherwise would go into the social insurance program to purchase private health insurance.⁴¹² In the United States, current tax subsidies for employment-related insurance cost nearly \$125 billion in 1998,⁴¹³ over half the amount spent on the Medicare or Medicaid programs. The current tax credit and voucher proposals in the United States would serve the same end, though without supplemental regulation to improve access, they probably would do so poorly.⁴¹⁴

IV THE COMPARATIVE CHOICE

Throughout the developed world we see that where private insurance is relied upon as a primary means of health insurance coverage, and also where it is predominantly sold on an individual rather than group basis, it invariably is regulated to overcome the barriers to access that occur naturally in insurance markets where adverse selection and cream skinning are permitted to exist. This regulation seems to follow a fairly natural progression, beginning perhaps with limitations on preexisting conditions exclusion clauses or minimal coverage mandates, progressing through community rating requirements or other bans on risk underwriting, and ending up with publicly sponsored risk

⁴¹⁰ See Swartz & Garnick, *supra* note 407, at 68 (discussing issues raised by Individual Health Coverage Program in New Jersey). As noted above, individual insurance currently covers only about twenty percent of those not otherwise insured in the United States. Pauly & Percy, *supra* note 41, at 13-14.

⁴¹¹ See *supra* text accompanying note 253.

⁴¹² Of course, in countries like Australia and Chile, which have parallel public and private systems, the redirection of tax revenue to pay for private insurance, in part, is in recognition of the fact that privately insured persons relieve the burden of the public, tax-financed system.

⁴¹³ Sheils & Hogan, *supra* note 62, at 178 (critiquing distribution of federal health benefits tax expenditures to population with highest incomes).

⁴¹⁴ See generally Gruber & Levitt, *supra* note 31. Among the many problems posed by tax credit proposals is the fact that tax credits at the level being mooted simply will not purchase much insurance, even for the healthy. One analysis notes that, in the individual market, a \$500 children's policy would either buy a policy with a \$10,000 deductible or a policy with first-dollar coverage and a \$1600 benefit maximum. A \$500 credit for adults would buy a policy with a \$67,000 deductible or first-dollar coverage with an \$840 cap. Blumberg, *supra* note 24, at 34-35. Expansion of tax credits, on the other hand, would in all likelihood result in many employers dropping health insurance coverage, leading to an overall increase, rather than decrease, in the numbers of uninsured. See generally Large Health Insurance Tax Credits Seen Destroying Employer-Provided Coverage, *Health Care Daily Rep.* (BNA), June 9, 2000, WL 6/9/2000 HCD d12.

adjustment systems. Tax subsidies of private insurance are also ubiquitous. On the other hand, where private health insurance plays a purely supplemental role, and also where it is sold predominantly to large groups, it is regulated to a lesser extent, and private markets govern.⁴¹⁵

Without further study, one only can speculate what the political forces are that drive this tendency towards regulation and subsidization. All of the nations studied, however, are democracies. Although Chile was ruled by a military dictator at the time it established essentially unregulated private insurance markets, as it has returned to democracy it has regulated private insurance increasingly. Clearly democratic governments, whether or not they expressly embrace a solidarity principle, will not tolerate purely competitive markets for health insurance, because the resulting separation equilibria are too inequitable. Health insurance seems to be viewed not as an economic good, available to those who can afford it and choose to purchase it, but rather, at least in part, as a “merit good,” or perhaps not even as a good at all, but rather as something that should be available to all regardless of ability to pay.⁴¹⁶ Low-risk voters, indeed, may support health insurance market restrictions, realizing that, though the restrictions often disfavor them in the short run, the restrictions may ensure that if and when the low-risk individuals become high-risk individuals, insurance will be available.⁴¹⁷ Recent opinion polls find that even in the United States, ninety percent of those polled favor “making sure that all families and children have access to affordable health insurance,” and sixty-nine percent of Americans, including more than half of Republicans polled, are willing to pay higher taxes to ensure coverage for the uninsured.⁴¹⁸ Even nations that have social or tax-based

⁴¹⁵ One apparent exception to this observation is Medicare Supplement (Medigap) insurance in the United States, which supplements a public insurance program, but also is heavily regulated. See Furrow et al., *supra* note 117, § 9-8. Medicare cost-sharing obligations are so high, however, and Medicare’s gaps so broad (e.g., noncoverage of prescription drugs), that Medigap insurance, in fact, plays more than a mere supplemental role. Also, the elderly and disabled population that purchases Medigap insurance arguably needs special regulatory protection.

⁴¹⁶ See generally David S. Bloch & William Robert Nelson Jr., *Defining “Health”: Three Visions and Their Ramifications*, 1 *DePaul J. Health Care L.* 723 (1997) (discussing policy implications of viewing “health” as either nongood, merit good, or economic good).

⁴¹⁷ Nichols, *supra* note 324, at 186-87.

⁴¹⁸ Robert Wood Johnson Found., *supra* note 46. In the same poll, seventeen percent said that they or a family member had gone without insurance at some point during the previous three years, and an additional forty-three percent said that they personally knew someone who had been uninsured. Twenty-six percent said that either they or a family member had had to delay receiving medical treatment because of lack of insurance. *Id.*

insurance do not seem to be able to tolerate unregulated private insurance markets unless coverage is limited to nonessential health care.

On its face, moreover, this political drive would not seem to be led by narrow special interests. Insurers and health care providers undoubtedly favor liberal subsidies for private health insurance,⁴¹⁹ and also may favor some forms of regulation as a lesser evil than abolition of private insurance.⁴²⁰ On the whole, however, it would seem that political support for the forms of regulation we have seen is broad-based in most countries.⁴²¹ A number of the current tax credit proposals, for example, would maintain high levels of government regulation of private insurance, including requirements such as rating band limitations and creating state reinsurance risk pools.⁴²² Unless one values markets more than democracy (as did Pinochet), one must accept the fact that the populace does not want pure, unregulated markets for private health insurance.⁴²³

As this seemingly irresistible impulse towards equity drives government intervention in private health insurance markets to become increasingly intrusive, however, private insurance begins to resemble ever more closely a public program.⁴²⁴ Private insurers acting as pri-

⁴¹⁹ See, e.g., Kahn & Pollack, *supra* note 21.

⁴²⁰ The particular circumstances of some insurers may, in fact, make them vigorous advocates of reform. Blue Cross plans pushed for individual market reform in a number of U.S. states to maintain the viability of their position as insurers of last resort. In the United States, however, most insurers largely have opposed reforms, and political support for reforms often has proved fragile and transient. Robert B. Hackey, *The Politics of Reform*, 25 *J. Health Pol. Pol'y & L.* 211, 219-20 (2000).

⁴²¹ In the United States, insurance reforms also undoubtedly are driven by the fact that, given a lack of consensus for the provision of public insurance, cross-subsidization through market reforms is the best that advocates of universal coverage can hope for. See Nichols, *supra* note 324, at 182.

⁴²² See Nancy W. Dickey, *AMA Proposal for Expanding Coverage (2000)* (advocating for alternatives to employer-sponsored coverage subsidies), http://www.rwjf.org/rw_news_and_events/eventshc2000/ama1.htm. The U.S. Chamber of Commerce proposal would also establish risk pools. U.S. Chamber of Commerce, *Affordable Access to Quality Health Care, Health Coverage 2000* (focusing on enhancing employer-based coverage), http://www.rwjf.org/app/rw_news_and_events/eventshc2000/bak-new/uschamberfnl2.htm. The Heritage Foundation proposal for tax credits recognizes that regulatory responses may be necessary to deal with the adverse selection and cream-skimming problems that undermine private insurance markets, but does not endorse specific solutions. John Sheils et al., *Nat'l Coalition on Health Care, Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy (1999)* (comparing Heritage Foundation proposal to more equitable proposals for extending tax subsidies that do not address resulting increase in costs), http://www.nchc.org/releases/healthinstaxes_10_18_99.html.

⁴²³ For a more elegant exposition of this subject, see Mark A. Hall, *Public Choice and Private Insurance: The Case of Small Group Market Reforms*, 1998 *U. Ill. L. Rev.* 757, 760-61.

⁴²⁴ This point often is made by those who challenge regulation of private insurance. See, e.g., Arnett, *supra* note 14, at 6-7. Advocates of deregulation argue that regulation makes private insurance less accessible to the uninsured. While this very well may be true, the

mary insurers more and more become constrained in their ability to respond to the consumer preferences of their insureds as they are conscripted to serve the redistributive goals of government.⁴²⁵ The arguable benefits of private health care finance—its agility, flexibility, and capacity for innovation—are crippled as the government increasingly dictates the terms of the insurance relationship. A low-risk insurance applicant who wants to buy a policy with long preexisting condition exclusions (since she has no preexisting conditions), or with low rates reflecting her low risk, cannot find one for sale. The insurer who dreams up a new product to capture a niche market must face a daunting gauntlet of regulatory approvals and limitations. To their already considerable administrative expenses, all insurers now must add regulatory compliance costs.⁴²⁶

Further, subsidized private insurance is subject to one of the most important inefficiencies attending public insurance. Arguably one of the most significant advantages of private insurance over public is lower societal cost: Public insurance is paid for through taxes, and tax collection in itself imposes costs.⁴²⁷ The individual who purchases life, fire, or theft insurance in a competitive market chooses freely how much insurance he wants and how much money he is willing to pay for it.⁴²⁸ The price he chooses to pay is equivalent to the value of the policy to him. The utility derived from public health insurance by an individual probably bears no necessary relationship to the marginal tax rate of thirty to forty percent he pays in the United Kingdom for, among other things, a tax-based insurance program, or the payroll taxes of eleven to thirteen percent, on top of income taxes, that he pays in Germany for a social health insurance program.⁴²⁹

If, as often will be the case for a healthy, productive individual, the utility derived is far less than the cost, the individual may waste money pursuing tax loopholes, or even, at the margin, forego produc-

opposite is also true: Unregulated insurance markets also will exclude many of the uninsured.

⁴²⁵ As one prominent American health policy expert has noted, we could eliminate the problem of cherry picking and the need for risk adjustment mechanisms completely if we only had one private insurer, but then we must ask why this kind of arrangement would be more efficient than public provision. Katherine Swartz, *Reducing Risk Selection Requires More than Risk Adjustments*, 32 *Inquiry* 6, 7 (1995).

⁴²⁶ Hall, *supra* note 423, at 774.

⁴²⁷ See Danzon, *supra* note 33, at 36-37; Shieber & Maeda, *supra* note 39, at 18-19.

⁴²⁸ See Epstein, *supra* note 19, at 52.

⁴²⁹ Knox, *supra* note 86, at 63 (presenting average contribution rates in 1990 for various categories of German sickness funds as percentages of gross wages approximately under \$27,000); E-mail from Paul Fenn, Professor, University of Nottingham Business School, to Timothy Stoltzfus Jost, Professor of Law, Ohio State University (Mar. 15, 2000) (on file with the *New York University Law Review*).

tive activity altogether to avoid additional payroll taxes.⁴³⁰ The “excess burden” of taxation—the indirect economic losses from the disincentives taxation imposes—has been estimated to be as high as two dollars for every dollar raised.⁴³¹ This deadweight loss, to which also must be added the compliance costs of collecting taxes, supports a substantial argument against public provision.

When, however, private insurance is funded through fully refundable tax credits, as in American proposals, or direct public rebates, as in Australia, this deadweight loss attributable to public insurance also attends private insurance. Tax money now is simply paying for private rather than public insurance; it still needs to be collected. Even tax exclusions and deductions for private health insurance, as are common throughout the world, encourage inefficient behavior and impose deadweight losses, as the advocates of tax credits are fond of pointing out.⁴³²

As noted early on in this Article, one also must remember that private insurance is more expensive than public insurance from the outset because it must cover costs not experienced by public systems, such as marketing, increased risk, and underwriting (though, of course, underwriting costs are significantly decreased if underwriting is largely prohibited).⁴³³ Individual policies are also much more expensive than group policies with equivalent benefits. Finally, creating a bureaucracy to administer a tax credit program for the purchase of insurance also will impose additional administrative costs.⁴³⁴ One therefore must ask again, when publicly regulated and subsidized systems resemble public systems so closely, what justifies the added cost of private systems?⁴³⁵

⁴³⁰ Danzon, *supra* note 33, at 36-37.

⁴³¹ Jönsson & Musgrove, *supra* note 80, at 57 (citing Martin Feldstein, *Tax Avoidance and the Deadweight Loss of the Income Tax* 32 (Nat'l Bureau of Econ. Research, Working Paper No. 5055, 1995)).

⁴³² See Pauly, *supra* note 47, at 58 (arguing for replacement of tax exclusion with “better system”); Tanner, *supra* note 30, at 29-32 (explaining how third-party private insurance payment of health care bills increases health care costs).

⁴³³ See Blumberg, *supra* note 24, at 34, 35 (describing “risk pool problems” and “large administrative loads”); see also *supra* text accompanying notes 39-46.

⁴³⁴ See Sherry Glied, *An Assessment of Strategies for Expanding Insurance Coverage* 18 (1999).

⁴³⁵ Clark Havighurst, one of the most articulate spokespersons for private markets in health care, has raised the same challenge, noting:

Although a single-payer system might be only a second-best solution to our cost problems, a strong argument can be made for preferring it over the current regime of private intermediaries that lack—and do not appear even to want—the tools that are needed to tackle the cost problem at its root.

Clark C. Havighurst, *Why Preserve Private Health Care Financing?*, in *American Health Policy: Critical Issues for Reform* 87, 88 (Robert B. Helms ed., 1993). Professor

Arguably, these additional costs may be offset by the additional value that private insurers may offer their customers, for example by devising innovative approaches to managing health care costs or assuring quality.⁴³⁶ Private health care insurers in the United States have been able to thrive during the past decade, even in states in which they have been regulated heavily, when they have taken innovative approaches to manage costs provided through managed care rather than simply trying to manage risk, as they traditionally have done.⁴³⁷ In most of the countries examined above, however, private insurers have been unwilling to engage in aggressive bargaining with providers, and in some countries they are barred legally from doing so.⁴³⁸ In most countries private insurers are price takers, and often pay higher prices than do public programs for practitioner services because their primary selling point is that they offer a better class of services than does the public system.⁴³⁹

Managed care innovations, moreover, have occurred at the interface between health plans and providers, not between health plans and their insureds. There is no inherent reason, moreover, why public as well as private insurers could not negotiate better deals with profes-

Havighurst blames insurers, as well as the law, for the absence of innovative, contract-based solutions to the problem of health care costs. See *id.* at 96-98.

⁴³⁶ See, e.g., Danzon, *supra* note 33, at 26 (describing methods used by private insurers, including "structured copayments, utilization review, case management, [and] selective contracting with preferred providers"). In fact, American health economists seem more concerned about the problem of health care costs, and particularly with the ramifications of the problem of moral hazard for these costs, than with the issue of access. See generally Evan M. Melhado, *Economists, Public Provision, and the Market: Changing Values in Policy Debate*, 23 *J. Health Pol. Pol'y & L.* 215 (1998) (tracing history of this trend).

⁴³⁷ See Hall, *Competitive Impact*, *supra* note 306, at 725-26 ("The movement toward managed care represents a profound shift in the nature of competition . . . and methods of competing based on risk selection are now greatly reduced in some states.").

⁴³⁸ In Australia, where recently adopted laws encourage insurers to negotiate payments with doctors, the Australian Medical Association has vigorously resisted such negotiations. See Nathan, *supra* note 230, at 12 (describing "vocal campaign" Australian Medical Association has waged against contracts between private health care funds, hospitals, and doctors). Similarly, in Chile, private insurers are moving very slowly towards managed care, in part because of expected resistance from organized medicine. See Jost, *supra* note 121, at 876-77. In Germany, private insurers pay doctors on the basis of a fee schedule, which is established by law. Wicks, *supra* note 195, at 31-32.

⁴³⁹ In Australia, for example, privately insured patients often have to pay an extra amount above their insurance cover for physician services in hospital, even though physician services in hospital are covered fully for public patients. See Hall, *supra* note 227, at 100-01 ("[T]wo patients can be given exactly the same treatment for which the private patient receives a large bill not reimbursed by insurance, while the uninsured [public] patient never sees a bill."). In the Netherlands, fees paid by private insurers to specialist doctors are nearly twice those paid by the sickness funds. Frederik T. Schut, *Health Care Reform in the Netherlands: Balancing Corporatism, Etatism, and Market Mechanisms*, 20 *J. Health Pol. Pol'y & L.* 615, 621 (1995).

sionals or providers.⁴⁴⁰ There seems to be, in fact, a worldwide trend in the recent past towards combining a universal mandatory public health insurance program with competition among providers for public contracts.⁴⁴¹ A number of nations, including the United Kingdom, Chile, and the Netherlands, have been experimenting with innovative approaches to health care purchasing.⁴⁴² By contrast, other nations, such as Germany, have precluded both private and public payers from negotiating with individuals or small groups of professionals.⁴⁴³

Public insurance systems, moreover, have their own intrinsic advantages. In the end, despite the adoption of extensive and intrusive market reforms, private markets cannot insure entire populations. To quote one observer, "The principal shortcoming of individual insurance market reforms in addressing the plight of the uninsured . . . is that all markets discriminate against those who cannot pay."⁴⁴⁴ Public insurance systems, by contrast, are in principle more equitable in that they cover entire populations, and in fact treat different population groups more equitably as well.⁴⁴⁵ They usually do a better job of controlling costs, in part because they can impose fixed budgets on at least some providers.⁴⁴⁶ They are more accountable to the priorities

⁴⁴⁰ In the Netherlands, for example, social insurance funds pay general practitioners on a capitated basis, whereas private insurers pay fee-for-service. AIM, *supra* note 261, at 142.

⁴⁴¹ See generally Richard B. Saltman & Casten von Otter, *Planned Markets and Public Competition: Strategic Reform in Northern European Health Systems* 123-54 (1992) (exploring objectives, benefits, and administrative framework required to sustain public competition); Wynand P.M.M. van de Ven, *Market-Oriented Health Care Reforms: Trends and Future Options*, 43 Soc. Sci. & Med. 655 (1996) (indicating such trends).

⁴⁴² Though these experiments resemble in some respects their American counterparts, they also reflect the values and politics of their national context. See generally Lawrence D. Brown, *Exceptionalism as the Rule? U.S. Health Policy Innovation and Cross-National Learning*, 23 J. Health Pol. Pol'y & L. 35 (1998) (arguing that other countries adapt, rather than adopt wholesale, U.S. health care innovations pursuant to their own politico-cultural milieu); Alan Jacobs, *Seeing Difference: Market Health Reform in Europe*, 23 J. Health Pol. Pol'y & L. 1 (1998) (comparing health care market reform in United Kingdom, Netherlands, and Sweden).

⁴⁴³ Timothy Jost, *German Health Care Reform: The Next Steps*, 23 J. Health Pol. Pol'y & L. 697, 706-07 (1998) (explaining that Germany's physician principles of free choice of unified physician self-governance, as well as structural impediments, stand in way of contracting between doctors and either private or public parties).

⁴⁴⁴ Hackey, *supra* note 420, at 215.

⁴⁴⁵ See, e.g., Adam Wagstaff et al., *Equity in Finance of Health Care: Some Further International Comparisons*, 18 J. Health Econ. 263, 288-89 (1999) (arguing that health care is financed most equitably in nations with national health insurance systems, followed by social insurance systems, and then private insurance systems).

⁴⁴⁶ See Wynand P.M.M. van de Ven, *Regulation, Competition and Equity: With or Without a Fixed Budget?*, in *Fixing Health Budgets: Experience from Europe and North America* 63, 64 (Friedrich Wilhelm Schwartz et al. eds., 1996) (proposing that "fixed budgets seem to be successful as cost containment strategy"). Fixed budgets also create problems of access and efficiency. See *id.* at 63-65.

of the community.⁴⁴⁷ They are striving to do a better job of providing public health and preventive health services to communities.⁴⁴⁸

Any definitive judgment between public and private financing of health care must await another day, and perhaps never will be possible.⁴⁴⁹ As has already been noted, public programs are far from perfect. The British NHS increasingly seems to suffer from underfunding, which is arguably a risk of any tax-supported program. It would, however, be interesting to see how the American health care system would function at NHS funding levels.⁴⁵⁰ The German system seems to be stuck in a political gridlock in which the demands of providers and of insureds seem ever the more in sharp conflict.⁴⁵¹ Throughout the world, those waiting in queues in public systems seem increasingly fidgety.

Moreover, even if we conclude that public systems are preferable to private systems for funding basic health care services, there is still a role for private health insurance. Private insurance could continue to play an important role, as in the United Kingdom, Canada, and France, in supplementing basic public insurance, covering either nonessential services or perhaps permitting basic care to be obtained with greater accommodation for patient convenience or choice than is possible in a public system.⁴⁵² As long as basic services are covered in a public program, a supplementary system arguably could be maintained to respond to consumer demands for additional luxury services, with minimal government regulation.⁴⁵³ In particular, those whose

⁴⁴⁷ See Robert G. Evans, *Going for the Gold: The Redistributive Agenda Behind Market-Based Health Care Reform*, 22 *J. Health Pol. Pol'y & L.* 427 (1997) (describing process by which narrow interest groups seek advantage through privatization of health care system).

⁴⁴⁸ See Albert F. Wessen, *Structural Differences and Health Care Reform*, in *Health Care Systems in Transition: An International Perspective* 369, 385-86 (Francis D. Powell & Albert F. Wessen eds., 1999) (describing efforts of examined countries to improve monitoring on part of providers and public health officials, as well as efforts to shift focus from curative to preventive medicine).

⁴⁴⁹ As one commentator has noted, "[t]he insurance market always operates in the world of the second best." Wortham, *supra* note 40, at 882.

⁴⁵⁰ See Lyall, *supra* note 29, at A20 (alluding to NHS funding problems).

⁴⁵¹ See Jost, *supra* note 443, at 701-04 (delineating events surrounding "political paralysis" with which Germany must grapple in order to realize health care reform).

⁴⁵² See generally Alessandro Petretto, *Optimal Social Health Insurance with Supplementary Private Insurance*, 18 *J. Health Econ.* 727 (1999) (presenting theoretical justification for such model). The more perceptive proponents of tax credit subsidies for private insurance share a similar recognition that all persons should receive basic coverage, regardless of ability to pay, with supplemental coverage provided through market transactions. They argue, however, that basic insurance should be provided through tax-subsidized private insurance plans. See Pauly, *supra* note 47, at 59-66.

⁴⁵³ This precise argument is made by those who focus more on the virtues of private arrangements, though we might draw a different line as to what services are essential. See

time is worth a great deal could buy access to care with a shorter wait or at more convenient times through supplemental insurance. Rates can be set to accord with risks, and if insurance is unaffordable to some, their basic health care needs still are covered. Permitting private insurance to supplement public systems in poorer countries also could channel extra money into the health care system, supplementing the income of health care professionals, financing new health care resources, and taking the pressure off strapped public budgets.

It should be noted, however, that the role of even supplemental private insurance that duplicates public coverage is hotly debated. A Canadian court recently upheld Quebec's total ban on private insurance for publicly covered medical costs, recognizing the threat that private insurance poses to a public insurance system.⁴⁵⁴ If the wealthy are permitted to opt out of the public system, they may withdraw their political and financial support from the public system as well, causing it to wither.⁴⁵⁵ Allowing a parallel private system leads almost inevitably to increased costs, as funds flow from private as well as public sources.⁴⁵⁶ The existence of a parallel private insurance system also can encourage providers to create artificial shortages and waiting lists in the public sector to encourage patients to move to the more lucrative private sector.⁴⁵⁷ Even where private insurance merely supplements public coverage, there is the danger that "essential" health care may be defined even more narrowly as a way of shifting costs from public to private programs, but leaving those who cannot afford private insurance increasingly at risk.⁴⁵⁸

It is not necessary, however, to resolve this debate here. Whether private insurance as a supplement to public insurance is advisable or not, private insurance as an alternative means of insuring populations remains highly problematic.

CONCLUSION

Whether we would be better off with a private or public system of health care finance is a debate that in the end is of little relevance to the real-world politics of the United States. The considerable inertia

Hall, *supra* note 40, at 29 ("Concerns about equity should address how high to set the social minimum or whether we should have a private system at all.").

⁴⁵⁴ *Chaoulli v. Quebec*, No. 500-05-035610-979 (Que. Super. Ct. Feb. 25, 2000).

⁴⁵⁵ Expert Witness Report of Theodore R. Marmor at 7-9, *Chaoulli* (No. 500-05-035610-979); McAuley, *supra* note 257, at 14.

⁴⁵⁶ Expert Witness Report of Theodore R. Marmor at 9-11, *Chaoulli* (No. 500-05-035610-979).

⁴⁵⁷ *Id.* at 11-13.

⁴⁵⁸ See Gilmour, *supra* note 331.

of the American political system, the generous campaign contributions available from health insurers,⁴⁵⁹ and the antigovernment ideological bent of the American people and their elected politicians present a phalanx too powerful to be overcome by mere empirical evidence and reason. The international comparative evidence, however, tends to show that (1) private insurance markets are in fact very common, but tend to be highly regulated, and often government subsidized, (2) unregulated competitive individual-purchaser-based markets for private health insurance are inherently not viable for covering populations, and exist largely in the nirvanas of libertarian economists and their think tanks, except where insurance covers supplemental services, and (3) group insurance markets are more equitable, and thus less likely to be regulated, than are individual markets.

Given this evidence, we have every reason to proceed cautiously in embracing policies that would throw more tax money at an inefficient private insurance system, especially those based on individual insurance policies. Perhaps if we cannot limit private insurance to the margins, we might at least consider the creation of marginal public systems (expanded public hospitals and clinics, for example) that meet the needs of the uninsured without posing too great a threat to the private insurance establishment, rather than further expanding public support for private insurance.⁴⁶⁰ Development of this theme, however, will have to await another article.

⁴⁵⁹ See, e.g., Health Insurance Industry Campaign Gifts May Break Record, GOP Gets Biggest Share, *Health Care Daily Rep. (BNA)*, May 19, 1998, WL 5/19/1998 HCD d3.

⁴⁶⁰ A number of published analyses also suggest that, in a number of respects, direct public financing or provision programs are superior to tax credit proposals, though the comparative advantages of various programs depend heavily on the details of the particular proposal. One analysis, for example, found that fixed-dollar tax credits (set at \$500 per child) would expand coverage among uninsured children to about the same extent as might expansion of the CHIP program, but that it would be far less effective at expanding coverage of poor children, would have a much greater "crowd out" effect (in that ninety-five percent of children covered would be previously insured), and would cost several times as much in public funds. Judith Feder et al., *The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance* 11-16 (1999).