

HEALTH CARE REFORM FOR THE TWENTY-FIRST CENTURY: THE NEED FOR A FEDERAL AND STATE PARTNERSHIP

INTRODUCTION

Since the death of President Clinton's Health Security Act in September of 1994, the United States' health care delivery system has been in critical condition. The primary symptoms of the United States' failing health care system—lack of access¹ and increasing cost²—are readily apparent and the prognosis remains doubtful. Despite their having gathered the country's finest public policy doctors, neither the executive nor legislative branch of the federal government has found a cure. Furthermore, the President and Congress fundamentally disagree over the most effective way to treat the symptoms of the United States' diseased health care system.³ While the "policy doctors" bicker about a prospective treatment, their patient lies dying on the operating table.

At its core, the debate over national health care reform has devolved into a battle between President Clinton's philosophy of "universal" access and capitalist notions of a free market delivery system.⁴ Implementation of Clinton's Health Security Act (hereinafter the "HSA" or the

¹ See Angelo A. Stio III, *State Government: The Laboratory for National Health Care Reform*, 19 SETON HALL LEGIS. J. 322, 326 (1994). As of 1994, the United States was one of only two industrialized nations (along with South Africa) that failed to provide its citizens with some form of universal health care. See *id.*; see also George D. Lundberg, M.D., *The Failure of Organized Health System Reform—Now What?: Caveat Aeger—Let the Patient Beware*, 273 JAMA 1539 (1995). Forty-one million people in the U.S. are living without insurance. See Stio, *supra*, at 298. Fifty-six million citizens did not have adequate coverage in 1994 to cover their health care costs. See *id.*

² Jolee Ann Hancock, Comment, *Diseased Federalism: State Health Care Laws Fall Prey to ERISA Preemption*, 25 CUMB. L. REV. 383 (1995).

³ President Clinton believes that health care is a right of all citizens, while the Republican-dominated Congress is of the opinion that health care is a privilege. See H.R. REP. NO. 103-601, pt. 2 at 2 (1994).

⁴ Clinton's goal of universal access presupposes the recognition of a fundamental liberty interest in health care. Notwithstanding the Republican Party's unwillingness to recognize such a liberty interest, it is unclear whether health care premised on the substantive Due Process Clause of the Fourteenth Amendment could survive judicial scrutiny.

The lengthy (1,342 pages) and complicated Health Security Act of 1993, proposed by Clinton, would have been the first step toward the recognition of a fundamental right to health care. See The Health Security Act, H.R. 3600, 103rd Cong. (1993). Its failure in Congress suggests that the plan was "too radical, too complex, too intrusive, and too expensive" to be enacted. See Ann Reilly Dowd, *Fixing Clinton's Health Care Plan: The Key is a Go-Slow, Market Based Approach that Ensures Access to Medical Care—But Dumps the President's Reliance on Heavy-Handed Regulation*, TIME, Apr. 4, 1994, at 83.

“Plan”) called for extensive regulation and employer-mandates.⁵ Subsequent to the rejection of the Clinton Plan, less ambitious proposals came to the forefront of Congressional debate. Such plans, although potentially effective as stop-gap measures, do not present a long term solution to the problems of limited access and rising costs nor are they free of bureaucratic red tape.⁶

But while federal policymakers have failed to find a panacea for the United States’ ailing health care delivery system, local politicians have undertaken consideration of a variety of individual state cures. At the state level, where constitutional stumbling blocks do not impede the goal of universal coverage,⁷ legislatures have been able to refocus their attention on providing care and not on justifying universal access.⁸ Currently, states are contending with the question of “how to pay for health care.”⁹

This note examines the failure of national health care reform in recent years and the subsequent creation of effective state models for funding health care. Part I discusses the benefits of state solutions to the national health care problem. Part II explores the history of federal obstacles to such health care reform, concluding that the U.S. government should allow greater flexibility for state action. In Part III, the legislative reforms enacted in Hawaii, Florida, Oregon, and Tennessee—illustrative of four distinct approaches to increasing access and controlling costs associated with health care—are outlined and discussed. Finally, Part IV proposes a novel health care system that considers the lessons learned from the failures of the federal government and capitalizes on the qualified successes of the states.

I. THE BENEFITS OF INDIVIDUAL STATE SOLUTIONS TO THE NATIONAL HEALTH CARE DILEMMA

A. ADDRESSING THE PROBLEM: STRUCTURAL PROBLEMS WITH THE EXISTING UNITED STATES’ HEALTH CARE DELIVERY SYSTEM

In 1994, during a debate over the Mitchell Reform Plan, then Senate Majority Leader Robert Dole claimed “America has the best health care

⁵ Employer-mandates provide one alternative to funding health care; however, the involuntary nature of such a plan makes it unpopular. This sort of funding has generally met opposition from Republicans who favor a free market approach to health care, and specifically from large employers, who would prefer to self-insure, and small employers who currently are not compelled to provide health insurance to their employees. See *infra* note 38, at 547; see also Dowd, *supra* note 4, at 83.

⁶ The Health Insurance Portability and Accountability Act of 1996 [hereinafter HIPAA] is one of these measures. For further explanation of the goals HIPAA is designed to do, see T. David Cowart, *A New Twist on Portability*, SB51 ALI-ABA 805 (Feb. 13, 1997).

⁷ See *infra* Part IV.

⁸ See Dowd, *supra* note 4.

⁹ Thomas Bodenheimer, M.D., M.P.H. & Kevin Grumbach, M.D., *Paying for Health Care*, 272 JAMA 634, 635 (1994).

delivery system in the world.”¹⁰ Based on this lofty status, it should come as no surprise that the American health system is the most costly in the developed world.¹¹ But what is surprising is the rate at which the United States continues to pour money into health care.¹² In 1993, the U.S. health care budget had ballooned to \$900 billion (14.3 percent of gross domestic product) and prior to that, in the 1980s, it was growing at a rate of approximately 10.4 percent, more than twice the rate of inflation for other goods and services.¹³ Even more alarming is the fact that notwithstanding the increase in spending, the number of uninsured rose to almost forty billion Americans.¹⁴ Thus, taken together these figures challenge the validity of Senator Dole’s remarks.

Such disquieting trends are the direct result of market failures that arise out of the unique characteristics of the health care industry. Two types of market failures account for escalating health care costs. First, health insurance creates the problem of moral hazard. In this context, moral hazard denotes the concept that a person with health insurance is less likely to take measures to prevent illness and will instead incur more health care costs when she becomes sick.¹⁵ In an attempt to minimize this effect, insurance companies generally require insureds to share the cost of medical treatment through a co-payment.¹⁶ However, co-payments, premiums and deductibles have been only marginally effective in curbing health care spending by third party insurers. As a result, insurers are forced to restrict coverage to low-risk individuals in order to cover their reimbursement costs.¹⁷ These restrictions ultimately lead to an in-

¹⁰ S. 103-231, § 1321 (1994). The Mitchell Reform Plan embraces managed competition as the method for increasing access to health care at the lowest possible costs. In this way it is similar to the Health Security Act. The primary difference is that the Mitchell plan is voluntary and for all employers, and it entitles larger employers, with five hundred employees, the opportunity to join alliances distinct from those organized for smaller employees. See Karen A. Jordan, *Managed Competition and Limited Choice of Providers: Countering Negative Perceptions Through A Responsibility to Select Quality Network Physicians*, 27 ARIZ. ST. L.J. 875, 881 (1995); cf. Florida Health Care and Insurance Reform Act of 1993, *infra* Part III.B.2.

¹¹ See Note, *Universal Access to Health Care*, 108 HARV. L. REV. 1323, 1325 (1995). “The United States spends twice as much per capita on health care as developed European nations and nearly forty percent more than Canada, which has the world’s second highest spending on health care.” *Id.*

¹² *Id.*

¹³ See *id.* at 1324.

¹⁴ See *id.* This amounted to 14.3 percent of the population. See *id.*

¹⁵ See *id.* at 1326.

¹⁶ *Id.* (citing JOSEPH P. NEWHOUSE, INSURANCE EXPERIMENT GROUP, FREE FOR ALL?: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 98 (1993)). Cost-sharing will reduce the frequency of outpatient services, but will not have a great effect on in-patient services (because of the emergent nature of such care). Furthermore, cost-sharing is a “blunt instrument” that reduces appropriate, as well as inappropriate, uses of services. NEWHOUSE, *supra*, at 172-73.

¹⁷ See Note, *supra* note 11, at 1327.

crease in the number of uninsured citizens.¹⁸ This, in turn, exacerbates the second type of market failure—the problem of free riders. One desirable effect of living in a humane society is that safety nets are created to protect the less fortunate.¹⁹ However, there are consequences to this societal benevolence—a greater financial strain on providers and a greater need to shift the cost burden onto insured beneficiaries. A “vicious cycle” ensues in which the cost of services increases, forcing insurance companies to restrict coverage, resulting in a greater number of uninsured, which requires providers to further shift costs, forcing insurance companies to restrict coverage ad infinitum.²⁰

Accepting moral hazard and free-riding as the foundation of the health care dilemma suggests that the dual goals of providing universal access and lowering overall delivery costs may be coterminous.²¹ In an early attempt to stamp out the effects of moral hazard and free-riding, the federal government created the Medicare²² and Medicaid²³ systems to compensate providers that treated uninsured patients.²⁴

These programs, which cover citizens on the basis of age, income and disability, and generally serve the poor, elderly and disabled, have not cured the problem of limited access. Instead, they have shifted the financial burden and the accessibility of health care coverage onto a dif-

¹⁸ *Id.*

¹⁹ Note, *The Impact of Medicaid Managed Care on the Uninsured*, 110 HARV. L. REV. 751, 752 (1997) (arguing that Medicaid managed care undermines “urban public health ‘safety nets’”). The safety net is “the network of public hospitals and community health clinics that is the provider of last resort for both uninsured and the most disadvantaged members of society.” *Id.* (footnote deleted).

²⁰ See Note, *supra* note 11, at 1327.

²¹ Where access is limited, costs are often inflated because of the moral obligation of caregivers to treat sick patients. In other words, physicians, in an attempt to subsidize the treatment of the uninsured, raise costs for the insured, thus creating the “vicious cycle” noted earlier. See *id.* at 1327 and accompanying text. It is hypothesized here that increasing coverage to the uninsured and uninsurable will broaden the base of payers to the health care pool, drive down premiums, and create a healthier society.

²² Medicare is the common name for “Health Insurance for the Aged,” a federal insurance program for United States citizens over the age of sixty-five. See 42 U.S.C. §§ 1395-1396(d) (1988 & Supp. III 1991). Medicare consists of two parts: Part A - Hospital Insurance Benefits for the Aged and Disabled, and Part B - Supplementing Medical Insurance Benefits for the Aged and Disabled. The entire program is administered by the federal government. See *id.*

²³ Medicaid is the common name for “Grants to States for Medical Assistance Program,” and provides medical assistance to the poor, disabled, aged, and minor dependent children and their parents. See 42 U.S.C. §§ 1396-1396(u) (1988 & Supp. III 1991). Medicaid is funded in part by both the federal and state governments, and is administered by the state, in accordance with federal regulations. See James E. Holloway, *ERISA, Preemption and Comprehensive Federal Health Care: A Call for “Cooperative Federalism” to Preserve the States’ Role in Formulating Health Care Policy*, 16 CAMPBELL L. REV. 405, 414 (1995).

²⁴ See Hancock, *supra* note 2, at 402.

ferent group—the working poor.²⁵ The simultaneous rise in both the number of uninsured Americans and health care costs, forced the federal government to recognize that these plans alone were insufficient to create universal coverage. Consequently, politicians turned their attentions to health care reform at both the state and federal levels.

B. NATIONAL SOLUTIONS ARE INEFFECTIVE

1. *The Failure of President Clinton's Health Security Act*

The United States is one of only two industrialized nations in the world that does not provide universal access to health care.²⁶ This alone suggests that there are factors that make the delivery of health care in the U.S. too complex to administer on a national scale. A foray into recent attempts to devise a national health care policy to achieve universal access and cost containment, without sacrificing quality of care, will demonstrate the difficulties inherent in creating such a national plan.

At the federal level, the spectrum of health care policies that might be promulgated to achieve the aforementioned goals range from implementation of a single payer system²⁷ to complete deregulation of the existing health care market. At each extreme, however, the prospects for successful implementation seem bleak.²⁸ Consequently, most of the federal reform that has been proposed has occupied a compromise position between the two extremes. Congress rejected Clinton's HSA, a comprehensive bill to reform the nation's health care delivery system, and commentators have since suggested numerous reasons for its failure, positing both substantive and procedural criticisms.²⁹

²⁵ When Medicare and Medicaid were implemented, the reduced reimbursement rates funded by the federal government caused providers to shift costs to other payers. The result of this cost-shifting placed the burden of paying their medical costs on the rest of society. This increase in insurance premiums raised the marginal cost of health insurance, forcing low-income (above the federal poverty level) working families to forego their insurance.

One study of 1500 individuals demonstrated that low-income patients fared better under a fee-for-service model of health care, while individuals in the top forty percent of the income distribution fared better under MCO care. See generally Elizabeth M. Sloss et al., *Effects of a Health Maintenance Organization Physiological Health: Results from a Randomized Trial*, 106 ANNALS INTERNAL MED. 130 (1987); see also DAVID HIMMELSTEIN & STEFFE WOOLHANDLER, THE NATIONAL HEALTH PROGRAM BOOK 2330 (1994) (claiming that managed care works worst for those who are poor and ill).

²⁶ See Stio, *supra* note 1, at 324-26.

²⁷ See Jason B. Saunders, *International Health Care: Will the United States Ever Adopt Health Care for All? A Comparison Between Proposed United States Approaches to Health Care and the Single Source Financing Systems of Denmark and the Netherlands*, 18 SUFFOLK TRANSNAT'L L. REV. 711 (1995) (advocating that the United States should adopt a single payer system).

²⁸ See H. Richard Beresford, *The Health Securities Act: Coercion and Distrust for the Market*, 79 CORNELL L. REV. 1405, 1415-16 (1994).

²⁹ This paper only examines the substantive problems with the HSA. See generally Jerry L. Mashaw & Theodore R. Marmor, *The State as the Guarantor of Social Welfare: A Struc-*

Much of the substantive criticism of the HSA resonated from three doctrinal camps. The most serious criticism of the Clinton Plan is that it requires too much governmental oversight.³⁰ The major components of the Plan were regional purchasing alliances,³¹ which would interact with organized medical service providers³² to establish standard levels of premiums for all purchasers regardless of age, sex, or health. Overhauling the existing system to the extent proposed by the HSA would require federal oversight of both of the market players (purchasing alliances and medical providers) as well as maintenance of a federal fund for the unemployed. Such regulation would involve market price controls (including capitation),³³ quality controls,³⁴ service controls,³⁵ and information controls,³⁶ to name a few. As such, it is not surprising that in a nation where only two out of every ten citizens believe that the government “will do the right thing most of the time,”³⁷ skepticism over a government-administered health delivery system persists.

A second criticism of the HSA is that such “socialization” of medicine would result in decreased quality of service.³⁸ Allowing the government to allocate benefits and payments necessarily eliminates most of the freedom to contract in the area of medical services. Quality suffers when the government attempts to provide universal access without carefully considering the choice and breadth of services for those it intends to insure.³⁹

tural Perspective on Contemporary American Debates on Medical Care Reform, in PROFESSIONS, THE PRODUCTION OF HEALTH CARE AND THE STATE 2 (Patricia Days et al. eds., 1995) (analyzing the procedural deficiencies which led to the Plan’s demise); see also W. John Thomas, *The Clinton Health Care Reform Plan: A Failed Dramatic Presentation*, 7 STAN. L. & POL’Y REV. 83 (1996).

³⁰ See R. Shep Melnick, *Federalism and the New Rights*, 14 YALE J. ON REG. 325, 342 (1996). “In 1994 President Clinton’s health care proposal foundered on the shoals of public fear of government bureaucracy.” *Id.*

³¹ See Sylvia F. Kleinman & John Glasel, *The Clinton Health Plan: We Deserved Better*, 21 N.Y.U. REV. L. & SOC. CHANGE 241, 244 (1994-95). These alliances were developed by employer-mandates, requiring all employers to participate, without regard for alternative forms of employment insurance, or employee self-insurance. See *infra* notes 179-86 and accompanying text; see also H.R. 3600 §§ 6122, 6123 (1993); cf. FLA. STAT. ANN. § 408.702 (1993) (delineating the contours of the Florida purchasing alliances).

³² See Beresford, *supra* note 28, at 1407-10. Such providers were required to meet a federal minimum of comprehensive benefits. See *id.*

³³ See H.R. 3600, § 1002 (1993).

³⁴ See *id.* §§ 1101(a), 1111-28.

³⁵ See *id.* §§ 1402-1403.

³⁶ See Kleinman & Glasel, *supra* note 31, at 245.

³⁷ Melnick, *supra* note 30, at 342.

³⁸ Judith M. Rosenberg & David T. Zaring, *Managing Medicaid Waivers: Section 1115 and State Health Care Reform*, 32 HARV. J. ON LEGIS. 545, 547-48 (1995) (stating that managed care waivers were not the intention of § 1115 and will lead to a poorer quality of care).

³⁹ See *id.*

The Clinton Plan, however, is not alone in drawing criticism. Similar criticism has been lodged against state-created health plans as well. Thus, it may not be the nature of federal regulation, specifically, that causes a decrease in the quality of services, but rather, the nature of governmental regulation generally, that results in a lower level of care. It was in this context that Judith Rosenberg and David Zaring condemned the Clinton Administration's decision to "actively facilitate the approval of Section 1115 waivers."⁴⁰

A third substantive criticism of Clinton's plan is that it demands a change in doctrinal notions of constitutional entitlement. The Supreme Court has explicitly held that there is no fundamental right to health care⁴¹ nor is the United States obligated to provide health care to its citizens. This may be a reflection of prevailing notions of the division of government at the time. "In the interest of state autonomy, federalism, and the already developing local policies, the framers . . . did not provide for health care in the Constitution."⁴²

The debate over interpreting the Constitution to include a positive right to government-provided health care is not uniquely American. In fact, the constitutions of over thirty other nations guarantee health care to their citizens.⁴³ In light of this international recognition of health care as a fundamental right, proponents of constitutional recognition of such a right cite international law as a rationale.⁴⁴ Other commentators use communitarian principals to argue the existence of a constitutional right to health care.⁴⁵ Yet, another commentator, Professor Wendy Parmet, asserts that a constitutional right ought to be recognized because at the time the Constitution was written states were obliged to provide for the health and welfare of their citizens in return for their obedience.⁴⁶

Despite the existence of convincing arguments in support of the recognition of health care as a constitutional entitlement, there are equally compelling practical arguments for not recognizing such a right. R. Shep Melnick has noted four factors, which cast doubt upon both the legisla-

⁴⁰ *Id.*

⁴¹ See *Harris v. McRae*, 448 U.S. 297, 318 (1980); *Maher v. Roe*, 432 U.S. 464, 469 (1977) (holding that medical care is not a fundamental interest).

⁴² Saunders, *supra* note 27, at 719.

⁴³ See Melnick, *supra* note 30, at 325 n.1.

⁴⁴ See *id.* at 742.

⁴⁵ See Note, *supra* note 11, at 1327-28. Under communitarian analysis, the central question is whether "Universal Access to Health Care is more just than the current market-based distribution of health insurance . . ." and the answer, of course, is yes. *Id.* at 1328.

⁴⁶ Wendy E. Parmet, *Health Care and the Constitution: Public Health and the Role of the States in the Framing Era*, 20 HASTINGS CONST. L.Q. 267 (1993). Parmet employed social contract theory to explain the relationship between the individual and the state, which required the state to provide the individual protection (including medical care). *Id.* at 322.

tive and judicial creation of a right to health care.⁴⁷ The first two—the current composition of the Rehnquist Court and the Republican Congress—are procedural realities that work against the recognition of a constitutional right.⁴⁸ The latter two factors established by Melnick—the public’s lack of confidence in the government⁴⁹ and the resurgence of state-run programs⁵⁰—are not so much condemnations of a constitutional right to health care as they are reasons to bifurcate the health care delivery system.⁵¹ In addition, James Holloway has outlined the negative impact that federal health care regulation would have on federalism generally.⁵²

In light of the many practical concerns regarding federally administered national health care programs, it remains unlikely that a comprehensive policy will be established in the near future. This, however, does not mean that the federal government must entirely remove itself from the arena of promulgation and administration of health care reform.

2. *The Appropriate Role for the Federal Government*

The federal government should participate in the administration of health care “with authority, as opposed to exclusive control.”⁵³ In that regard, the federal government may set minimum standards for health care services, and reasonable cost control devices.⁵⁴ It should oversee the integration of Medicaid into state health programs and require states to promulgate policies that will ensure that all employed, low income, uninsured workers have access to a basic health care package, at little or no cost.⁵⁵ To the extent that the above proposal allows the federal gov-

⁴⁷ Melnick, *supra* note 30, at 339-45. Although many commentators suggest that universal access to health care should be a moral imperative, they also agree that the creation of a constitutional right (through either of these mechanisms) is inappropriate, and potentially dangerous.

⁴⁸ *See id.* at 342.

⁴⁹ *See supra* Part I.B.

⁵⁰ *See infra* Part I.C.

⁵¹ Melnick, *supra* note 30, at 342.

⁵² Holloway, *supra* note 23, at 408. Federal health care regulation requires a great deal of state law preemption, which in turn would “accelerate the decline of federalism by restricting the states’ ability to concern themselves with local medical care needs and to use local employment-based resources in formulating a comprehensive state health care policy.” *Id.* at 408.

⁵³ *Id.* at 453.

⁵⁴ Possible components could include: 1) uniform benefits packages; 2) accountable health care plans that compete at the local level; and 3) public sponsorship of individuals and small employers. *See* James B. Kenny & Sean Sullivan, *Health Care Reform: National, State and Local Direction*, 18 EMPLOYEE BENEFITS J. 41 (1993).

⁵⁵ The cost of insuring this group should be placed either on the state/federal Medicaid bill, or in the hands of employers, who may or may not receive tax credits for insuring their employees. One author writes that “[s]mall and large businesses should not be permitted to externalize (to Medicaid and other programs) the costs of health care for uninsured, employed,

ernment to facilitate, rather than exclusively govern, the health care delivery system of the states, it will produce a more effective means of achieving the national goals of universal coverage and reasonable costs.⁵⁶ One commentator has called this collaborative effort “cooperative federalism.”⁵⁷

C. STATE SOLUTIONS WILL SOLVE THE HEALTH CARE CRISIS

1. *States are Self-Interested Parties*

States are major purchasers of health care services spending nearly 20 percent of their budgets on health care in fiscal year 1992.⁵⁸ Due to this uncontrollable rise in health care costs⁵⁹ and the inability of the federal government to curb spending on medical care,⁶⁰ states have proposed a great deal of health care legislation over the past three decades.⁶¹ In addition, increased state expenditures on health care have decreased the amount of money that states have been able to allocate to other areas (i.e. education, *infrastructure* and tax relief).⁶² For these reasons, states have placed health care at the top of their local agendas.⁶³

The states’ familiarity with issues concerning local health care delivery dictates that they be the primary drivers of comprehensive health care reform across the nation. Additional evidence of the necessity for state-administered reform can be gleaned from public opinion polls regarding local government⁶⁴ and from the spectrum of legislative reforms

low income workers, and nonworkers if these businesses are subject to employer-sponsored health care programs.” Holloway, *supra* note 23, at 453. However, to the extent that such a program of federal employer mandates limits the ability of a state to implement a system specific to its own needs, it suffers from the same problems of overbreadth that have condemned other federal health care initiatives.

⁵⁶ See Holloway, *supra* note 23, at 453.

⁵⁷ *Id.* at 405, 452-54.

⁵⁸ *Id.* “Health care is ‘the single most important cost driver for states.’” NATIONAL ASSOCIATION OF STATE BUDGET OFFICERS, 1992 EXPENDITURE REPORT 2 (1993). According to NASBO, Medicaid accounts for “about 17 percent of all state spending in fiscal 1992.” NATIONAL ASSOCIATION OF STATE BUDGET OFFICERS, FISCAL SURVEY OF THE STATES: APRIL 1993 61 (1993).

⁵⁹ See *supra* note 55 and accompanying text.

⁶⁰ See *supra* note 25 and accompanying text; see also *supra* note 17.

⁶¹ See Holloway, *supra* note 23, at 415. In 1993, forty-eight state legislatures considered health care reform; see John K. Iglehart, *Health Care Reform the State*, 330 NEW ENG. J. MED. 75 (1994).

⁶² NATIONAL ASSOCIATION OF STATE BUDGET OFFICERS, FISCAL SURVEY OF THE STATES: OCTOBER 1992 32 (1992) (stating that health care costs make it difficult to fund other priorities).

⁶³ See Fernando R. LaGuarda, *Federalism Myth: States as Laboratories of Health Care Reform*, 82 GEO. L.J. 159 (1993). Many observers considered the Pennsylvania election of Harris Wofford to the U.S. Senate a sign that voters were sending a message to government to put health care at the top of the political agenda. See *id.* at 171 n.64 (citing HEALTH POLICY REFORM IN AMERICA: INNOVATIONS FROM THE STATES xii (Howard M. Leichter ed., 1992)).

⁶⁴ See Melnick, *supra* note 30, at 342.

that have been implemented to date.⁶⁵ States have implemented programs mandating employers to provide health insurance to their employees,⁶⁶ rationing medical services to the poor,⁶⁷ enlarging purchasing pools,⁶⁸ expanding Medicaid to cover all uninsured residents at or below the federal poverty level,⁶⁹ and providing improved benefits packages for children,⁷⁰ among other reforms. In each instance, the states have met with varying levels of success in their attempts to increase coverage and decrease costs, despite formidable federal obstacles.⁷¹ Initial successes in some states promise to spawn even greater success for future state health care reform, particularly in the absence of federal restrictions.⁷²

In addition to the states' interest in controlling the cost of health care, states are also interested in assuring that their citizens get a comprehensive health care package that comports with the specific concerns of the local populous. States are generally concerned about the welfare of their residents. The plight of the uninsured and underinsured has been brought to the fore in recent years, and questions about the adequacy of access for all state residents have spurred states into action.⁷³ It is, therefore, imperative that states be given the leeway necessary to achieve increased, if not universal, access.

2. *Federalism Demands State Participation*

Maintaining federalism as it was conceived of by the Framers of the Constitution is a second significant legal reason for allowing state regulation of health care reform. Indeed, "[t]he question of the relation of the states to the federal government is the cardinal question of our constitutional system."⁷⁴ In its original form, the political structure of the United States envisioned a balance of power between the federal government and the states, protected by the even hand of the judiciary. In recent years, however, the power of the states to influence national policy has

⁶⁵ See *infra* Part IV.

⁶⁶ See *infra* Part IV.A.

⁶⁷ See *infra* Part IV.B.

⁶⁸ See *infra* Part IV.C.

⁶⁹ See *infra* Part IV.D.

⁷⁰ See Minnesota Health Rights Act, Ch. 549, art. 1, 1, 1992 Minn. Laws 1487 (codified at MINN. STAT. § 62J.015 (1992)); Eric H. Chadwick, *Minnesotacare: Workable Finance or Just Wishful Thinking?*, 19 WM. MITCHELL L. REV. 961 (1993).

⁷¹ See *infra* Part III.

⁷² See Colleen M. Grogan, *Hope in Federalism? What Can the States Do and What Are They Likely to Do?*, 20 J. HEALTH POL. POL'Y & L. 477 (1995) (suggesting the future of state health care reform).

⁷³ See Holloway, *supra* note 23, at 422.

⁷⁴ WOODROW WILSON, CONSTITUTIONAL GOVERNMENT 173 (1908).

markedly decreased,⁷⁵ leaving only a procedural framework where federalism once stood as a powerful substantive force.⁷⁶

James Holloway argues that the implementation of a federal health care policy promises to preempt more state policy than ERISA currently does.⁷⁷ Holloway's concern is that "in providing a minimum standard and some uniformity, [a comprehensive national health care policy] will have to control health care and health-related interests which are intertwined with numerous fields of state law and public policy . . . result[ing] in the undermining of federalism."⁷⁸

Another argument in favor of preserving federalism revisits Professor Parmet's theory about national policy at the time of the Constitution.⁷⁹ Parmet, in advocating a governmental obligation to provide health care, recognized that the obligation rested with the states and not the federal government.⁸⁰ Under this interpretation, wresting this power away from the states would be constitutionally unjust. Additionally, states have already accepted the role of providing for the health and welfare of their citizens; thus, there is no need to recognize a constitutional obligation to achieve the same end, nor is there a need for federal interference in the administration of such policy. State control of health care reform is supported by constitutional notions of federalism, practical notions of administrability, and economic notions of efficiency.

II. FEDERAL OBSTACLES IMPEDE THE DEVELOPMENT OF STATE SOLUTIONS

Where state health care plans restructure the delivery and funding of health care to the indigent and the unemployed, they conflict with federal employment law and Medicaid. In these instances, many of the state-sponsored proposals have been preempted by the procedural rules of ERISA⁸¹ and/or Medicaid. The following section will discuss the impact of ERISA and Medicaid on the implementation of state health care programs in the past and the program's need for greater freedom in the future.

⁷⁵ See Holloway, *supra* note 23, at 446. Cf. Melnick, *supra* note 30, at 344 (stating that after a period of decline in the 1970s and 1980s, the states have experienced a resurgence in the 1990s).

⁷⁶ See Holloway, *supra* note 23, at 451.

⁷⁷ See *id.* at 445-51.

⁷⁸ *Id.* at 451.

⁷⁹ See Parmet, *supra* note 46 and accompanying text.

⁸⁰ See *id.* at 322.

⁸¹ ERISA is the Employee Retirement Income Security Act of 1974. See 120 Cong. Rec. 29216, 29963 (1974); G. Waldon Snyder, *Employee Retirement Income Security Act of 1974*, 11 WAKE FOREST L. REV. 219, 224 (1975).

A. ERISA PREEMPTION

The impact of ERISA on state health care policy has been deleterious. In the late 1970s, when state laws requiring employers to provide health insurance to employees were challenged, this issue came to a head.⁸² Whether Congress actually created ERISA as an obstacle to health care reform is doubtful, at best.⁸³ It is well established that the original purpose of ERISA was to protect employee pensions.⁸⁴ To accomplish this task, ERISA regulates the administration of employee health care benefits, among other things,⁸⁵ and provides a regulatory framework for the administration of employee benefit plans among the states.⁸⁶ Through a broad interpretation of the ERISA preemption clause,⁸⁷ courts have been able to strike down nearly all state attempts at comprehensive health care regulation.⁸⁸ As a consequence, states are

⁸² See Hancock, *supra* note 2, at 403. The most significant challenge occurred in *Standard Oil Company v. Aghalud*, 454 U.S. 801 (1981), *aff'g mem.* 633 F.2d 760 (9th Cir. 1980). See Hancock, *supra* note 2, at 404.

⁸³ See Hancock, *supra* note 2, at 404. "The Senate conferees did not discuss the effect of preemption with their associates who dealt with the health issues. Senator Bentsen claimed that the issue 'did not come before us on our hearing on the Finance Committee.'" *Id.* at 405 (citing *ERISA Improvement Act of 1978: Joint Hearing Before the Committee on Human Resources and the Commity on Finance*, 95th Cong. 266 (1978)).

However, "the Ninth Circuit recognized that 'ERISA contains one of the broadest preemption clauses ever enacted by Congress.'" Devon P. Groves, *ERISA Waivers and State Health Care Reform*, 28 COLUM. J.L. & SOC. PROBS. 609, 618 (1995) (quoting *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1439 (9th Cir. 1990)).

⁸⁴ See Groves, *supra* note 83, at 615.

⁸⁵ Under ERISA states may not: 1) set minimum benefits standards for all health coverage within their borders; 2) require employers to pay a minimum percentage of employee premiums; 3) mandate that employers provide health insurance; or 4) tax the premium of self insured plans or the payments they make to pay for the care of people without insurance. See Richard A. Knox, *Health Reform Fizzling in States: Legal, Political Obstacles Block Local Efforts*, *Officials Say*, BOSTON GLOBE, July 17, 1994, at 1.

⁸⁶ See generally Holloway, *supra* note 23, at 416-17, 419-20. See *supra* note 84 (for an explanation of 29 U.S.C. § 1144); see also Groves, *supra* note 83, at 616 n.53 (quoting Senator Harrison A. Williams, Jr. (D-NJ): "[section 1144 (a) is] intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent state and local regulations of employee benefit plans." 120 CONG. REC. 29,933 (1974).

⁸⁷ The ERISA preemption clause is embodied in 29 U.S.C. § 1144(a) (1994). This section provides that:

(a) Supersedure; effective date: Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

Id.

⁸⁸ See Holloway, *supra* note 23, at 410-11. Most state health care regulation either affects or at least relates to employee benefit plans, and as a result must fall under the blanket distinction of the preemption clause. *Id.*

forced to promulgate creative⁸⁹ health care legislation to avoid potential ERISA conflicts.⁹⁰

Still, no matter how creative a state is, ERISA preemption will generally allow only tangential changes in the health care delivery system.⁹¹ Moreover, because ERISA allows employers to maintain common law discretion regarding whether and to what extent they will offer their employees health care benefits, it forces states to rely on such employers' voluntary accessions to public policy to effectuate any significant change.⁹² Under the existing system, the success of public policy reform is inseparably tied to private interests, and frustration of legislative goals seems inevitable.⁹³

The most significant frustration experienced by the states is the inability to regulate the decision-making of large employers.⁹⁴ Because large corporations comprise nearly two-thirds of the national work force, when they opt out of statewide schemes⁹⁵ small companies and the self employed are forced to join higher risk pools and pay larger premiums.⁹⁶ Large employers can further frustrate a state's effort to finance health care because ERISA allows them to avoid paying taxes on their self-insurance plans.⁹⁷ In some cases, though, indirect taxes, which may ac-

⁸⁹ For instance, the Supreme Court recognized a distinction between state law mandating particular medical benefits and state law requiring insurance. *Metropolitan Life v. Massachusetts*, 471 U.S. 724, 743 (1985). Mandatory medical benefits (i.e. mental health benefits), because they regulate insurance providers, and not employers, would *not* be preempted despite the fact that mandated medical insurance (which effectively regulates employers) remained illegal. *See id.*

⁹⁰ *See Holloway, supra* note 23, at 422-38 (discussing state regulations which are and are not preempted by ERISA).

⁹¹ *See id.* Generally, states may set minimum benefit levels, restrict the cancellation of coverage due to claims, provide for portability between providers, mandate that insurance companies cover any group that applies, and set upper and lower limits for premiums. *See Groves, supra* note 83, at 625.

⁹² *See Holloway, supra* note 23, at 443. State health care reform depends on: 1) whether an employer will grant health care benefits under its self-funded plan; 2) whether employers will voluntarily purchase commercial insurance subject to mandated-benefits regulation; 3) whether the federal government will grant states an exception to or exemption from section 1144(a); and 4) whether the federal government will continue to subsidize medical care and assistance programs (i.e. Medicaid, etc.). *See id.* at 443-44.

⁹³ In other words, whenever the effectiveness of public policy necessarily relies on the accessions of private interest groups, the achievement of stated goals is indirect, with the interest group ultimately in control of whether or not the state reaches its goals.

⁹⁴ *See Stio, supra* note 1, at 336.

⁹⁵ A large corporation may opt out of state regulation by self-insuring. *See Groves, supra* note 83, at 625.

⁹⁶ *See Stio, supra* note 1, at 336.

⁹⁷ *See id.* This result is exacerbated when states promulgate mandated benefits, because self-insured large corporations may negotiate the mandated benefit out of their insurance package, thus forcing all other individual purchasers to subsidize the high risk pool. The dual consequences of this exemption are frustration of state policy objectives and higher premiums for individual insurance purchasers. *See id.* at 337 n.51.

tually carry through to employers covered by ERISA, have been upheld because of their negligible burden on the administration of ERISA plans and "because the economic impact on ERISA plans [i]s tenuous, remote and peripheral."⁹⁸

Congress has been reluctant to restructure the ERISA preemption to allow states to implement health care reform because of the perceived need for uniformity in employment law.⁹⁹ As a result of Congress's decision to favor federal employment law over health care policy, states must continue to find ways to regulate health care without triggering ERISA preemption of employers. The difficulty of this task has stalled important reforms in the delivery of health care and will continue to do so until either Congress or the Supreme Court grant states the ERISA exemption necessary to implement meaningful change.

B. MEDICAID PREEMPTION

Medicaid is a jointly-funded, state-administered federal program that provides health care to the indigent.¹⁰⁰ The federal government established broad guidelines¹⁰¹ under which states are allowed to structure Medicaid programs specific to the needs of their citizens. Nevertheless, because of an inability to meet certain eligibility criteria, many of the targeted residents are not eligible for Medicaid assistance.¹⁰² The resulting ineffectiveness of Medicaid programs has increased the states' will-

⁹⁸ Groves, *supra* note 83, at 627 n.99 (quoting *Boyle v. Anderson*, 849 F. Supp. 1307 (D. Minn. 1994)). Similarly, New York's eleven percent tax on rates to patients covered by commercial insurance has been allowed. *See id.*; *see also* *New York State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co.*, 514 U.S. 645 (1995) (unanimous opinion holding that ERISA does not preempt a New York rate-setting law that imposes surcharges on hospital bills paid by commercial insurers and certain self-funders but not on those paid by Blue Cross & Blue Shield plans); *DeBuono v. NYSA-IIA Medical and Clinical Services Fund*, 520 U.S. 806 (1997). "The law was designed to help Blue Cross & Blue Shield, which insures a broader array of patients, compete more effectively with commercial insurers." Jesselyn Alicia Brown, *ERISA and State Health Care Reform: Roadblock or Scapegoat?*, 13 *YALE L. & POL'Y REV.* 339, 343 (1995). *See generally* Stio, *supra* note 1 (proposing that under the *Travelers* decision, states do not necessarily need relief from ERISA preemption, but rather clarification of precisely what ERISA preempts).

⁹⁹ *See* Stio, *supra* note 1, at 338. Companies that are protected by ERISA preemption are not forced to comply with fifty different sets of state insurance regulations. *See id.* at 338 n.57. "Members of Congress believe that 'if we have each state doing its own thing, we are going to have an unworkable maze' for those employers that operate in several states." *Id.* Further, "it is unreasonable to expect employers to invest in efficiently managing benefits when the employer's role in covering workers is subject to ever changing political factions in each state." *Id.*

¹⁰⁰ *See* Vernellia Randall et al., *Section 1115 Medicaid Waivers: Critiquing the State Applications*, 26 *SETON HALL L. REV.* 1069, 1070 (1996).

¹⁰¹ These guidelines include: amount, duration, scope of services, eligibility, and payment structures. *See id.*

¹⁰² *See* Randall, *supra* note 100, at 1072. Most of the ineligible citizens have difficulty meeting the Aid for Dependent Children criteria of Medicaid. The problem has been exacer-

ingness to experiment with demonstration projects.¹⁰³ However, such experimentation is not easy. In order for a state to experiment with health care, it must obtain a Medicaid waiver. The most typical type of Medicaid waiver is a section 1115 demonstration waiver.¹⁰⁴ Section 1115 of the Social Security Act of 1935¹⁰⁵ states that:

(a) In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of [the Act] . . . e

(1) the Secretary may waive compliance with any of the requirements of [various sections of the Act] . . . to the extent and for the period he finds necessary to enable such State or States to carry out the project . . . e¹⁰⁶

The language of section 1115 does not provide the Secretary of the Department of Health and Human Services ("HHS") guidance about the manner in which each state proposal should be evaluated. As a result, a great deal of debate arose amongst scholars¹⁰⁷ and politicians (both federal and state)¹⁰⁸ over how waiver review should be undertaken. Currently, demonstration waivers are granted to programs that are beyond the scope of the waiver rationale, as it was originally conceived.¹⁰⁹ This

bated by states failing to adjust income eligibility criteria in consonance with the rate of inflation. *See id.*

¹⁰³ *See id.* at 1073. "By April 1995, six states had received [Medicaid] waivers, seven applications were pending, and other proposals were being drafted." *Id.* The majority of state waiver programs require participants to enroll in managed care and expand the eligibility criteria of Medicaid. *See id.* at 1074.

¹⁰⁴ President John F. Kennedy was the driving force behind the creation of the section 1115 waiver in 1962. The waiver was originally created to permit experimentation with all types of welfare programs existing and not-yet developed (i.e., Medicaid). *See Rosenberg & Zaring, supra* note 38, at 546-47.

¹⁰⁵ 42 U.S.C. § 1315 (1988).

¹⁰⁶ *Id.* The Senate report pertaining to the section recognized that federal guidelines "often stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. REP. NO. 87-1589, at 1961 (1962).

¹⁰⁷ *See* Susan Bennett & Kathleen Sullivan, *Disentitling the Poor: Waivers and Welfare Reform*, 26 U. MICH. J.L. REFORM 741 (1993) (recommending a set of procedures that is consistent with the core values of the Aid to Families with Dependent Children for evaluating waiver requests); Elizabeth Andersen, *Administering Health Care: Lessons for the Health Care Financing Administration's Waiver Policy-Making*, 10 J.L. & POL. 215 (1994) (arguing that criticism of the HCFA's policy-making is the result of the agency's failure to calibrate its waiver process); Rosenberg & Zaring, *supra* note 38 (stating that managed care waivers were not the intention of Section 1115 and will lead to a poorer quality of care).

¹⁰⁸ *See* Andersen, *supra* note 107, at 219 (discussing the inherent conflict that arises from state administration of a federally-funded program).

¹⁰⁹ *See id.* at 226. "Since the late 1970s, cost-conscious states have, in the guise of section 1115 demonstration applications asked the federal government for permission to implement long-term, comprehensive health care reform." *Id.* at 229.

expansive interpretation of section 1115 demands that greater scrutiny be applied by the Secretary of HHS before approving a state proposal.

The first step in the waiver process requires a state to submit a detailed proposal to HHS delineating the mandates it would like waived.¹¹⁰ A detailed discussion of the program's cost (to both the state and federal government), the relevant laws, and the anticipated effect on former and future beneficiaries of Medicaid should be included in the proposal.¹¹¹

The second step involves the comprehensive review of the waiver by the Health Care Financing Agency (hereinafter HFCA) of the HHS. A technical review panel convenes to score the proposal's methodology and design, objectives, expected cost and returns, and the applicant's knowledge and experience in administering such reform.¹¹² Depending on this score, the panel will recommend that HHS either approve or reject the plan, or condition approval on certain necessary changes.¹¹³ At that point, the proposal is delivered to the HFCA's Office of Research and Development, which incorporates the panel's recommendation and an independent review into a decision memorandum forwarded to the agency's Administrator, who has ultimate discretion.¹¹⁴ Notwithstanding technicalities, which require even more stringent review,¹¹⁵ this process is extremely cumbersome and time-consuming. It may take anywhere from a few months to two years¹¹⁶ and may require many drafts of the proposal before it obtains HFCA approval.

The problem with the section 1115 waiver, as it is employed currently, is that in the absence of comprehensive federal health care reform, states are not provided with enough information to efficiently promulgate demonstration proposals. State proposals are therefore written with a blind eye toward specific federal concerns. In some cases, state interests

Originally, the Secretary of HHS was not required to consider the effects on beneficiaries or costs when evaluating a Medicaid program. Recently, however, "access to health care programs, quality of care, and budgetary concerns have emerged as prominent factors of waiver decision-making." *Id.* at 226.

¹¹⁰ See Rosenberg & Zaring, *supra* note 38, at 547.

¹¹¹ *Id.*

¹¹² See *id.* at 548. Also considered are risks to the potential beneficiaries of the program. See *id.*

¹¹³ See *id.* at 547.

¹¹⁴ See *id.*

¹¹⁵ A demonstration project, which affects more than three hundred Medicaid recipients and anticipates federal costs in excess of one million dollars, requires the additional approval of the HHS Assistant Secretary for Management and Budget and the White House Office of Management and Budget (OMB). These proposals, because of their potential burden on federal funds, often require strict budget-neutrality. See *id.*

¹¹⁶ See Andersen, *supra* note 107, at 22; cf. Bennett & Sullivan, *supra* note 107, at 743 ("waivers [are] granted relatively quickly, sometimes with thirty days of the state request."). The short evaluation period enunciated by Bennett may have been a function of President Bush's push for health care reform. See Michael Wiseman, *Welfare Reform in the States: The Bush Legacy*, FOCUS, Spring 1993, at 23-25.

will encompass many of the same concerns held by the federal government. More often than not, however, strict (and time-consuming) scrutiny of the proposal will be necessary to ensure that federal funds and interests do not become completely subverted. As such, efficiency demands that the federal government explicitly state its non-fiscal interests, or that it scrutinize state proposals with regard only to cost.

III. CASE STUDIES OF FOUR STATE PLANS FOR DELIVERY AND FINANCING OF HEALTH CARE

A. HAWAII PLAN¹¹⁷

Hawaii utilizes employer mandates to achieve almost universal health care coverage. This is the only state that can effectively employ such a method because its health care delivery system was devised in 1974, prior to the passage of ERISA. Thus, Hawaii was able to gain a waiver for its health care policy, albeit a limited one. Hawaii is not allowed to implement changes to the policy after 1974.¹¹⁸

B. OREGON PLAN

1. *Brief History of Health Care in Oregon Prior to the Oregon Health Plan*

In Oregon, the legislature was confronted with the typical health care dilemma of escalating costs and decreasing access. As a result, the state legislature promulgated a health plan that has been deemed among the most controversial in the country.¹¹⁹ The Oregon Health Plan, which finally received the Medicaid waivers necessary for implementation on March 19, 1993, demanded a shift in fundamental values in order to gain widespread acceptance as a viable system for delivering health care.¹²⁰

The Health Plan is comprised of seven pieces of legislation enacted in 1987, 1989 and 1991 with the intention of providing universal access at competitive costs.¹²¹ In order for the Oregon plan to be fully implemented, the federal government had to grant Medicaid waivers allowing the state to deviate from the mandates of national health policy.¹²² Sec-

¹¹⁷ See generally Stio, *supra* note 1; LaGuarda, *supra* note 63.

¹¹⁸ Stio, *supra* note 1, at 350.

¹¹⁹ See *id.* at 359.

¹²⁰ See Catherine Grace Vanchiere, *Stalled on the Road to Health Care Reform: An Analysis of the Initial Impediments to the Oregon Demonstration Project*, 10 J. CONTEMP. HEALTH. L. & POL'Y 405 (1994) (citing Daniel Callahan, *Rationing Medical Progress—The Way to Affordable Health Care*, 322 NEW ENG. J. MED. 1810, 1810-11 (1990)).

¹²¹ See Stio, *supra* note 1, at 359.

¹²² See *supra* Part III.B. Prior to any experimentation with Medicaid, a state must submit a request for waiver to the Secretary of the Department of Health & Human Services for permission to waive the requirements of the Social Securities Act. 42 U.S.C. § 1315(3)(a) (1993).

retary of HHS Louis W. Sullivan initially rejected this proposal because it conflicted with the Americans with Disabilities Act.¹²³ Ultimately, after working in close connection with the Health Care Financing Administration ("HCFA"), the Oregon legislature was able to make the changes necessary to receive the desired waivers.¹²⁴

During the time in which the Oregon legislature promulgated and refined its health plan, the State was faced with 400,000 uninsured residents under the age of sixty-five,¹²⁵ and a Medicaid bill that had grown by almost 300 percent.¹²⁶ In 1987, faced with fiscal concerns over the rising costs of Medicaid, Oregon restructured its Medicaid coverage to exclude organ transplants.¹²⁷ The rationale behind Oregon's shift in services presupposed that the existing United States system also rations health care.¹²⁸ In theory, the Oregon approach seemed a reasonable alternative to the existing U.S. system; in practice, however, the pitfalls in the Oregon system became apparent.¹²⁹

Failure of the transplant-rationing experiment forced the Oregon legislature to reevaluate its original policy decision to eliminate transplants from coverage. John Kitzhaber, then-President of the Oregon Sen-

¹²³ See Vanchiere, *supra* note 120, at 405.

¹²⁴ See *id.*

¹²⁵ See *id.* at 406.

¹²⁶ See Eric L. Robinson, *The Oregon Basic Health Services Act: A Model for State Reform?*, 45 VAND. L. REV. 977, 988 (1992). In 1965, states expended about 5 percent of their budgets on Medicaid. In contrast, it was estimated that in 1995 Medicaid expenditures would rise to 15 percent of state budgets. *Id.*

¹²⁷ See *id.* The exclusion of organ transplants from Medicaid coverage was Oregon's first experience with rationing health care services. The state legislature recognized that the money saved (\$1,100,000) on thirty-four transplants would be better spent providing basic health and prenatal services to fifteen hundred pregnant women. See Robinson, *supra* note 126, at 988-99.

¹²⁸ See Marsha F. Goldsmith, *Oregon Pioneers "More Ethical" Medicaid Coverage With Priority-Setting Project*, 262 JAMA 176 (1989). The United States rations health care to the extent that access is not universal. As a result, with respect to health care, it is people that are rationed and not services. See David M. Eddy, *What's Going on in Oregon?*, 266 JAMA 417, 418 (1991). Two other ways in which it has been claimed that health care is rationed in the present system are by age and by "inappropriate and ineffective application of resources." Vanchiere, *supra* note 120, at 412 n.43 (citing BUREAU OF NAT'L AFFAIRS, SPECIAL REPORT: OREGON PLAN SPARKS DEBATE 172 (1990)). The fact that one half of the Medicaid budget is spent on care for people in their last thirty days of life is evidence of the latter type of rationing. See *id.*

¹²⁹ In 1988, Oregon refused to fund the bone marrow transplant of seven-year-old leukemia patient Coby Howard. Despite the Howard family's ability to raise 70 percent of the \$100,000 cost of the transplant, the state reasoned that because Coby was not in remission he was not a strong candidate for the transplant. Ultimately, Coby died without receiving the bone marrow transplant. See Harvey D. Klevit et al., *Prioritization of Health Care Services; A Progress Report by the Oregon Health Services Commission*, 151 ARCH. INTERN. MED. 912 (1991).

ate, claimed, “we had no framework for making the decision.”¹³⁰ The governor then appointed the Governor’s Commission on Uncompensated Care, a special task force, to evaluate the state’s health care system.¹³¹ The result of the Commission’s study was passage of the Oregon Basic Health Services Act (“OBHSA”) in 1989,¹³² created to “ensure equitable access without excessive burdens to an adequate level of health care for all Oregonians.”¹³³

2. Legislation

Simply put, OBHSA rations health care.¹³⁴ The state policy behind the act was to “keep all Oregonians healthy,” rather than simply providing them with access to health care.¹³⁵ In order to achieve this goal, the OBHSA established a three-pronged plan to provide basic health care services to virtually all Oregon residents.¹³⁶ First, Senate Bill 27, known as the Oregon Medicaid Demonstration Project,¹³⁷ established the scheme under which medical services would be distributed among Oregon residents.¹³⁸ Second, Senate Bill 534 created a high risk, state-subsidized insurance pool for the uninsurable and the chronically ill.¹³⁹ Finally, Senate Bill 935 mandated that employers provide employees and their dependents with a minimum level of health insurance.¹⁴⁰

¹³⁰ Julie Rovner, *Oregon Plan Sparks Emotional Debate over Rationing Health Care*, 49 CONG. Q. 1278 (1991).

¹³¹ See Vanchiere, *supra* note 120, at 412.

¹³² See *id.* at 421. The OBHSA consists of three bills that are codified at Or. Rev. Stat. 414.705-.750 (1990).

¹³³ Vanchiere, *supra* note 120, at 422.

¹³⁴ See Stio, *supra* note 1, at 358. “Rationing is a health care reform theory that entails controlling costs and extending insurance coverage to a greater number of people by limiting the amount of care an individual receives and using the savings to fund basic health services for others who are insured.” *Id.* at 358 n.138.

The idea of rationing health care on the basis of services produced a great deal of criticism early on, as people thought that it devalued the importance of life and discriminated against the poor (who would no longer receive the same level of benefits they were granted prior to the act). See *id.* at 359 n.143.

¹³⁵ Vanchiere, *supra* note 120, at 406 n.11 (citing John Kitshaber, *Presentation to the Conference on Health Care: The Oregon Solution* 1, 13 (Aug. 9, 1991) (transcript on file with the *Journal of Contemporary Health Law & Policy*)). Health care is only one of many factors that influence health. The Oregon legislation was an attempt to develop “not simply a health care policy, but a health policy: an integrated approach in which resources allocated for health care are balanced with allocations in related areas which also affect health care.” *Id.*

¹³⁶ See Robinson, *supra* note 126, at 990.

¹³⁷ See *id.*

¹³⁸ See *id.*

¹³⁹ S. 534, 66th Leg. (Or. 1989) (codified as amended in scattered sections of OR. REV. STAT. Ch. 735 (Supp.1992)).

¹⁴⁰ See Vanchiere, *supra* note 120, at 415. The minimum benefit package must be equal to the services provided to Medicaid recipients. See Klevit et al., *supra* note 129, at 912.

Senate Bill 27 also created the Oregon Health Services Commission¹⁴¹ ("HSC") for the purpose of ranking all of Medicaid's treatments and services.¹⁴² The basis for prioritizing¹⁴³ the "condition/treatment pairs"¹⁴⁴ is an examination of the benefit they provide to the population served. In order to develop the final list of ranked condition/treatment pairs, the HSC employed a "four step process for health resource allocation."¹⁴⁵ The first step was for the HSC to devise a prioritized list of services.¹⁴⁶ To accomplish this, the HSC was required to "solicit input from the public and to build consensus on the criteria used in the prioritization process."¹⁴⁷ Upon completion of the ranked list of services,¹⁴⁸ the HSC must submit the list to the legislature, which sets the budget.¹⁴⁹

¹⁴¹ The Health Services Commission is an eleven-member board appointed by the governor, consisting of five doctors, a health nurse, a social worker, and four health care consumers. OR. REV. STAT. § 414.715(1) (Supp. 1990).

¹⁴² *Id.* §§ 414.065(1), 414.720(3).

¹⁴³ Prioritizing is the key innovation of the OBHSA. See Vanchiere, *supra* note 120, at 415-18. "In the face of budget constraints most states have set priorities concerning which of the optional Medicaid services would be funded. Oregon's novelty is in ranking and prioritizing all health services covered by Medicaid, including services ordinarily considered 'mandatory services' under federal law." Vanchiere, *supra* note 120, at 415 n.78 (quoting Michael J. Garland, *Justice, Politics and Community: Expanding Access and Rationing Health Services in Oregon*, LAW, MED. & HEALTHCARE 67 (1992)).

¹⁴⁴ "Condition/treatment pair" is a medical phrase classifying the diagnosis and treatment of a specific disease or affliction. The Oregon list was created from the Current Procedural Terminology Codes and the International Classification of Diseases. See John A. Kitzhaber, *Prioritizing Health Services in an Era of Limits: The Oregon Experience*, 307 BRIT. MED. J. 373 (1993).

¹⁴⁵ See Garland, *supra* note 143, at 68.

¹⁴⁶ A new list must be submitted to the legislature annually, so the number of condition/treatment pairs may change, and the number of funded services may change as well. See Kitzhaber, *Prioritizing Health Services*, *supra* note 144, at 376.

¹⁴⁷ Robinson, *supra* note 126, at 991 n.130 (citing OR. REV. STAT. § 414.720 (1)-(2) (Supp. 1990)). After forty-seven community meetings conducted by Oregon Health Decisions, a consensus of thirteen health-related values emerged. These "community values" were grouped into three categories: value to individual, value to society, and essential to basic health care. See David C. Hadorn, *Setting Health Care Priorities in Oregon: Cost-Effectiveness Meets the Rule of Rescue*, 265 JAMA 2218, 2220 (1991). After the determination of the categories, the HSC placed the treatments into each category according to its own judgment. See Robinson, *supra* note 126, at 991.

¹⁴⁸ The HSC ranked 709 condition treatment pairs into seventeen categories. See Garland, *supra* note 143, at 68. Categories one through nine were deemed "essential," categories ten through thirteen were mostly dubbed "very-important," and categories fourteen through seventeen were classified as "non-essential." See Robinson, *supra* note 126, at 992. For a complete list of the categories, see *id.* at 992 n.134.

In May 1990, the HSC released an initial list of sixteen hundred conditions. However, this list was not used because the results did not comport with common sense (i.e., crooked teeth were ranked ahead of early treatment for Hodgkin's disease). See *id.* at 993 n.138 (citing Daniel M. Fox & Howard M. Leichter, *Rationing Care in Oregon: The New Accountability*, HEALTH AFF. 7, 21-22 (1991)).

¹⁴⁹ See Garland, *supra* note 143, at 68. The legislature funded the first 587 services in 1991. See Vanchiere, *supra* note 120, at 417 n.88. "For the vast number of treatments below line 587, there is either no effective treatment, or the treatment only expedites recovery and

The third step involves the Office of Medical Assistance Programs ("OMAP") requesting federal Medicaid waivers, and the agencies preparing themselves to run the programs.¹⁵⁰ The last step is implementation of the plan across the applicable region.¹⁵¹

Additionally, under Senate Bill 27, income level is established as the sole test for Medicaid eligibility.¹⁵² Thus, any resident with an income below the federal poverty line is eligible for Medicaid coverage.¹⁵³ Consequently, the state will fund as many services as it can afford under the Medicaid budget allotment for the year.¹⁵⁴ In the event of an increase in the number of qualifying Medicaid recipients, the state will reduce the number of funded condition/treatment pairs, rather than deny coverage to residents in need.¹⁵⁵

Senate Bill 534 calls for the creation of an Oregon Medical Insurance Pool Board to formulate insurance risk pools.¹⁵⁶ The purpose of risk pools is to enable people who do not qualify for private insurance, due to a pre-existing condition, to buy health insurance through the pool, which spreads out the risk.¹⁵⁷ Within these pools, the only criteria taken into consideration when setting premiums are age and geographic location.¹⁵⁸ Further reductions in the cost of premiums to high-risk individuals will come from placing surcharges on insurance companies who do business in the state, and State reserve funds, when necessary.¹⁵⁹

Senate Bill 935 grants small business owners tax credits if they provide health insurance for their employees.¹⁶⁰ To qualify for a credit, an employer must make available an insurance package equal to state-

recovery would occur either with or without treatment." Richard C. Wopat, *The Oregon Health Plan: To Cover All Diagnostic Visits*, 268 JAMA 790 (1992).

¹⁵⁰ See Garland, *supra* note 143, at 68. The difficulty in obtaining the necessary federal waivers is discussed at *supra* notes 95-113 and accompanying text.

¹⁵¹ See Garland, *supra* note 143.

¹⁵² See Vanchiere, *supra* note 120, at 415.

¹⁵³ See OR. REV. STAT. § 414.036(2) (Supp. 1990). Federal poverty level for a family of three is \$991 per month. See Kitzhaber, *supra* note 144, at 375. Previously, the state had provided Medicaid to 66 percent of residents below the federal poverty line. Edward Chen, *Oregon Wins OK to Ration Medical Care*, L.A. TIMES, Mar. 20, 1993, at 1.

¹⁵⁴ See Robinson, *supra* note 126, at 991; OR. REV. STAT. § 414.720(5) (Supp. 1990) (services will be funded to the extent that funding allows).

¹⁵⁵ See Robinson, *supra* note 126, at 991; OR. REV. STAT. § 414.720(2) (Supp. 1990).

¹⁵⁶ See Stio, *supra* note 1, at 361; OR. REV. STAT. § 735.625 (1993).

¹⁵⁷ See Robinson, *supra* note 126, at 994; see also OR. REV. STAT. § 743.737(1) (1993). An estimated ten thousand to twenty thousand uninsurable residents will be able to obtain insurance through risk pools. See Fox & Leichter, *supra* note 148, at 11. The likelihood of a person with a pre-existing condition bringing a claim typically makes it impossible for an insurance company to set a reasonable premium. Risk pools spread the risk and costs by increasing the premiums of a larger group of residents, allowing insurance companies to issue policies to high-risk applicants. See Stio, *supra* note 1, at 362 n.151.

¹⁵⁸ See Stio, *supra* note 1, at 361.

¹⁵⁹ See Robinson, *supra* note 126, at 994-95.

¹⁶⁰ See *id.* at 994.

funded Medicaid.¹⁶¹ The goal of Senate Bill 935 is to establish a means for offering insurance to those residents who are not eligible for Medicaid and cannot afford private insurance.¹⁶²

Lastly, the Oregon Health Plan established statutory protection for physicians who refuse to provide unfunded services.¹⁶³ The goal of this legislation is to reduce the occurrence of medical malpractice suits and thus drive the costs of health care down even further.¹⁶⁴

C. FLORIDA PLAN

1. *Brief History of Health Care in Florida Prior to the 1992 and 1993 Acts*

In Florida, the "Health Care and Insurance Reform Act of 1993"¹⁶⁵ (the "1993 Act") was enacted to address the rising costs of health care and the high percentage of individuals without health insurance.¹⁶⁶ According to 1993 statistics, approximately 2.5 million Floridians are uninsured¹⁶⁷ and the percentage of uninsured non-elderly residents is 22.9 percent as compared to 16.6 percent nationally.¹⁶⁸ Furthermore, 75 percent of the 2.5 million uninsured Floridians are employed or are the dependents of employed residents.¹⁶⁹

The numbers above, however, do not tell the whole story. Consider further that the total health care bill in Florida rose by eight billion dollars between 1991 and 1992.¹⁷⁰ At the current rate, the health care expenditure in Florida is expected to reach ninety billion dollars by the year 2000.¹⁷¹ This rise in health care costs is attributable in large part to the cost-shifting associated with uninsured individuals receiving health care.¹⁷² Uninsured individuals who cannot pay for their medical services create losses for providers who treat them. These losses are covered by

¹⁶¹ See *id.*

¹⁶² See *id.* at 995.

¹⁶³ See *id.*

¹⁶⁴ See *id.*

¹⁶⁵ 1993 Fla. Laws ch. 93-129.

¹⁶⁶ See Bruce D. Platt, *A Summary of the Health Care and Insurance Reform Act of 1993: Florida Blazes the Trail*, 21 FLA. ST. U.L. REV. 483 (1993).

¹⁶⁷ STAFF OF FLA. H.R. COMM. ON HEALTH CARE, REPORT ON SENATE BILLS 1914, 2006, 1784, & 406 (1993) Staff Analysis 1 (final May 11, 1993) (on file with comm.) [hereinafter HEALTH CARE STAFF ANALYSIS].

¹⁶⁸ AGENCY FOR HEALTH CARE ADMIN., A BLUEPRINT FOR HEALTH SECURITY 11 (1992) [hereinafter BLUEPRINT]. This places Florida third among all states in regard to its percentage of uninsured non-elderly residents. See *id.*

¹⁶⁹ See HEALTH CARE STAFF ANALYSIS, *supra* note 167, at 7.

¹⁷⁰ See *id.* at E-1. In 1991, health care in Florida cost thirty-one billion dollars; in 1992, the cost rose to thirty-eight billion dollars. See *id.*

¹⁷¹ See *id.* at E-1.

¹⁷² See BLUEPRINT, *supra* note 168, at 15.

shifting the costs to insured individuals in the form of artificially inflated premiums.¹⁷³

2. Legislation

The Florida legislature enacted the Health Care Reform Act of 1992 ("1992 Act")¹⁷⁴ to address the problems of increasing costs and decreasing access. The Health Care and Insurance Act of 1993 was then promulgated to improve upon and facilitate implementation of the provisions of the 1992 Act. These acts, in tandem, establish managed competition¹⁷⁵ as the delivery system for health care in Florida. Such managed competition was first considered as a viable health care delivery system by the Jackson Hole group.¹⁷⁶ The goals of managed competition are to "promote the pooling of purchaser and consumer buying power; ensure informed, cost-conscious consumer choices of managed care plans; reward providers for high quality, economical care; increase access to care for uninsured persons; and control the rate of inflation of health care costs."¹⁷⁷

¹⁷³ See *id.* at 15. The premiums paid by insured individuals are artificially increased because providers must account for their losses in treating uninsured patients. Because uninsured patients do not have full access to health care, diagnosis and treatment is usually delayed, increasing the cost of care when it is ultimately provided.

¹⁷⁴ See Platt, *supra* note 166, at 484-85. The 1992 Act included four major provisions to achieve its stated purpose: 1) the creation of the Employee Health Care Access Act to reform the small group health insurance market; 2) the creation of the Florida Health Plan to develop strategies and implement goals relating to access, cost containment, health care regulation, and insurance reform; 3) the creation of the Florida Health Care Services Corps, which was designed to stimulate the provision of medical services in under-served areas; and 4) the creation of the Agency for Health Care Administration to streamline the regulation of health care in the state.

¹⁷⁵ *Health Care A to Z*, CONG. Q., Sept. 25, 1993, at 60. Managed competition is a health care system in which insurance companies and health care providers create health plans that compete with other health plans for large groups of consumers. Through managed competition, individuals are organized into large purchasing groups to buy insurance at lower premiums. Health care providers, organized into networks, then vie for business. See *id.*

¹⁷⁶ See Thomas Rice & Richard Brown et al., *Holes in the Jackson Hole Approach to Health Care Reform*, 270 JAMA 11 (1993).

Boiled down to its fundamentals, the Jackson Hole approach to managed competition requires three major changes in the U.S health care system. First, regional Health Insurance Purchasing Cooperatives (HIPCs) are formed to manage the marketplace for health care coverage, especially for small firms and individuals. Second, employers and HIPCs contribute the same amount of money for coverage regardless of which plan a consumer chooses. This provision requires limiting the tax excludability of health benefits to the rate charged by the least costly qualified health plan, so that premium payments above that level would be with after tax dollars. Third, to level the playing field among all health plans, new rules make it more difficult for plans to avoid enrolling high risk individuals.

Id. at 1357.

¹⁷⁷ 1993 Fla. Laws ch. 657, 738.

The most distinctive feature of Florida's managed competition is that participation is voluntary. Opponents of this plan argue that a voluntary system does not go far enough to guarantee universal access to health care.¹⁷⁸ Meanwhile, proponents claim that starting with a voluntary phase and creating a system that makes medical insurance premiums less expensive without using excessive amounts of state money is the proper way to undertake reform.¹⁷⁹

Florida's health care reform was also novel in that it was the first state plan to set a timetable for providing health care for all state residents.¹⁸⁰ The 1992 Act, which created the Agency for Health Care Administration,¹⁸¹ also established a two-phase plan for achieving universal coverage.¹⁸² Phase One is voluntary. It creates incentives for small employers to provide insurance to their employees by using purchasing groups to achieve lower premiums.¹⁸³ Phase Two of the Act is only employed if voluntary participation in Phase One fails to produce universal coverage. Under this phase, an employer mandate, similar to that implemented in the Hawaiian system, requires that all employers provide coverage for their employees.¹⁸⁴

Having established a direction in which to steer health care reform through the 1992 Act, the Florida Legislature promulgated the 1993 Act to create the mechanism by which the proposals would be implemented.¹⁸⁵ The 1993 Act created eleven Community Health Purchasing

¹⁷⁸ See Rosalind Resnick, *Florida Grapples with Universal Health Care*, 12 Bus. & HEALTH 56 (1992). Marshal Litvak, executive director of the Florida Health Care Campaign, has said, "[a]sking businesses and insurers to voluntarily enroll in health care reform is like asking people to voluntarily pay their income taxes. It just will not happen." *Id.*

¹⁷⁹ See *id.* at 56. The Florida system has also gained support because it seems to rely on market forces and requires little bureaucratic interference. See Stio, *supra* note 1, at 347 n.92.

¹⁸⁰ See Sandra Greenblatt & Michael J. Cherniga, *New Florida Health Reform Plan is First Large Scale Test of Clinton's Managed Competition Theory*, 10 HEALTHSPAN 7 (1994).

¹⁸¹ See FLA. STAT. ANN. § 2042 (1993). The Agency for Health Care Administration is an "11-member Governor-appointed department with responsibilities of regulating hospital rates, licensing facilities and professionals, planning, reviewing hospital budgets, and overseeing the health care reforms." Stio, *supra* note 1, at 348; see also *supra* note 168 and accompanying text.

¹⁸² See Stio *supra* note 1, at 348.

¹⁸³ FLA. STAT. ANN. § 627.6699(b) (1993); see also Stio, *supra* note 1, at 348 & n.99.

¹⁸⁴ *Id.* at 349. If by December 31, 1994 the state's employees and their dependents do not reach a level acceptable to the Florida legislature, coverage of a basic health plan will be mandated. However, in no event shall the legislature consider any system of employer-mandated coverage unless it finds that the cost-containment goal has not been met and that mandated coverage is still necessary. Any implementation of legislation after December 31, 1994 shall consider the potential impact on employment levels and shall provide a mechanism through appeal to the agency for an exemption to mandated coverage upon a showing of hardship. See FLA. STAT. ANN. § 408.006 (West 1993).

¹⁸⁵ See Stio *supra* note 1, at 348.

Alliances (“CHPAs”)¹⁸⁶ to assist members¹⁸⁷ in obtaining health insurance by establishing purchaser pools and disseminating information on the costs, quality, and efficiency of the available providers.¹⁸⁸ Because of their size,¹⁸⁹ CHPAs are able to obtain volume discounts on health services for their members and CHPAs make it easier for health care providers to capture greater market shares more efficiently.¹⁹⁰ As a result, the economies of scale achieved by providers, regarding marketing expenditure, are realized by consumers in lower premiums.

Membership in a CHPA is voluntary because the Florida legislature did not mandate that employers provide health insurance to their employees under Phase One of the 1992 Act.¹⁹¹ Currently, businesses may join CHPAs as either alliance members or associate alliance members.¹⁹² The primary distinction between an alliance and an associate alliance membership is the rate at which a member is entitled to purchase insurance.¹⁹³ Additionally, alliance members, because they are entitled to the CHPA rates, must pay a small administrative fee, and offer a minimum

¹⁸⁶ CHPAs are state-chartered, private, non-profit organizations that are designed to bring members within a defined geographic region together to obtain better health insurance rates than would be available to members on an individual basis. *See* Platt, *supra* note 166, at 485.

¹⁸⁷ Members include small businesses (under 50 employees), state employees, and Medicaid recipients. *See* Platt, *supra* note 166, at 485, 487 (citing FLA. STAT. ANN. § 627.6699(3)(w) (West 1993)). The statute states:

A small employer is defined as: any person, sole-proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50 percent of its working days during the preceding calendar quarter, employed not more than fifty eligible employees, the majority of whom were employed within this state.

Id.

¹⁸⁸ *See* Platt, *supra* note 166, at 485.

¹⁸⁹ There are only eleven CHPAs throughout the state of Florida. *See id.*

¹⁹⁰ *See id.* at 485.

¹⁹¹ *See supra* note 167 and accompanying text; *see also* FLA. STAT. ANN. § 408.702(5) (West 1993).

¹⁹² Small businesses, state employees and their dependents, and Medicaid recipients are all eligible to become alliance members and to receive the benefits of purchasing medical plans at the CHPA rate. *See* FLA. STAT. ANN. § 408.702(3). For the State to participate in the CHPA as an employer entity, a number of distinct requirements must be met. The Department of Management Services must offer health plans offered by all AHPs within the CHPA to all state employees within the district. *See id.* § 408.7042; *see also* Platt, *supra* note 166, at 488. Specifically, through one or many AHPs, the State must be able to make available at least five HMOs, at least five preferred provider organizations, an exclusive provider organization, and managed-care pure indemnity health plans. *See* Platt, *supra* note 161, at 488.

Big businesses that traditionally provide insurance to their employees are not eligible for alliance memberships, but nevertheless can participate in the CHPA as associate members. In fact, almost “any entity that is not eligible to become an alliance member is eligible to become an associate alliance member. *See id.* at 488-89. The benefit of such participation is that associate members receive information—on medical provider cost, participant satisfaction, and quality of care—which is typically helpful during contract negotiations.

¹⁹³ Associate members are not entitled to the CHPA rate. *See* FLA. STAT. ANN. § 408.704 (West 1993).

number of benefit packages based on the number of individuals they employ.¹⁹⁴

Since the CHPAs were established, the State has remained actively involved in their operation through the Agency for Health Care Administration (“AHCA”). Among the regulatory tasks of the AHCA have been the development of state practice parameters for hospitals and physicians,¹⁹⁵ the development of a standardized claim form for providers and insurers,¹⁹⁶ and the establishment of minimum care standards for CHPAs.¹⁹⁷ With these general regulations in place, the AHCA is responsible for conducting performance reviews,¹⁹⁸ monitoring the CHPA’s conformance with state laws,¹⁹⁹ and establishing a data system with regard to information on provider price, utilization, patient outcome, quality and patient satisfaction.²⁰⁰

More importantly, the AHCA has kept a close eye on the potentially anti-competitive pricing schemes, which conflict with the very rationale behind managed competition. Upon promulgation of the 1993 Act, there was a fear that the creation of AHPs²⁰¹ might allow providers to realize monopoly power, resulting in inflated prices.²⁰²

A second feature of the Act, the Accountable Health Partnership (“AHP”), is a conglomerate of health care providers and health insurance carriers intended to offer health care coverage as a package to CHPA members.²⁰³ Only certified members of an AHP are allowed to negotiate with a CHPA to provide insurance to the CHPA’s members. Certifica-

¹⁹⁴ See FLA. STAT. ANN. § 408.703(5) (West 1993). For example, employers with less than thirty workers must offer their employees at least two Accountable Health Partnerships (AHPs), whereas employers with over thirty employees must offer at least three AHPs to its workers. *Id.*

¹⁹⁵ Practice parameters are important in establishing the reasonable standard of care that physicians must meet. See *id.* § 408.02. The legislature proffered that such standards would “reduce unwanted variation in the delivery of medical treatment, improve the quality of medical care, and promote the appropriate utilization of health care services.” *Id.* § 408.02(1). In reality, such standards may reduce costs through an alternative means. The establishment of a legal reasonable care standard may enable Florida to contain the cost of malpractice insurance by creating greater certainty with regard to the adequacy of care.

¹⁹⁶ See *id.* § 408.7071.

¹⁹⁷ See *id.* § 110.123.

¹⁹⁸ See *id.* § 408.704(3).

¹⁹⁹ See *id.* § 408.704(1) and (3).

²⁰⁰ See *id.* § 408.704(5)(b)(1).

²⁰¹ See HEALTH CARE STAFF ANALYSIS, *supra* note 167.

²⁰² Mandating certification as an AHP member would necessarily eliminate all non-AHP members from the pool of possible health care providers. In turn, this would allow AHPs to set prices low—inducing employers to join CHPAs, thus destroying any external markets. At that point, realizing monopoly power over the market, the AHP would be able to charge whatever cost it wished. See Platt, *supra* note 166, at 491. To regulate this, the Act requires the AHPA to oversee CHPAs to ensure that actions affecting market competition are not for private benefit. See FLA. STAT. ANN. § 408.7041 (West 1993).

²⁰³ See Platt, *supra* note 166, at 486.

tion as a bona fide provider of health care insurance under the AHP criteria requires that the provider be willing to become a Health Maintenance Organization (“HMO”)²⁰⁴ or an insurance provider licensed by the Department of Insurance.²⁰⁵

Once certified, an AHP provider is subject to a number of responsibilities imposed by the State legislature.²⁰⁶ Most importantly, the 1993 Act requires all AHPs to offer both a basic health benefit plan and a standard health benefit plan.²⁰⁷ Plans include coverage for the following: inpatient hospitalization, outpatient services, newborn care, child care supervision, care for adopted and handicapped children, mammography, emergency care out of the geographic area, and hospice coverage when appropriate.²⁰⁸ The purpose of these requirements is to guarantee CHPA members certain services and to attract business by defining the parameters of competition among AHPs to improve services and lower premiums.²⁰⁹ The primary difference between the types of plans is the level of coverage that they provide.²¹⁰

²⁰⁴ See *infra* note 234.

²⁰⁵ See FLA. STAT. ANN. § 408.706(2) (West 1993). To gain certification, the AHP must also demonstrate that it:

- (a) Is licensed or certified with the [Department of Insurance] and the licensure agency for participating providers;
- (b) Has demonstrated the capacity to administer the health plans it is offering;
- (c) Has the ability, experience, and structure to arrange for the appropriate level and type of health care services;
- (d) Has the ability, policies, and procedures to conduct utilization management;
- (e) Has the ability to achieve, monitor, and evaluate the quality and cost-effectiveness of care provided by its provider network;
- (f) Has the ability to assure enrollees adequate access to providers of health care, including geographic availability and adequate numbers and types;
- (g) Has the ability and procedures to monitor access to its provider network;
- (h) Has a satisfactory grievance procedure and the ability to respond to enrollees' calls, questions, and complaints;
- (i) Has the ability to use medical outcome data to educate network providers, update utilization review procedures, and recommend modifications to benefit designs;
- (j) Has the ability to recruit and retain health care practitioners who are minorities as defined in 288.703(3), with special emphasis on recruitment and retention of African-American health care providers; and
- (k) Has the ability and policies that allow patients to receive care in the most appropriate, least restrictive setting.

Id.

²⁰⁶ For a list of requirements, see Stio, *supra* note 1, at 354 n.119; see also FLA. STAT. ANN. § 408.706 (West 1993) for a list of requirements. The statute holds that any accountable health partnership not in compliance with the requirements may have its designation as a health care network suspended or revoked. *Id.*

²⁰⁷ See FLA. STAT. ANN. § 627.6699(12) (Supp. 1992).

²⁰⁸ See *id.* § 627.6699(12)(b)(4) (Supp. 1992).

²⁰⁹ See *id.* § 627.6699(2).

²¹⁰ See Platt, *supra* note 166, at 493. For example, a basic policy has an annual maximum of \$50,000, whereas a standard policy might have a lifetime benefit cap of \$1,000,000. See *id.* at 493 n.87.

In conjunction with voluntary managed competition, Florida planned to implement a Medicaid buy-in program and a MedAccess program. MedAccess provides primary and preventive care along with certain mandatory insurance²¹¹ capped at \$500,000 (for life)²¹² for eligible residents.²¹³ The Florida legislature provided for the MedAccess program to be paid for through the collection of premiums,²¹⁴ while health care reimbursements would take place at the appropriate Medicaid rates.²¹⁵ This system promised to reduce the cost of providing health care to eligible residents by using the existing provider structure in a more efficient way.²¹⁶

The final component of Florida's reform effort is the realignment of the state's Medicaid program, through the creation of the Medicaid buy-in program.²¹⁷ Under the program, eligible residents must contribute a small amount to the premium, determined by an income-based sliding scale.²¹⁸ The buy-in program was established to subsidize health care for individuals who are not eligible for Medicaid but cannot afford health insurance (namely, those residents with incomes between the federal poverty level and 250 percent of the federal poverty level).²¹⁹ The Medicaid buy-in program is the only part of the Florida plan that requires a federal waiver.

D. TENNESSEE PLAN

1. *Brief History of Tennessee Health Care Prior to Implementation of TennCare*

As was the case with the other states in this survey and most states across the country, Tennessee faced problems of rising health care costs and diminishing access to quality care.²²⁰ These problems were exacerbated by the state's inability to bring the medical services problem under

²¹¹ See FLA. STAT. ANN. § 408.904(2) (West 1993).

²¹² See *id.* § 408.905(5).

²¹³ Eligibility is based on the following requirements: 1) family income must be equal to or below 250 percent of the federal poverty level (250 percent of the federal poverty level for a family of four in 1993 was approximately \$36,000. See *Association of Voluntary Hospitals of America, CHPA's: Florida's Prescription for Health Care Reform: 20 of the Most Asked Questions About the 1993 Reform Bill*, at question 8 (1993)), 2) must have been without health insurance for the last year, and 3) cannot otherwise be eligible for Medicare or Medicaid. See FLA. STAT. ANN. § 408.903(1)-(3) (West 1993).

²¹⁴ See *id.* § 408.908(7).

²¹⁵ See *id.* § 408.906(2).

²¹⁶ See Platt, *supra* note 166, at 493-94.

²¹⁷ See Stio, *supra* note 1, at 357.

²¹⁸ See FLA. STAT. ANN. § 409.914 (West 1993).

²¹⁹ See *id.* § 409.914(2)(a).

²²⁰ David M. Mirvis, M.D. et al., *TennCare—Health System Reform for Tennessee*, 274 JAMA 1235 (1995). Medicaid costs rose from \$692 million in 1988-1989 to \$2.7 billion in 1993-1994. The number of recipients grew from 540,000 to 1,000,000 in the same time pe-

control. Thus, the rapid growth in Medicaid enrollment was a reflection on the inability of Tennesseans to afford private health insurance and not on the comprehensive nature of the State's health coverage.²²¹ Faced with these problems, the Tennessee legislature explored three different options before arriving at TennCare as the State's health delivery system.

Initially, the Tennessee legislature contemplated an increase in taxes accompanied by a restructuring of the tax burden as a source of funding for the state health care delivery budget.²²² The proposal called for the imposition of a tax on hospitals and other professional health care delivery agents. Not surprisingly, the idea was met by vigorous opposition from powerful health care lobbyists.²²³ Ultimately, the taxation option was rejected because it posed too great a financial burden on a relatively poor state.²²⁴

A second option was to reduce either the number of services provided, or the reimbursement rates for those services, without affecting the state delivery or finance systems.²²⁵ This, however, did not comport with the state's goals of increasing access and controlling costs while providing a comprehensive set of services. To the contrary, implementing such a system would have shifted the cost of financing health care to the privately insured, while reducing Medicaid patient's access to treatments and raising the absolute fee (as compared to the Medicaid reimbursement fee) for medical services.²²⁶

The final solution reached by the Tennessee state government was TennCare²²⁷—a comprehensive reform of the State's health delivery and finance systems.²²⁸ An important difference between the Tennessee health care plan and that of other states is the fact that although Tennessee's plan may be facially similar, in practice it has *not* made universal health care coverage an explicit goal.²²⁹ Interestingly, the Tennessee ap-

riod. As a result, Tennessee ranked eleventh in number of Medicaid enrollees and seventeenth in total Medicaid expenditure among the fifty states. *See id.*

²²¹ In fact, despite the growth in enrollment, 470,000 residents had no health insurance in 1993. Mirvis et al., *supra* note 220, at 1235.

²²² *See id.* Tennessee does not have a state income tax. *See id.* As such, the significance of such a tax increase would be significantly less than expected in other states.

²²³ *See id.* The federal government also restricted this sort of financing, placing an even greater burden on the state's plan. *See id.*

²²⁴ *See id.* Tennessee's mean per capita income ranks 36th among the states. *See* U.S. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 1993 (1994).

²²⁵ U.S. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 1993 (1994).

²²⁶ *See* Mirvis et al., *supra* note 220, at 1235-36.

²²⁷ TennCare became effective state law on January 1, 1994. *TennCare Medicaid Program Goes into Effect in Tennessee*, BNA HEALTH CARE DAILY, Jan. 13, 1994, at 1.

²²⁸ *See* Mirvis et al., *supra* note 220, at 1236.

²²⁹ The goal was to provide comprehensive health insurance at a cost borne by the state government for all Tennessee residents who could not obtain it by traditional means. *See id.* at

proach regulates both the supply and demand of health care by fixing the amount of money committed to the program for a given year and placing similar pre-defined restraints on the group of people recognized as beneficiaries.²³⁰

In order for TennCare to be implemented, Medicaid waivers from the federal government were required. Similar to the Oregon Project, Tennessee submitted its waiver to the Health Care Financing Administration under section 1115 "research and demonstration" projects. Legislators hoped to gain the necessary waivers by September 1993 in order to facilitate implementation by the January 1, 1994 deadline.²³¹ Although the HCFA did not grant Tennessee its Medicaid waiver until late November 1993, the plan went into effect, as scheduled, on January 1, 1994.²³²

2. Legislation

TennCare has been called the "boldest health care reform that any state has ever undertaken." It is based on the premise that opening enrollment to all of the state's Medicaid and uninsured residents (both above and below the poverty line) will create a large enough pool of beneficiaries to defray the cost of insuring high risk residents. Such an initiative would not have appeared so bold had the legislature not simultaneously capped the amount of money spent on the program by both the state and federal government. These two factors in concert are what make TennCare unique.

To achieve universal access, TennCare established a maximum enrollment of 1.775 million people.²³³ Among those eligible for coverage under the program were former Medicaid patients,²³⁴ formerly uninsurable patients (on the basis of pre-existing conditions), and people who were not formerly eligible for employer of state-sponsored health coverage. Upon Tennessee's application for a Medicaid waiver, the federal government expressed concern about the program's ability to provide adequate care for almost twice as many patients without substantially af-

1235. "The net result, it was hoped, would be to extend coverage to *more* citizens without increasing taxes and public expenditure." *Id.*

²³⁰ See James F. Blumstein, *Health Care Reform: The Policy Context*, 29 WAKE FOREST L. REV. 15, 40 (1994). Such a model has been recognized as a "hybrid" plan, commingling notions of obligation and entitlement in order to justify the plan's existence. See *id.*

²³¹ See Mirvis et al., *supra* note 220, at 1236.

²³² *Id.* at 1239. Many blame the short amount of time between recognition and implementation as responsible for substandard delivery and informational systems.

²³³ See *id.* Had Tennessee reached a 1.775 million enrollment level for TennCare, it would have covered 98 percent of the state population.

²³⁴ When TennCare was implemented, the Medicaid community was one million members strong. See *id.*

fecting costs.²³⁵ As a result, the federal government required Tennessee to lower its enrollment cap to 1.4 million people.²³⁶

Similar to Florida's program, the Tennessee legislature divided the state into regions for the purpose of administering the delivery of health care. The Community Health Agency Act created twelve regions statewide. A Managed Care Organization ("MCO")²³⁷ has the right to choose which regions it would like to compete for patients, but once it has made that determination, it may not exclude any patient from enrollment because of a preexisting condition.²³⁸ Under TennCare, MCOs, which may be either HMOs or Preferred Provider Organizations ("PPOs"),²³⁹ must be non-profit, private organizations licensed by the state to provide the full range of services to all insured.²⁴⁰

Logically, after establishing this coordinated provider system, the Tennessee legislature was required to establish exactly what services would fall under "the full range of services" guaranteed to all enrollees. Specifically, TennCare covers a wide range of inpatient and outpatient services. Preventative care for beneficiaries up to the age of twenty-one, comprehensive hospital and physician services, laboratory and x-ray services, home health care, medications, medical equipment and supplies, and emergency ambulance transport are all covered without limits.²⁴¹ Limited services include inpatient mental health and substance

²³⁵ See *id.* To ensure adequate care, the federal government required the state to provide evidence that each participating managed care organization had a panel of physicians large enough to treat all covered patients. Other safeguards included adequate informational and quality assurance systems, and patient satisfaction evaluations.

²³⁶ See *id.*

²³⁷ A Managed Care Organization is an organization that coordinates the provision of care to a group of insured individuals. Typically, the goal of these organizations is cost containment, and as such, they employ a number of different mechanisms for assuring that the cost of care is cheaper than it would be under a similar third-party payer system. Examples of MCOs are HMOs and PPOs. See *infra* note 239.

²³⁸ See Mirvis et al., *supra* note 220, at 1239. Only two of the state's twelve MCOs accept patients statewide, and five MCOs only function in one region. See *id.*

²³⁹ See *id.* The distinction between HMOs and PPOs is that HMOs guarantee particular rates to providers, whereas PPOs may adjust the rates they award providers if the reimbursed amount exceeds the capitalization funding they receive from the state. As such, HMOs shoulder most of the financial burden and risk of service, but PPOs pass that risk on to health care providers. The regulatory consequence of this provider dichotomy is that HMOs are required by state law to maintain a significant capital reserve while PPOs are not. Of the twelve existing Tennessee MCOs, eight are HMOs, but as of March, 1995, nearly two-thirds of all TennCare participants were enrolled in a PPO, with Blue Cross/Blue Shield of Tennessee covering nearly half (48.9 percent) of all TennCare patients. See *id.* at 1236.

²⁴⁰ See *id.* at 1236.

²⁴¹ "TennCare covers a wide range of inpatient and outpatient services, such as preventative care . . . limits." See *id.* at 1237. Under Medicaid, the extent to which each of these services was available was restricted. For example, Medicaid patients were allowed only seven prescriptions per month and only twenty-four physician visits per year. See *id.*

abuse treatment, as well as outpatient mental health services.²⁴² Not covered under TennCare are long term care and Medicare premiums, which receive the same level of reimbursement they had under the state Medicaid program.²⁴³

TennCare's financing requires that its members be subject to premiums, copayments and deductibles on the basis of income.²⁴⁴ Residents formerly insured by Medicaid and those generating incomes under the federal poverty level typically do not have to pay a premium for their services under TennCare.²⁴⁵ All other participants are required to pay monthly premiums, copayments and/or deductibles on the basis of a sliding scale, relative to their income.²⁴⁶ Carrier MCOs may throw participants who fail to pay their premiums out of the program.²⁴⁷

The bulk of the financial support for TennCare, of course, comes from the state and federal governments. Thus, in order to obtain the waivers necessary to implement the program, Tennessee had to convince the HCFA that its proposal would be budget neutral²⁴⁸ as far as the federal government was concerned.²⁴⁹ Recognizing that federal support would be no greater than the state could have expected under Medicaid, and that it was necessary to cap state payments to health care, the legislature was forced to devise a creative plan for insuring nearly 50 percent

²⁴² *See id.* Also covered, but to a lesser degree, are inpatient mental health and substance abuse treatments, as well as outpatient mental health services. *Id.* For example, in-patient psychiatric care for adults under the age of sixty-five was not covered by Medicaid. Originally, Tennessee had proposed to provide this service without limits but was denied that opportunity by the federal government. *See id.* Recent developments have resulted in further reductions in psychiatric services, which have prompted special interest groups to criticize the state program. *See id.*

²⁴³ *See id.* These services account for nearly \$1 billion per year. *Id.*

²⁴⁴ *See id.* at 1237.

²⁴⁵ *See id.* at 1239.

²⁴⁶ *See id.* The premium may not take into account anything besides age, gender, geographic region and income. In other words, factors such as pre-existing conditions cannot be selected against under this fee scale.

Those individuals earning incomes at 200 percent of the federal poverty level or greater may pay premiums equal to, or in excess of, the capitation rate. This, however, does not render coverage useless because capitation rates only restrict payments to MCOs and not the overall package of services the policyholder is entitled to receive. "All providers . . . are paid by negotiated rates; the state is not involved in establishing provider rates." *Id.*

²⁴⁷ This problem may make it impossible for Tennessee to ever achieve universal access to health care.

²⁴⁸ Budget neutrality requires that the federal government expend no greater amount of money on TennCare than it would have under the Medicaid plan, had it remained in effect. *See id.* at 1239.

²⁴⁹ *See id.*

more people²⁵⁰—who would likely be less healthy as a group²⁵¹—with approximately the same amount of money.²⁵² The solution was an elaborate per person capitation system that discounted²⁵³ the payment schedule the state would pay to each MCO.²⁵⁴

It is crucial to note that the distinctive feature of Tennessee's program is that the budget is set independent of any anticipated number of insured. The number of people that the state can provide coverage for is then calculated from that number.²⁵⁵ In real terms, the state and federal government agreed on a \$2,192,950,800 budget for TennCare for 1994.²⁵⁶ From this total the state calculated an annual capitation rate of \$1641 per person²⁵⁷ and then discounted it to \$1214.²⁵⁸ This formula explains the increase in access to health care, but because it is not discussed in absolute dollars, it does not address the overall savings that the Tennessee legislature promised as a result of the plan's adaptation.

Thus, the last feature of Tennessee's unique proposal was that the real savings created by TennCare stem from the legislative requirement that the state cap the program's growth rate at a rate equal to the expected growth rate of the state economy.²⁵⁹ In this way the state can effectively reduce the annual growth rate of health care delivery from approximately 18 percent to under 5 percent.²⁶⁰

²⁵⁰ In its first year of implementation, TennCare capped its enrollment at 1.2 million people, despite setting goals to cover 1.4 million. *See id.* at 1237.

²⁵¹ Because TennCare provides insurance to previously medically uninsurable residents, it is reasonable to believe that the addition of 400,000 enrollees of this character would create a greater financial burden on the delivery system.

²⁵² *See supra* notes 233-36 and accompanying text.

²⁵³ *See* Mirvis et al., *supra* note 220, at 1237. Discounts were taken for continuing charity care, local government contributions, and average co-payments by beneficiaries. *See id.*

²⁵⁴ *See id.* at 1239.

²⁵⁵ Oregon also sets its state health care budget prior to allocating funds. The difference, however, is that Oregon rations services while Tennessee caps the number of enrollees that its plan can bear, without severely restricting the services to which they are entitled.

²⁵⁶ *See* Mirvis et al., *supra* note 220, at 1239.

²⁵⁷ The state compared this rate to the adjusted payments made for state employees in 1991-1992 (\$1664) and Medicaid recipients in 1993-1994 (\$1643), as well as the average national individual premium rate for HMOs in 1993 (\$1636), and argued that it was appropriate. *See id.* at 1237-38.

²⁵⁸ *See id.* at 1237.

²⁵⁹ *See id.* at 1239.

²⁶⁰ The proposed Medicaid expenses for 1994-1995 were \$3,965,900,000, for 1995-1996 they were projected to be \$4,662,700,000, and for 1996-1997 they were projected to be \$5,498,200,000. *Id.* In contrast, the TennCare expenses were figured to be \$3,176,600,000, \$3,331,800,000, and \$3,496,700,000 for the same three-year period. *Id.* at 1238.

IV. EXPLORING THE OPPORTUNITIES FOR “COOPERATIVE FEDERALISM”: AN ALTERNATIVE TO THE FEDERAL SOLUTION

As demonstrated, federal solutions have been unable to remedy the major problems plaguing the United States’ health care delivery system.²⁶¹ The federal government’s inability to reach a consensus on a national health care plan suggests not only that the differences between the executive and the legislature are irreconcilable, but also that congressional representatives remain adamant about individual interests.²⁶² For these reasons, it may be assumed that most, if not all, comprehensive federal proposals would meet a fate similar to that of President Clinton’s Health Security Act of 1993. In light of this, the following proposal builds on the idea of “cooperative federalism.”²⁶³ It assumes that the only way to obtain a consensus on health care in Congress is to allow states to administer health care in a manner consistent with their individual needs, subject to the general mandates of the federal government.²⁶⁴

A. GOALS OF HEALTH CARE REFORM

It has been the premise of this paper that the most pressing problems with the United States health care delivery system are limited access and escalating costs.²⁶⁵ In addition to these concerns, there are a number of other problems that must be addressed by any comprehensive health care reform. The most significant secondary concerns include quality assurance,²⁶⁶ breadth of coverage,²⁶⁷ preservation of employee autonomy

²⁶¹ See *infra* Part I.B.1; see also Beresford, *supra* note 28, at 1422.

There is an apparent public consensus that some health care reform is needed and there is no dearth of ideas about how to accomplish it. But uncertainty surrounds the durability of the consensus and the ability of Congress to produce a plan that will substantially remedy agreed upon problems of inadequate access and high costs.

Id.

²⁶² Notwithstanding the obvious schism between the Republican and Democratic solutions discussed above, each state’s representatives advocate personal agendas specific to the needs and desires of their constituents. See generally LaGuarda, *supra* note 63, at 170 (noting that states are only one of many interests represented in Congress).

²⁶³ See *supra* Part I.B.2; see also Holloway, *supra* note 23.

²⁶⁴ See *id.*

²⁶⁵ See *supra* Part I.A. See generally Note, *supra* note 11, at 1327 (arguing that private restructuring of the health care delivery market is the cause of rising health care costs and a growing number of uninsured).

²⁶⁶ Marc A. Rodwin, *Conflicts in Managed Care*, 332 NEW ENG. J. MED. 604, 604 (1995). See also Marc A. Rodwin, *Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs*, 32 HOUS. L. REV. 1321, 1332 (1996). “Many quality problems in managed care probably also flow from the failure of the organizations to review medical decisions or ensure quality in other ways.” *Id.*

²⁶⁷ Breadth of coverage is an illusive concept that implicates access to medical services, generally, as well as those specific services that are made available. See generally Mark A. Rodwin, Symposium on Consumer Protection on Managed Care: Mechanisms of Consumer

(with regard to health benefits),²⁶⁸ and protection of the medical profession.²⁶⁹ These related concerns consistently frustrate the implementation of a national health care policy. Further, each of these issues reflects a concern of a distinct sector of society and demand important consideration in formulating national health care reform. The achievement of certain goals will not necessarily subvert the need to address the others.

1. *Quality Assurance*

It has been the longstanding foundation of the medical profession that the best interests of the patient are paramount to any other concern.²⁷⁰ Initially, the ethical standards at the heart of medical practice were developed and regulated by clinicians. This prolonged era of self-regulation coincided largely with the dominance of fee-for-service payment schemes.²⁷¹ Self-regulation, in conjunction with various legal remedies arising under both contract²⁷² and

Protection—the Marketplace and Regulation: *Managed Care and Consumer Protection: What Are the Issues?*, 26 SETON HALL L. REV. 1007 (1996). “Most HMOs and some PPOs shift part of their financial risk for providing services to doctors, giving them an incentive to make frugal use of diagnostic tests, referrals, and hospitalization.” *Id.* at 1012.

²⁶⁸ “More than two-thirds of the employees in this country have no choice in which medical plan they receive.” Stio, *supra* note 1, at 324 n.8 (citing Release to State Hospital Administrators on the Clinton Plan—Health Security Act, on file with the Seton Hall Legislative Journal).

²⁶⁹ See Beresford, *supra* note 28, at 1421-22 (relating the restrictions that the Clinton HAS would place on physicians); see also Barry M. Manuel, M.D., F.A.C.S., *Physician Liability Under Managed Care*, 182 J. AM. COLL. SURG., 537-46 (1996).

²⁷⁰ See generally Edward B. Hirshfeld & Gail H. Thompson, *Symposium: On Physician Decision-Making and Managed Care: Medical Necessity Determinations: The Need for a New Legal Structure*, 6 HEALTH MATRIX 3 (1996). The American Medical Association adopted the Hippocratic Oath, which emphasizes the obligation of the physician to put the patient’s interest first, shortly after its formation in 1847. See *id.* at 6; see also Marcia Angell, *Medicine: The Endangered Patient-Centered Ethic*, HASTINGS CENTER REP., Feb. 1987, at S12; Arnold S. Relman, *The Future of Medical Practice*, HEALTH AFF., Summer 1983, at 5, 18 (physicians should act as “fiduciaries or representatives for their patients in evaluating and selecting the services offered by the health care industry.”).

²⁷¹ Michael J. Malinowski, *Capitation Advances in Medical Technology and the Advent of New Era in Medical Ethics*, 22 AM. J.L. & MED. 331, 334 (1996). During the era of self-regulation, medical ethics were delegated to the province of practicing clinicians. Ethical concepts were used to generate codes of professional conduct enforced by the profession itself, primarily through boards and institutional proceedings. Patient well-being as defined in a ‘highly paternalistic and authoritarian fashion’ and beneficence—the best interest of the patient as determined by his or her caregiver—served as the guiding principle. *Id.* (citing Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 728 (1994)).

²⁷² Initially courts developed the notion of an implied contract between a doctor and her patients. See Hirshfeld & Thompson, *supra* note 270, at 9. This implied contract action saddled physicians with a fiduciary duty toward their patients. *Id.* (citing 61 AM. JUR. 2D §§ 166-173 (1981)). “The origin of this duty is the ethical obligation of the physician to make concerns for the patient the physician’s first consideration, and the obligation of the physician to do all that is possible to benefit the patient.” *Id.* at 9.

tort,²⁷³ provided patients with adequate protection from incompetent, or unethical, doctors.

The creation of Medicaid, Medicare, and managed care, however, has had a dramatic effect on the delivery of medical services. These systems have significantly altered the payment schedules of physicians delivering medical services to plan members. Under each of these programs, physicians are no longer able to charge all patients the market rate for services. In fact, in the case of many managed care organizations, services were no longer the standard by which to determine payment.²⁷⁴ Instead, physicians were compensated on a per patient basis.²⁷⁵ The changed dynamic forced physicians to alter their collective notion of adequate care.²⁷⁶ In the managed care world, physicians reap the largest rewards for practicing "assembly-line medicine."²⁷⁷ Assembly-line medicine demands that physicians spend less time with each individual patient, because profits are linked directly to the number of patients served, notwithstanding the quality of care provided. The clear economic implications of managed care for physicians were less care for each individual patient, but more patient care in the aggregate.

If one accepts the idea that quality of care is in some way tied to the amount of time that a physician spends with a patient, then it seems clear that managed care plans tend to reduce the level of the quality of care

²⁷³ *Id.* A physician must apply the care and skill commonly possessed by a member of the profession in good standing. Typically, each side will introduce evidence about the standard of care, and the court will decide what that standard is for the particular case. In the case where a physician does not provide all of the necessary care, the court must determine the following: 1) what medical care would have benefited the patient, and 2) whether that benefit would have been significant enough to provide in light of all other considerations. *See id.*

²⁷⁴ Under the traditional fee for service model of health care delivery, many HMOs believed that physicians had an incentive to provide too much health care because they were paid according to services rendered. *See* Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399, 402 (1996). More common managed care schemes involve either salary or capitation payments. *See id.*

²⁷⁵ Capitation is a system under which a physician is paid a fixed amount per patient per month. In return, the physician agrees to provide all of the necessary services, irrespective of their ultimate cost. *See id.* (citing HCFA Final Regulations, 61 Fed. Reg. at 13,432; HCFA Proposed Regulations, 57 Fed. Reg. at 59,026).

²⁷⁶ Marc A. Rodwin, *The Marketplace and Regulation: Managed Care and Consumer Protection: What Are the Issues?*, 26 SETON HALL L. REV. 1007, 1011 (1996). "Most HMOs and some Preferred Provider Organizations (PPOs) shift part of their financial risk for providing services to doctors, giving them an incentive to make frugal use of diagnostic tests, referrals, and hospitalization. Physician risk sharing can bias physician judgment and lead doctors to deny appropriate services." *Id.*

²⁷⁷ Assembly-line medicine is the term I use for providing as little care to as many people as possible. Under a system of capitation, a physician is rewarded for the number of patients he is responsible for, not the amount of care that he provides. Thus, the physician has an incentive to see as many people as he possibly can. This creates the appearance of practicing medicine on an assembly-line, where the physician passes patients through as quickly as possible.

administered.²⁷⁸ Nevertheless, proponents of managed care put a slightly different spin on this argument. They insist that insurance, generally, creates the problem of moral hazard—artificially raising the standard of adequate care.²⁷⁹ Their rationale is that in a third party-payer system patients are more likely to accede to care that they would refuse if they had to pay for it themselves.²⁸⁰ This potential undesirable incentive, coupled with the other practical, financial and personal incentives,²⁸¹ and the fact that physicians have to administer a greater amount of care, results in patients actually receiving excess care in the fee-for service system.²⁸² For the purposes of proposing a solution, it will be assumed that both of these assertions are, in fact, viable.

Alternatively, it should be noted that there may be a second direct correlation between reducing compensation rates and decreasing the quality of care. Specifically, as capitation rates and negotiated medical services contracts continue to handcuff the invisible hand of the free market for health care, the monetary incentive to practice medicine diminishes. The consequence of this reduced monetary incentive is that some individuals with the greatest potential will self-select themselves out of the pool of medical school candidates, thus lowering the quality of medical care over time.²⁸³

²⁷⁸ This reduction in the time and amount of services rendered by physicians is the express intent of managed care. Some commentators argue that it actually increases the level of quality. For example, see Francis H. Miller, *On Physician Decision Making and Managed Care: Capitation & Physician Autonomy: Master of the Universe or Just Another Prisoner's Dilemma? What Can Britain's National Health Service Experience Teach Us?*, 6 HEALTH MATRIX 89, 91 (1996). "Provider capitation is marketed as a win-win strategy for coping with both cost and quality problems perennially bedeviling the world's health care systems. It gives physicians incentives to shop carefully when they exercise their economic power to order clinical treatments for patients." *Id.*

²⁷⁹ See *supra* note 267.

²⁸⁰ Furthermore, the doctor is more likely to prescribe as much care as necessary, and in some cases more, because he is not financially at risk for the ineffectiveness of the additional units of care.

²⁸¹ In a fee-for-service system, physicians get paid for the services they administer to patients. Hence, the more services they provide, the more money they make. In administering extra (excessive) medical care, physicians can also shield themselves from liability in the event that something unforeseen happens to the patient.

²⁸² This theoretical self-satisfaction has not yet manifested itself in the number of applications being filed for medical school.

Some commentators argue that there is a medically optimal and socially optimal level of care that can be utilized in any given instance. Under a fee-for-service system, the medically optimal level was favored. The expectation was that any treatment deemed to have a positive marginal value was to be considered. Under a managed care system, the socially optimal level of care is more appropriate. In this situation, a patient's medical needs are considered in concert with those of the rest of the patient population, and the scarce health care resources are administered in their most cost-effective fashion.

²⁸³ Motivated by increasing their profit margins, managed care organizations and large employers are constantly looking for ways to reduce the costs of providing medical care. One of the most effective methods they have found to date is capitation. See *infra* notes 270-78 and

2. *Breadth of Coverage*

The uncertainty associated with illness creates an incentive for individuals to acquire medical insurance. However, insurance does not suggest security, *per se*. Security is related to the comprehensiveness of the insurance policy. For example, an individual whose insurance package does not cover hospital care has no assurance that he will not have to pay a considerable portion of his yearly health care expense out of pocket. Essentially, the greater the scope of coverage an insurance policy provides, the greater the security of the individual. As a result, premiums increase at a rate commensurate with the scope of coverage. Thus, in a world where individuals are faced with the reality of finite resources, they must make difficult decisions about how much security (medical coverage) to purchase.²⁸⁴

The individual's decision, in most cases, will be directly impacted by the policy provided by his employer (if his employer chooses to insure), managed care organizations, insurance companies, and the government. Historically, the interests of these parties have stood in direct opposition to the individual seeking coverage.²⁸⁵ The success of an insurance provider is contingent on its ability to contain costs.²⁸⁶ Therefore, insurance companies promulgated physician reimbursement limits as an additional cost-saving mechanism in conjunction with restrictions placed on benefit packages.²⁸⁷

For-profit managed care plans found that the restriction of benefits could lead to generous profit margins.²⁸⁸ Although these institutions may be reaping the benefits of a system that sacrifices overall public welfare, they should not be made the system's scapegoats. The federal government and large employers are equally culpable.²⁸⁹ By refusing to establish a consistent federal minimum level of benefits for both insurance companies and large employers and concurrently refusing to lift the

accompanying text. Capitation is effective at keeping costs down because it shifts the financial risk of excessive treatments to physicians, thus encouraging them to consider the marginal costs of additional units of treatment. *See generally* Andrew Ruskin, *The Legal Implications of Using Capitation to Affect Physician Decision Making Processes*, 13 J. CONTEMP. HEALTH L. & POL'Y 391 (1997). *See also* *Universal Access to Health Care*, *supra* note 11, at 1326-27.

Patients covered by third-party insurance in a fee-for-service system prospered because their interests were aligned with doctors, with respect to treatment decisions. Specifically, the fact that neither the patient nor physician bore the cost of treatment allowed the physician to utilize every available treatment that produced or might produce even the slightest benefit to the patient. *See generally* Stephen Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399 (1996).

²⁸⁴ *See generally* Ruskin, *supra* note 283.

²⁸⁵ *Id.*

²⁸⁶ *Id.*

²⁸⁷ *See infra* notes 22-23 and accompanying text (discussing Medicaid and Medicare).

²⁸⁸ *Id.*

²⁸⁹ *See supra* note 22 and accompanying text.

ERISA restriction on state legislation, the federal government tacitly encouraged large corporations to opt out of state-mandated health insurance floors.²⁹⁰ Ultimately, low-income employees were forced to purchase health insurance that was severely limited in scope.²⁹¹ Limiting insurance coverage for these individuals results in increased costs²⁹² for the rest of the privately-insured public (who are forced to pay for the uninsured services required by the growing number of underinsured).²⁹³

3. *Whither ERISA?: Limiting Large Employer Autonomy*

The maintenance of ERISA suggests a federal governmental preference for large employer autonomy in the area of employee benefit decisions.²⁹⁴ Despite the fact that health care is seemingly easy to exempt from the ERISA scheme, Congress has refused to recognize such an exemption for health care. The result of Congress's decision to maintain the scope of the ERISA preemption has been the protection of employer autonomy and, typically, the frustration of state health care policy objectives.²⁹⁵ Congress has offered a number of rationales for refusing to recognize a health care policy exemption from ERISA. These rationales include the following: 1) permitting state regulation of employee benefits will create significant administrative difficulties for corporations that operate in several states;²⁹⁶ 2) recognizing an ERISA exemption for health care reform implicitly recognizes the greater importance of employer

²⁹⁰ See *supra* notes 93-97 and accompanying text.

²⁹¹ *Id.* Managed Care capitation systems operate similarly. The creation of a per patient reimbursement rate made it considerably more difficult for physicians to shift costs among patients. The theoretical consequence of a physician's inability to shift costs is the potential creation of a "tiered" health care system. See generally E. Haavi Morreim, *Economic Disclosure and Economic Advocacy*, 12 J. LEGAL MED. 275, 288 (1991) (discussing the phenomenon of "stratified scarcity" whereby "it is sometimes literally impossible for the physician to provide for the indigent patient the same level of care that the better funded majority receives.").

²⁹² The cost increase may manifest itself in a number of ways, including tax increases, raised premiums, or increased fee-for-services charges.

²⁹³ See Bodenheimer, *supra* note 9, at 634.

²⁹⁴ See generally *supra* notes 82-99 and accompanying text. See Groves *supra* note 83, at 619. "The courts are unlikely to interpret ERISA in a manner deferential to state health care reforms if the interpretation interferes with national policies of uniformity and protection of employee benefit plans—policies that emerge from a reading of the statute and its legislative history." *Id.*

²⁹⁵ See generally Hancock, *supra* note 2; Groves, *supra* note 83; cf. Brown, *supra* note 93 (concluding that ERISA need not be amended for states to effectively regulate health care).

²⁹⁶ See *supra* note 86. "ERISA is intended to preempt the field for federal regulation, thus eliminating the threat of conflicting or inconsistent state and local regulations of employee benefit plans." 120 CONG. REC. 29,933 (1974). ERISA was created to promote uniformity in the treatment of corporations that operate in many states. *Id.* As such, section 514 states that the Act supersedes "any and all State law insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144 (1994). See Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J.L. & MED. 251 (1997); Stio, *supra* note 1.

health care mandates,²⁹⁷ which run counter to one of the purposes of ERISA;²⁹⁸ and 3) cracking large corporations' ERISA shield will result in diminished efficiency due to reduced autonomy in their business decisions.²⁹⁹

Compelling though they may be, these arguments should not end the debate over the efficacy of ERISA preemption. Rather, state and federal legislators ought to establish a balance between public health care policy and private corporate interests. ERISA and national health care policy need not be mutually exclusive. It is foreseeable that a regime could be established under which employers maintain autonomy over decisions pertaining to their business; but after making an affirmative decision to insure, they would be subject to state minimum benefit laws, thus guaranteeing the sufficiency of employer-sponsored health care insurance plans.³⁰⁰

4. *Protection of the Integrity of the Medical Profession*

In most cases, those forgotten in the battle over health care delivery are the medical service providers. Under the current status of the law, physicians are subject to unlimited liability for treating (or not treating) illnesses on the basis of decisions that are overseen (and sometimes ultimately made) by uninformed insurance agents.³⁰¹ Additionally, by placing direct incentives on physicians, managed care has strained the relationship between physicians and patients, two groups whose interests were commonly aligned under the fee-for-service model of payment.³⁰²

²⁹⁷ Hawaii currently utilizes employer mandates to provide health care to the majority of its citizens. As anticipated, the consequence of this regime is that Hawaii is considered one of the worst states in the country to open a small business in. See Stio, *supra* note 1, at 339 n.58. "Opponents of this method of financing health care argue that an employer mandate is a 'free lunch' for the employees of this country and is simply an additional cost that will result in small businesses laying off workers and instituting hiring freezes." *Id.*

²⁹⁸ See *supra* notes 88-90 and accompanying text; cf. *supra* note 98 (noting that the Supreme Court in *Travelers* suggested a narrowing of the interpretation of the ERISA preemption clause).

²⁹⁹ This argument recognizes the possibility that a limited ERISA exemption for health care could lead to greater exemptions in the future, resulting in employer mandates and/or the promulgation of state prescribed procedural requirements governing the decision-making processes of large corporations.

³⁰⁰ See *infra* Part IV.B.4. At least two commentators have argued that "amending ERISA would only confuse sincere federal efforts to design a national health care program." Holloway, *supra* note 23, at 451.

³⁰¹ See generally Hirshfeld & Thompson, *supra* note 270, at 11 (discussing the bar on the corporate practice of medicine and other statutory safeguards, including the prohibitions on fee-splitting and self-referrals).

³⁰² See David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141 (1995). Capitation and other methods of payment have forced physicians to practice a "cost efficient" brand of health care that eliminates treatments with diminishing marginal utility. Utilization review is a system under which an MCO analyzes a physician's treatment decisions to determine if he is practicing such "cost efficient" care even

Not surprisingly, as managed care continues to present a viable form of medical insurance, the physicians' predicament grows steadily worse.

Equally distressing for physicians has been the federal government's unwillingness to allow them to protect themselves. Under anti-trust law, physicians may not organize to obtain competitive prices³⁰³ despite the fact that the government does not place similar obstacles in the way of insurance providers or purchasers, whom the government affirmatively assists in enhancing their bargaining position.³⁰⁴ As a result of the artificial market dynamic created by the federal government, physicians are called upon to offer the best possible care to the most people in the least time despite a lack of autonomy regarding treatment decisions, limited resources and less compensation. As long as the suppression of physicians' interests persists, patients run the risk of receiving less effective treatments, longer delays, and, most significantly, less autonomy.³⁰⁵

B. THE SOLUTION

The aforementioned issues complicate the process of arriving at a viable health care delivery system. Nevertheless, an examination of the systems outlined above presents all of the necessary components of a realizable health care delivery system, within the context of "cooperative federalism." As "cooperative federalism" suggests, the legislative burden must fall equally on the state and federal governments.³⁰⁶ The remaining sections outline the responsibilities of each governmental body in the proposed system, concluding that federal oversight of state-administered health care delivery programs will provide the most efficient, cost effective way to achieve universal access and simultaneously address the additional concerns discussed above.

under a fee-for-service payment plan. *See* Brian P. Battaglia, *The Shift Toward Managed Care and Emerging Liability Claims Arising From Utilization Management and Financial Arrangements Between Health Care Providers and Payers*, 19 ARK. LITTLE ROCK L.J. 155 (1997).

³⁰³ State and federal laws bar physicians from the corporate practice of medicine. The impetus for this sort of legislation was a recognition of the conflicting loyalties held by physicians and corporate directors and officers. The latter must act in the best interest of the shareholders, while the former must act in the best interest of the patient (read: consumer). *See generally* Hirshfeld, *supra* note 270, at 11. Similarly, physicians are not allowed to engage in self-referrals or fee-splitting. *See id.* at 11-15.

³⁰⁴ HMOs were originally created by federal legislation. *See* Battaglia, *supra* note 302, at 174. Over a ten-year period between 1973 and 1983, the U.S. government provided over \$350 million to finance HMOs. *See id.*

³⁰⁵ *See generally* Rodwin, Consumer Protection, *supra* note 266.

³⁰⁶ Two commentators have proposed a similar sort of cooperative approach. *See* Holloway, *supra* note 23; Farrell, *supra* note 293.

1. *Role of the Federal Government*

The federal government's role in the proposed system will be two-fold. First, the federal government will be responsible for establishing guidelines and promulgating laws which facilitate state administration of health care. Second, the federal government should provide financial assistance to states administering health care in concert with this proposal. Specifically, this advisory role would require the creation of: 1) a federal law mandating that all states provide a minimum benefits package based on a federally-determined dollar figure, derived from per capita cost of living estimates for the states; 2) a federal ERISA exemption for health care, allowing states to create minimum benefits packages that apply to all insurers; 3) automatic Section 1115 Medicaid waivers for states to broaden utilization of managed care in Medicaid; 4) a federal law mandating that all self-insuring employers with operations in five or more states respect the minimum benefit laws of either their state of incorporation, or their principle place of business; and 5) a federal limit on malpractice liability for doctors, or an explicit, objective "reasonable care test" to determine liability.

a. A Federal Law Mandating that All States Provide Minimum Benefits Packages

A great health care mystery in the United States is the absence of a federal law mandating minimum benefits. The establishment of such a law must be the first step toward comprehensive health care reform.³⁰⁷ It is essential because without such a law states and insurance providers alike necessarily remain in the dark about the appropriate level of benefits to provide purchasers. Furthermore, much of the delay built into the waiver applications processes for both Medicaid and ERISA waivers is the result of states' inability to approximate federal prerogatives concerning appropriate levels of benefits.³⁰⁸

A federal minimum level of benefits is not novel to the health care agenda.³⁰⁹ However, such a minimum is usually presented as a package

³⁰⁷ Farrell argues that there may be a need for "nationally uniform policy determinations with regard to problems of underutilization provider selection, rate setting, and solvency requirements, but the federal government may not be the institutionally appropriate body to flesh out and enforce those standards." Farrell, *supra* note 293, at 289. She proposes that this sort of reform is a better alternative to the "fragmentary approach taken by Congress" to date. *Id.* at 285.

³⁰⁸ See *infra* notes 99-116 and accompanying text; see also Rosenberg & Zaring, *supra* note 38, at 547-48.

³⁰⁹ Clinton's HSA included a defined benefits package that included comprehensive coverage. See Beresford, *supra* note 28, at 1410.

[The HSA] provides coverage for physician and hospital care, preventive services, mental health and substance abuse services, family planning, hospice and home health care, prescription drugs, and outpatient diagnostic testing and rehabilitation

of services that must be covered by insurers.³¹⁰ This note rejects the idea that the legislation proposed should be in the form of an explicit list of benefits. Instead, Congress should establish a minimum benefits package as a monetary amount. The price of the benefits package should be determined by assessing the nation-wide average health care cost and converting it into a percentage of the per capita cost of living. In this way, the federal government retains the ability to determine the appropriate level of care, without expressing an opinion about the specific benefits insurers must provide.

b. A Federal ERISA Exemption for Health Care

Commentators have hotly debated the necessity of an ERISA exemption for health care systems.³¹¹ The Florida model suggests that an ERISA exemption is not the *sine qua non* of health care reform.³¹² However, there is evidence that the Florida model would function more smoothly if an ERISA exemption allowed the state to regulate employers.³¹³ In addition, there is no reason to believe that providing such an exemption would greatly *infringe* on the existing statutory right that grants employers autonomy in deciding upon employee benefits.

An ERISA exemption for health care laws is necessary because without the ability to enforce the federally-mandated minimum benefits packages established above, such a law would be mere window dressing. Under the present regime, states have the power to mandate particular benefits, but ERISA allows employers to opt out of state regulation by self-insuring.³¹⁴ With the health care delivery exemption in place, states would be able to require all insurers, including self-insured employers, to

services. It also covers durable medical equipment and devices, vision and dental care, and investigational treatments that are part of an approved research protocol. *Id.* (citing H.R. 3600, 103d Cong.t §§ 1101(a), 1111-1128 (1993)).

³¹⁰ *See id.*

³¹¹ *See, e.g.,* Jessica Alicia Brown, *ERISA and State Health Care Reform: Roadblock or Scapegoat*, 13 *YALE L. & POL'Y REV.* 339 (1995).

³¹² *See supra* notes 166-219 and accompanying text.

³¹³ For a discussion of the process by which Medicaid Waivers are currently granted, I advocate automatic waivers in order to expedite the process by which states can undertake health reform. The current inefficiency that plagues the waiver process stems from the federal government's expectation that states explicitly state their goals in achieving a Medicaid waiver. I believe that simply demanding budget neutrality is an effective way to ensure that states do not take advantage of the waiver process. Furthermore, in the absence of federally mandated budgets, there is no actual standard by which the states can expect to be judged during the waiver application process. *See supra* notes 310-14 and accompanying text for a complete discussion.

³¹⁴ Although most commentators agree that the current waiver process is in need of reform, many authors do not share the view that automatic waivers present the best alternative. For a discussion of some of the other possible waiver reforms that have been proposed, see Randall, *supra* note 100; *see also* Rosenberg & Zaring, *supra* note 38; Andersen, *supra* note 107.

provide at least the minimum level of benefits federally, but only when they affirmatively chose to provide insurance. This mandate would not require the state to infringe upon the employer autonomy concerning the decision about whether or not to offer employee benefits.

c. Automatic Section 1115 Waivers

Granting “automatic” Section 1115 waivers to states for “demonstration projects” is another way for the federal government to facilitate the transition into a model of cooperative health care reform.³¹⁵ Such waivers should be granted to states that agree to implement Medicaid managed care in order to expand the covered portion of the population to include the presently uninsured and underinsured.³¹⁶ The purpose of waiving the requirements of Medicaid, as prescribed by the federal government, allows greater flexibility for the individual state to devise a plan that increases the number of covered persons.³¹⁷ Concentration on the budgetary component of the application would limit the federal government’s expenditure on the program to a predetermined level.³¹⁸

The Section 1115 waiver should be “automatic” upon the state’s ability to demonstrate the budget neutrality of its plan. In this way, the federal government would be able to effectively utilize the states as laboratories in which to explore the many possibilities for expanding the scope of government funded health care, without sacrificing its own primary financial interest.

d. Federal Law Governing Self-Insuring Employers

The creation of an ERISA exemption for health care requires that the federal government establish a set of rules clarifying the insurance obligations of self-insuring large employers. As discussed earlier, there is a concern among politicians, and business people alike, that large businesses operating in a number of different states would be subject to multiple benefit laws—creating administrative and economic ineffici-

³¹⁵ The rationale behind granting automatic Medicaid waivers is similar to the rationale behind carving out an ERISA exemption for state health care reform. Namely, permitting states the flexibility to create their own individualized health care systems will ensure that local concerns are at the center of most policy decisions. This will allow states to determine more effective ways of providing adequate care to a greater percentage of their population.

³¹⁶ See *supra* section II.B.

³¹⁷ See generally Rosenberg & Zaring, *supra* note 38. Although the authors ultimately disagree with the use of section 1115 waivers to promote the creation of new state health care programs, they provide a good discussion of how the process works.

³¹⁸ Budget neutrality guarantees that the states do not try to take advantage of the more lenient Medicaid waiver standards. Such a requirement assures that the state plan does not cost the federal government any more than it would otherwise be spending on health care, absent such a waiver program.

encies.³¹⁹ While this rationale supports maintaining the ERISA preemption doctrine in its entirety, the importance of health care reform demands that an exception be carved out. This proposal includes a law mandating employers who operate in five or more states, and who may be unwilling to comply individually with the requirements of each state in which they operate, to comply with the minimum benefit laws of either their state of incorporation or their principle place of operation.

Such a rule would create uniformity and predictability in health benefits regulation, thus eradicating the necessity for ERISA preemption in this area. Furthermore, this rule would not create perverse incentives to locate in one state over another, because the federal government sets the minimum benefit level. Thus, each state would be obliged to recognize the supremacy of other states' health care laws. This would eliminate any potential advantages a corporation could derive from establishing its principle place of operation or place of incorporation in a particular state.

e. Federal Limit on Malpractice Liability

The final piece of statutory health care reform to be undertaken by the federal government should be legislation limiting the liability of physicians who do not have exclusive autonomy over treatment decisions.³²⁰ The government has previously addressed legislation limiting the liability of perpetrators of "federal torts," when Congress rewrote the liability section of Title VII in 1991.³²¹ This note proposes that limits be placed on physician liability, similar to those imposed by Title VII on employers.³²² In addition, where the insurer makes treatment decisions, either in

³¹⁹ See *supra* note 298 and accompanying text.

³²⁰ Alternatives to limited liability have been proposed and would be equally effective. The true goal of this limitation is to cap the liability of physicians who operate under financial incentive arrangements with managed care organizations. Any system which incorporates the HMO into the liability equation would be acceptable. Some examples include enterprise liability for HMOs, vicarious liability, ostensible agency, or respondeat superior. Under any of these theories of liability, physicians would only be the primary risk bearer in situations of gross negligence. See Manuel, *supra* note 269; Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 AM J.L. & MED. 301, 314-23 (1996); see also *supra* note 301-05 and accompanying text; Latham, *supra* note 274.

³²¹ The Civil Rights Act of 1964, 42 U.S.C. § 1981A (1994).

³²² The Civil Rights Act, in pertinent part, provides that:

- (3) The sum of the amount of compensatory damages awarded under this section for future pecuniary losses, emotional pain, suffering, inconvenience, mental anguish, loss or enjoyment of life, and other nonpecuniary losses, and the amount of punitive damages awarded under this section, shall not exceed, for each complaining party —
- (A) in the case of a respondent who has more than 14 but fewer than 101 employees in each of 20 or more calendar weeks in the current or preceding calendar year, \$50,000;
 - (B) in the case of a respondent who has more than 100 and fewer than 201 employees in each of 20 or more calendar weeks in the current or preceding calendar year, \$100,000; and

whole or in part, he should bear the burden of indemnifying the injured party in the case of any wrongful act.³²³ Such a scheme would comport with the existing vicarious liability regime recognized under Title VII.³²⁴

In the event that the federal government remains hesitant about expressly limiting the liability of physicians, an objective standard of reasonable care may be adopted in its place. Such a standard, despite its inability to limit liability, would provide physicians with a guideline for acceptable medical practices. Assuming that a physician stays current with what is deemed acceptable medical practice and adheres to the guidelines when providing care, he should be able to anticipate his own liability. This would result in lower malpractice premiums. Similarly, the reduction of malpractice premiums would help offset the loss of profits resulting from lower per capita reimbursement fees, thereby stabilizing the physician's bottom line profits.

2. *The Role of State Governments*

Under the proposed model, federal health care law would only provide the skeleton of the system. State laws would then be used to fill in the gaps to create a functioning health care delivery system. The necessary state legislation includes the following: 1) state laws mandating minimum benefits; 2) development of Medicaid managed care programs in every state; and 3) establishment of voluntary purchasing alliances for small businesses.

a. State Law Mandating Minimum Health Care Benefits Package

The states will be individually responsible for selecting the particular benefits that comprise the minimum package in order to account for geographically and demographically created differences. The procedure for deciding the scope of coverage should resemble the state of Oregon's

(C) in the case of a respondent who has more than 200 and fewer than 501 employees in each of 20 or more calendar weeks in the current or preceding calendar year, \$200,000; and

(D) in the case of a respondent who has more than 500 employees in each of 20 or more calendar weeks in the current or preceding calendar year, \$300,000.

Id. § 1981A(b)(3)(A)-(D).

³²³ See *supra* note 320. It is beyond the scope of this note to explain in detail the workings of each type of liability. However, it should be noted that where MCOs are permitted to shift risk, as through capitated payment schemes, there must be some federal regulatory structure in place so that companies do not place unreasonable burdens on the physicians they employ. Furthermore, in the case of utilization review, physicians should not have to affirmatively demand or perform treatments that are declined by the MCO upon initial request. The doctor's duty under this new payment scheme must be one of guaranteed diagnosis, not of guaranteed treatment.

³²⁴ See *supra* note 322 (explaining liability under Title VII).

model for determining the priority of condition/treatment pairs.³²⁵ Through this mechanism, the state legislature can insure public input into the service included in the minimum benefits package. Such a system is desirable because it can be presumed that the hierarchy of treatments will differ to some extent across state lines. Further, this process allows the residents of a particular state to take an active role in choosing the benefits that they will obtain, thus creating a greater personal interest in their health care.

Another advantage of this system is that it allows states to predict the cost of health care more readily, with the minimum benefits package providing a point of departure. This should prove particularly useful for states attempting to create Medicaid managed care packages sponsored by state and federal funds. The ability to anticipate the baseline per person cost of the program will, in turn, allow the state to establish more accurate estimates of the program's coverage capacity. In this way, the state can reduce the risk that the program will fall into debt.

b. The Development of Medicaid Managed Care

The goal of universal access is well served by granting the states freedom to create demonstration projects that increase the number of insureds in state programs. Incorporating Medicaid into the managed care system provides an opportunity to reduce costs and insure additional patients at the same level of expenditure. Low-income workers, who are required to pay a premium, will be induced to enter the managed care program in order to obtain health care coverage at reduced rates. The return of this group of individuals to the program will allow states to capture a greater percentage of the remaining consumer surplus, which will necessarily create greater efficiency and consequent cost savings.

To accomplish the transition from Medicaid to Medicaid managed care, states should look to Tennessee's model.³²⁶ TennCare raised the percentage of insured residents by 50 percent, while containing costs at a level approximating the rate of inflation.³²⁷ The Tennessee profile contains no salient feature suggesting that the results of their demonstration project were anomalous or state-specific. The most significant problem that states should anticipate in implementing Medicaid managed care is the potentially adverse effect it may have on physician enrollment numbers in the major state health plans. In Tennessee, the number of participating physicians dropped at an alarming rate during the early stages of

³²⁵ See *supra* notes 142-55 and accompanying text.

³²⁶ See *supra* Part III.D.

³²⁷ Profiles of the population of the state of Tennessee suggest that such a demonstration project could be effective under similar conditions in other states.

TennCare's development.³²⁸ However, the number of physicians enrolled in TennCare currently resembles the level of participation in Medicaid that existed prior to TennCare's creation.³²⁹ Nonetheless, the federal government is in the position to protect states against reliving the Tennessee experience. By enacting a law reducing or limiting the liability of participating physicians, the federal government could provide ample incentive for doctors to remain in the program. Such a law would also reduce malpractice claims. Ultimately, such a system would be favorable to physicians because every malpractice insurance dollar saved enables them to retain a greater share of the reimbursements offered by the plan.

c. The Establishment of Voluntary Purchasing Alliances

Finally, state law should establish voluntary purchasing alliances. As the Clinton Plan suggested, managed care may be the most effective economic delivery system to contain the costs in the health care industry. The failure of the HAS, however, may have caused many politicians to stop considering managed competition as a viable economic engine for distributing private insurance at a relatively low cost. Still, in Florida, a more conservative model of managed competition has proven to be an effective way of achieving greater market efficiency.³³⁰ The Florida Health Care and Insurance Act of 1993 provides a workable model to pool employer purchases of employee health care.³³¹ Furthermore, the voluntary aspect of Florida's plan makes it preferable to the employer mandate systems of the HSA and the Hawaii model.³³²

An important feature of the Florida model that should be adopted in every state is the non-profit status of the purchasing alliance.³³³ In this capacity, purchasing alliances can truly concentrate on obtaining the best health care benefits package, while for-profit insurance providers will continue to concern themselves with the financial stability of the market.

³²⁸ See Mirvis, *supra* note 220, at 1240. "According to data collected by the [Tennessee Medical Association] in December 1993, only 32.7% of the state's physicians had decided to participate in Tennessee, while 40.4% had decided not to join. . . ." *Id.*

³²⁹ *Id.*

³³⁰ See *supra* Part III.C.

³³¹ See *supra* notes 170-72 and accompanying text.

³³² S. 231, 103d Cong. § 1321 (1994). The Mitchell Reform Plan embraces managed competition as the method for increasing access to health care at the lowest possible costs. In this way, it is similar to the Health Security Act. The primary difference is that the Mitchell Plan is voluntary and for all employers, and it entitles larger employers (500 employees) the opportunity to join alliances distinct from those organized for smaller employees. See Karen A. Jordan, *Managed Competition and Limited Choice of Providers: Countering Negative Perceptions Through a Responsibility to Select Quality Network Physicians*, 27 ARIZ. ST. L.J. 875, 881 (1995). Cf. Florida Health Care and Insurance Reform Act of 1993, *supra* Part III.B.2.

³³³ See *supra* note 186.

Thus, this system assures that consumers' interests are not sacrificed for the sake of profits.

CONCLUSION

The time has come for the United States to gain control of its unstable health care system. Although previous attempts by both federal and state legislatures to efficiently regulate health care delivery have failed, the United States should remember the power of unity. A problem as endemic as the woes of the United States' health care system requires a collaborative solution. The approach discussed herein effectively considers the most salient problems of our current health care system and proposes a framework in which they can be solved. The ultimate success of such a proposal requires the coordinated participation of state and federal governments in the regulation and administration of health care services. Hence, the only viable option for treating the ills that plague our health care delivery system is a plan, similar to the one proposed above, that coordinates the efforts of all actors in the pursuit of a solitary goal—efficiently delivered, universal health insurance coverage.

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