

Health Reform: What's Insurance Got to Do With It?

Recognizing Health Insurance as a Separate Species of Insurance

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I. INTRODUCTION

Health reform debates in the United States are typically conducted using the language of insurance.¹ President Barack Obama described his hopes for expanding access to care as “health insurance reform.”² Both proponents and opponents of reform debated the merits of reform proposals leading to the Patient Protection and Affordable Care Act of 2010 in insurance terms.³ Yet, disagreements over the structure of reform reveal deep differences in what proponents and opponents of reform mean by insurance and the role it should

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¹ See, e.g., TOM DASCHLE ET AL., CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH-CARE CRISIS 4 (2008); Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 CONN. INS. L.J. 199, 199 (2008).

² See, e.g., *Transcript, Obama's Fifth News Conference*, N.Y. TIMES, July 22, 2009, available at www.nytimes.com/2009/07/22/us/politics/22obama.transcript.html; *Remarks by the President in the State of the Union Address*, Jan. 27, 2010, available at <http://www.whitehouse.gov/the-press-office/remarks-president-state-union-address>.

³ The Patient Protection and Affordable Care Act, Pub. L. 111-148, Mar. 23, 2010, as amended by the Health Care and Education Affordability Act, Pub. L. 111-152, Mar. 30, 2010 [hereinafter “the 2010 Act”]. See, e.g., REGINA HERZLINGER, WHO KILLED HEALTH CARE? 15 (2007) (criticizing *insurance* benefits); LAURENCE KOTLIKOFF, THE HEALTHCARE FIX – UNIVERSAL INSURANCE FOR ALL AMERICANS 15 (2007) (arguing for a single health *insurance* system for the entire country).

play in mediating access to health care. Scholars of insurance law are likely to describe insurance somewhat narrowly as a risk spreading device.⁴ Industry representatives, among others, often view conventional indemnity insurance as the norm.⁵ From this perspective, reforms that move too far beyond underwriting risks can be seen as undermining actuarial fairness, threatening the very idea of insurance and possibly the industry itself.⁶ In contrast, most reform proponents discuss insurance as though it were simply a mechanism for financing health care: Health insurance ought to be universally available (on affordable terms, if not free), because health care ought to be universally available,⁷ perhaps a human right.⁸ From this perspective, most underwriting techniques are incompatible with the goals of reform.⁹

⁴ See, e.g., KENNETH ABRAHAM, *DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY* (1986) (finding one of the primary values of insurance law is the proper distribution of risk); MALCOLM CLARKE, *POLICIES AND PERCEPTIONS OF INSURANCE: AN INTRODUCTION TO INSURANCE LAW 5-6* (1997) (describing health insurance as a risk spreading device). Insurance law casebooks typically describe insurance in these terms and, until recently, included only brief sections on health insurance. See, e.g., EMERIC FISCHER ET AL., *PRINCIPLES OF INSURANCE LAW* (3d ed. 2006) (devoting 19 pages—of 1080 pages—to discussion of health insurance); KENNETH ABRAHAM, *INSURANCE LAW AND REGULATION: CASES AND MATERIALS* (4th ed. 2005) (devoting 53 pages—of 774 pages—to discussion of health insurance).

⁵ See *INSIDE THE MINDS: THE INSURANCE BUSINESS: INDUSTRY LEADERS ON MANAGING RISKS, ENSURING INVESTMENTS, & PROTECTING ASSETS* 8 (Marissa Berenson ed., 2004); Press Release, America's Health Ins. Plans, AHIP Statement on House Passage of HR 3962 (Nov. 7, 2009), available at <http://www.ahip.org/content/pressrelease.aspx?docid=28730>; STAFF OF H.R. COMMITTEE ON WAYS & MEANS REPUBLICANS, *THE COMMONSENSE HEALTHCARE REFORM AND AFFORDABILITY ACT: MAKING HEALTH INSURANCE MORE AFFORDABLE FOR FAMILIES, AFFORDABLE FOR SMALL BUSINESSES & AFFORDABLE FOR AMERICA 2* (Comm. Print 2009) (prohibiting "arbitrary caps" and "unjust" rescission).

⁶ Bruce G. Bodaken, *Where Does the Insurance Industry Stand on Health Reform Today?*, 27 *HEALTH AFF.* 667, 670-71 (2008) (noting that guaranteed issue and not basing rates on health status threaten "basic and long-standing principles of the health insurance business," although some insurers favored reforms like individual mandates that expand the market). See also Interview by Bill Moyers with Wendell Potter, *Bill Moyers Journal: Profits or Patients* (PBS television broadcast July 10, 2009), available at <http://www.pbs.org/moyers/journal/07102009/watch2.html>. For an historical perspective, see *THE POLITICS OF HEALTH CARE REFORM: LESSONS FROM THE PAST, PROSPECTS FOR THE FUTURE* (James A. Morone & Gary S. Belkin eds., 1994) (providing a compilation of articles discussing insurance reform).

⁷ See, e.g., DASCHLE, *supra* note 1, at xiii (arguing for a universal health care system); COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, INSTITUTE OF MEDICINE, *INSURING AMERICA'S HEALTH: PRINCIPLES AND RECOMMENDATIONS* 110-11 (2004) (describing a vision to expand coverage to those without health insurance); The Physicians' Working Group for Single-Payer National Health Insurance, Special Communication, *Proposal of the Physicians' Working Group for Single-Payer National Health Insurance*, 290 *JAMA* 798, 798-805 (2003).

⁸ See, e.g., The Universal Declaration of Human Rights, G.A. Res. 217A, U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 12, 1948); Sofia Gruskin & Daniel Tarantola, *Health and Human Rights*, in *PERSPECTIVES IN HEALTH AND HUMAN RIGHTS* 3, 11 (Sofia Gruskin, Michael Grodin, George Annas & Stephen P. Marks eds. 2005); Norman Daniels, Brendan Saloner & Adriane H. Gelpi, *Access, Cost, and Financing: Achieving an Ethical Health Reform*, 28 *HEALTH AFF.* w909, w909-16 (2009); Sofia Gruskin et al., *Health and Human Rights 1, History, Principles and Practice of Health and Human Rights*, 370 *LANCET* 449, 449-55 (2007); Eleanor D. Kinney, *The International Right to Health: What Does This Mean for Our National and World?*, 34 *IND. L. REV.* 1457, 1457-58 (2001).

⁹ See, e.g., *Deceptive Health Industry Practices: Are Consumers Getting What They Paid For?—Part I: Hearing Before the S. Comm. on Commerce, Sci., & Transp.*, 111th Cong. (Mar. 26, 2009); *Deceptive Health Industry Practices: Are Consumers Getting What They Paid For?*

I have argued elsewhere that such conflicting conceptions of health insurance can impede agreement on a unified structure of reform.¹⁰ Here, I argue that it is possible to reconcile these conceptions if we recognize health insurance as a separate species of insurance – distinct in function, and therefore content, from conventional indemnity insurance models. Both regulation and industry practices already have moved health insurance a long way toward becoming an identifiably separate species by limiting some risk classification methods, but universal coverage requires purging or greatly circumscribing most tools of conventional insurance. In addition, health plans no longer limit coverage to fortuitous losses, as does conventional indemnity insurance; by covering preventive care, they have added a service component to pay for regular care. This is a familiar concept in social insurance systems, which are more concerned with financing care than spreading risk. The role of insurance in such systems, especially in Western European countries, offers a model for integrating insurance plans and actuarial expertise into a financing mechanism for universal access to care.¹¹

Thus, health insurance can be, and to a large extent already is, a separate species of insurance. Little conventional insurance remains in today's health plans,¹² and there is little reason to believe that conventional insurance is necessary to provide access to health care.¹³ However, even our hybrid species of health insurance is not likely to be universally affordable without ensuring participation by virtually all Americans.¹⁴

Part II: Hearing Before the S. Comm. on Commerce, Sci., & Transp., 111th Cong. (Mar. 31, 2009); see also Coverage Denied: How the Current Health Insurance System Leaves Millions Behind, http://www.healthreform.gov/reports/denied_coverage/index.html. For a different perspective on assumptions about reform, see David A. Hyman, *Employment-Based Health Insurance and Universal Coverage: Four Things People Know That Aren't So*, 9 YALE J. HEALTH POL'Y, L. & ETHICS 435, 435-52 (2009).

¹⁰ Mariner, *supra* note 1, at 200.

¹¹ This will also require modifying some insurance law doctrines to accommodate the hybrid nature of health insurance, a topic that deserves more extensive discussion, but is beyond the scope of this article. See Thomas Morawetz, *Insurance: How It Matters as Psychological Fact and Political Metaphor*, 6 CONN. INS. L.J. 1, 8 (1999) ("The line between insurance as a commodity, as an option, and insurance as a compulsory part of government regulation is always a moving target.").

¹² Kaiser Family Foundation & Health Research & Educational Trust, *Employer Health Benefits 2008 Annual Survey*, 1, available at <http://ehbs.kff.org/pdf/7790.pdf> [hereinafter "Employer Health Benefits 2008 Annual Survey"].

¹³ Congress could achieve universal coverage without the use of private sector insurance by expanding Medicare coverage to all or creating new, supplementary programs funded from tax revenues, as some scholars, policy analysts, and organizations have recommended. See, e.g., JULIUS B. RICHMOND & RASHI FEIN, *THE HEALTH CARE MESS: HOW WE GOT INTO IT AND WHAT IT WILL TAKE TO GET OUT* 243 (2005); John Nichols, *Three Words Mr. President: "Medicare for All," THE NATION*, Sept. 8, 2009, http://www.thenation.com/blogs/thebeat/469901/three_words_mr_president_medicare_for_all (Sept. 8, 2009, 10:07 EST). Political, as well as scholarly, opposition has precluded such an approach. Jacob S. Hacker, *Putting Politics First: Health System Reform Can Be Successful This Time If Policymakers Learn the Lessons From the Past*, 27 HEALTH AFF. 718, 721 (2008). See, e.g., DAVID HYMAN, *MEDICARE MEETS MEPHISTOPHELES* (2006); Alan B. Miller, *Opinion, Medicare for All Isn't the Answer*, WALL ST. J., Aug. 13, 2009, at A15; Peter Ferrara, *Medicare for All Is a Killer*, AMERICAN SPECTATOR, May 27, 2009, <http://spectator.org/archives/2009/05/27/medicare-for-all-is-a-killer>.

¹⁴ See the 2010 Act, §1501 (adding §5000A to the Internal Revenue Code of 1986), as amended by the 2010 Act, § 10106, and by the Reconciliation Act, §1002. At least fourteen states have filed challenges to the 2010 Act, claiming that it violates Congress's power under

II. CONVENTIONAL INSURANCE RISK CLASSIFICATIONS ARE INCOMPATIBLE WITH EXPANDED ACCESS

A key goal of health reform is to give everyone access to health care. Health insurance is simply a means to that larger end: appropriate, affordable health care regardless of employment, residence, health status, age or other factors that currently inhibit access. To use insurance to pay for care, insurance must be available to everyone. Thus, as reform proposals recommended, the 2010 Act requires plans to pay for health care in ways that necessarily limit the scope of conventional insurance techniques. President Obama and members of Congress stressed that reform legislation should prohibit insurers from classifying people according to their risks in order to refuse coverage or greatly increase insurance premiums.¹⁵ The 2010 Act,¹⁶ as well as the Affordable Health Care for America Act,¹⁷ which the House of Representatives passed on November 7, 2009, and virtually all the reform bills seriously considered by Congressional Committees, prohibit insurers¹⁸ from refusing to cover preexisting medical conditions,¹⁹ refusing people

the Commerce Clause, the power to tax and spend, the Tenth Amendment or federalism generally. See Warren Richey, *Attorneys General in 14 States Sue to Block Healthcare Reform Law*, THE CHRISTIAN SCI. MON., Mar. 23, 2010, <http://www.csmonitor.com/USA/Justice/2010/0323/Attorneys-general-in-14-states-sue-to-block-healthcare-reform-law>. The constitutional authority for a federal requirement that all individuals have coverage is beyond the scope of this article. For the basic arguments for and against the propositions that that an individual mandate is within Congress's Commerce Power and that fees levied on individuals without coverage are not direct taxes, see David B. Rivkin, Jr. et al., Debate, *A Healthy Debate: The Constitutionality of an Individual Mandate*, 158 U. PA. L. REV. PENUMBRA 93 (2009), <http://www.pennumbra.com/debates/pdfs/HealthyDebate.pdf>. If challenges to the individual mandate succeed, Congress could achieve the same result without raising constitutional questions by increasing the income tax, Medicare tax, or Social Security tax, or imposing a new tax on all taxpayers, accompanied by a tax credit or deduction for those who have public or private coverage. See the 2010 Act, § 1401 (adding § 36B to the Internal Revenue Code of 1986), as amended by the 2010 Act, § 10105, and by the Reconciliation Act, §1001.

¹⁵ Remarks by the President in Discussion on Insurance Reform at Bipartisan Meeting on Health Care Reform, Feb. 25, 2010, available at <http://www.whitehouse.gov/the-press-office/remarks-president-discussion-insurance-reform-bipartisan-meeting-health-care-reform>; Michael D. Shear & Debbi Wilgoren, *As House and Senate Negotiate, Obama Fine-Tunes His Pitch*, WASH. POST, July 29, 2009, http://voices.washingtonpost.com/44/2009/07/29/obama_to_offer_eight-point_arg.html?hpid=topnews; see also Affordable Health Choices Act, S. 1679, 111th Cong. § 2701 (1st Sess. 2009); America's Healthy Future Act of 2009, S. 1796, 111th Cong. § 2204 (1st Sess. 2009); America's Affordable Health Choices Act, H.R. 3200, 111th Cong. § 113 (1st Sess. 2009).

¹⁶ Patient Protection and Affordable Care Act, *supra* note 3, originally H.R. 3590, 111th Cong. (as passed by Senate Dec. 24, 2009).

¹⁷ Affordable Health Care for America Act, H.R. 3962, 111th Cong. (as passed by House Nov. 7, 2009).

¹⁸ The prohibitions and requirements of the 2010 Act apply to private insurance plans in the individual and group market, including qualified plans offered in new health insurance exchanges, the 2010 Act, Title I, Subtitle D, and not to grandfathered employer-sponsored plans subject to the Employee Retirement Income Security Act, 29 U.S.C. §§1001 et seq, although certain provisions will apply to new employer-sponsored plans.

¹⁹ The 2010 Act, § 1201 (2010) (adding Public Health Service Act, § 2704, 42 U.S.C. §§300gg et seq.); H.R. 3962, 111th Cong. § 211 (2009); S. 1679, 111th Cong. § 101 (2009) (to amend Public Health Service Act, 42 U.S.C. § 2705); S. 1796, 111th Cong. § 1001 (2009) (same); H.R. 3200, 111th Cong. § 111 (2009).

coverage because of their medical history,²⁰ dropping coverage after illness occurs,²¹ discriminating on the basis of health status,²² discriminating in benefits on the basis of age or disability,²³ charging much higher premiums on the basis of age,²⁴ providing less coverage for mental health and substance abuse disorder benefits than for medical conditions,²⁵ capping the dollar amount of coverage,²⁶ and charging high out-of-pocket expenses.²⁷ The public also appears to support regulating health insurance coverage in this manner.²⁸

These prohibitions remove tools of risk classification that insurers have regarded as essential to permit underwriting in conventional insurance, if not inherent in the concept of insurance itself.²⁹ Conventional indemnity insurance in an unregulated, competitive market relies on risk classification (by definition, a discriminatory process) to exclude bad risks and to underwrite or price those accepted according to their risk profiles.³⁰ Familiar examples include homeowners insurance and life insurance. To achieve universal (or nearly so) access to health care, therefore, reform legislation must prune and pad health plans so that they no longer look or function like conventional indemnity insurance policies. Medical underwriting and preexisting condition exclusions must be suppressed like bad genes, while guaranteed issue and preventive measures are grafted on.

²⁰ The 2010 Act, § 1201 (2010) (adding Public Health Service Act, §§ 2702, 2703 to guarantee issue and renewal, respectively); H.R. 3962, 111th Cong. § 212 (2009); S. 1679, 111th Cong. § 101 (2009); S. 1796, 111th Cong. § 1001 (2009); H.R. 3200, 111th Cong. § 122 (2009).

²¹ The 2010 Act, § 1001 (2010) (adding Public Health Service Act, § 2712 to prohibit rescission); H.R. 3962, 111th Cong. § 103 (2009); S. 1679, 111th Cong. § 101 (2009); H.R. 3200, 111th Cong. § 112 (2009).

²² The 2010 Act, § 1201 (2010) (adding Public Health Service Act § 2705); H.R. 3962, 111th Cong. § 211 (2009).

²³ The 2010 Act, § 1302(b)(4)(B) (2010); H.R. 3962, 111th Cong. §§ 213, 214 (2009); S. 1679, 111th Cong. § 101 (2009); S. 1796, 111th Cong. § 1001 (2009); H.R. 3200, 111th Cong. § 113 (2009).

²⁴ The 2010 Act, § 1201 (2010) (adding Public Health Service Act, § 2701(a)(1)(A)(iii) to limit premium rate variation based on age to 3:1); S. 1679, 111th Cong. § 101 (2009); S. 1796, 111th Cong. § 1001 (2009); H.R. 3200, 111th Cong. § 114 (2009); H.R. 3962, 111th Cong. § 214 (2009).

²⁵ 2010 Act, § 1311(j) (2010); H.R. 3962, 111th Cong. § 214 (2009); H.R. 3200, 111th Cong. § 114 (2009).

²⁶ The 2010 Act, § 1001 (2010) (no lifetime or annual limits on dollar value of benefits); H.R. 3962, 111th Cong. §§ 106, 109 (2009); S. 1697, 111th Cong. § 101 (2009); H.R. 3200, 111th Cong. § 122(a)(3) (2009).

²⁷ The 2010 Act, §§ 1201, 1302(c); H.R. 3962, 111th Cong. § 222(c) (2009); S. 1796, 111th Cong. § 1201 (2009); H.R. 3200, 111th Cong. § 122(c) (2009).

²⁸ KAISER FAMILY FOUNDATION/HARVARD SCHOOL OF PUBLIC HEALTH, THE PUBLIC'S HEALTH CARE AGENDA FOR THE NEW PRESIDENT AND CONGRESS 10 (Jan. 2009), <http://kff.org/kaiserpolls/7853.cfm>. A recent poll of public opinions of the 2009 House and Senate Bills find that 63% of those surveyed favor provisions that prohibit insurers from denying coverage on the basis of health conditions. KAISER FAMILY FOUNDATION, KAISER HEALTH TRACKING POLL: PUBLIC OPINION ON HEALTH CARE ISSUES 5 (Jan. 2010), <http://kff.org/kaiserpolls/8042.cfm>.

²⁹ Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371, 377 (2003).

³⁰ EMMETT J. VAUGHAN & THERESE M. VAUGHAN, FUNDAMENTALS OF RISK AND INSURANCE 169-71 (10th ed. 2008); Harry A. Woodman, *Principles of Risk Selection and Classification*, in MEDICAL SELECTION OF LIFE RISKS 25, 35 (R.D.C. Brackenridge & W. John Elder eds., 4th ed. 1998).

What remains of conventional insurance is risk rating – setting premiums according to risk profiles, analogous to charging loan interest rates according to credit-worthiness. Neither the Act nor the reform proposals that preceded it restrict premiums beyond imposing rate bands for plans to be offered on exchanges, limiting the degree to which the premium for an insurer's highest priced product may exceed the premium for its lowest priced product for a defined population.³¹ Thus, it will still be necessary to estimate a population's total need for medical services in order to calculate premium rates that can cover the cost of providing benefits, as well as administrative costs, profit and taxes.³² However, to make premiums affordable to all, subsidies will be needed for low-income people with higher health risks.³³ Moreover, if health plans must accept anyone who applies, then plans (public or private) with high risk populations will need subsidies or access to reinsurance if premiums are to remain competitive across the market,³⁴ possibly financed by taxes on individuals or health plans with healthy populations.³⁵ Such redistributive measures are necessary to achieve affordable premiums, but they distance premium rates from individual and even group risk. Indeed, the calculations may differ little from those needed for financing many non-insurance services. The more that risk rating is diluted with redistributive funding, the more health plans look like vehicles to finance health care.

III. CONVENTIONAL INDEMNITY HEALTH INSURANCE IS DISAPPEARING

The health insurance industry in the United States is already far down the path toward becoming primarily a health care payer, and only secondarily an insurer of health risks. Federal and state laws have circumscribed insurers' freedom to use risk classification by mandating coverage of specific benefits and prohibiting the exclusion of some risks or charging higher premiums for others.³⁶ For example, federal and many state laws prohibit discriminating against or excluding anyone from health coverage on the basis of a health factor,³⁷ experiencing domestic violence,³⁸ or genetic testing.³⁹ Some states

³¹ See, e.g., the 2010 Act, § 1201 (2010) (adding Public Health Service Act, § 2701 to allow premium rate variations based on individual or family coverage, rating area, age, and tobacco use); H.R. 3962, 111th Cong. § 213 (2009); H.R. 3590, 11th Cong. § 1201 (2009). Both bills also limit cost sharing. *Supra* note 28.

³² National health spending was \$2.3 trillion in 2008, or \$7,681 per person, and 16.2% of GDP. See Micah Hartman et al., *Health Spending Growth At A Historic Low in 2008*, 29 HEALTH AFF. 147, 147 (2010).

³³ Jonathan Gruber, *Covering the Uninsured in the United States*, 46 J. ECON. LIT. 571, 572, 587 (Sept. 2008). The 2010 Act provides for tax credits and subsidies.

³⁴ ELLIOT K. WICKS, RESTRUCTURING HEALTH INSURANCE MARKETS, NATIONAL ACADEMY OF SOCIAL INSURANCE 1, 13-14 (Jan. 2009), available at <http://www.nasi.org/research/2009/restructuring-health-insurance-markets>.

³⁵ Victor R. Fuchs, *The Proposed Government Health Insurance Company – No Substitute for Real Reform*, 360 NEW ENG. J. MED. 2273, 2275 (2009); Jacob S. Hacker, *Health Care 2009 – The Why and How of “Public-Plan Choice,”* 360 NEW ENG. J. MED. 2269, 2269 (2009); Mark Hall, *The Structure and Enforcement of Health Insurance Rating Reforms*, 37 INQUIRY 367, 377-78 (2001).

³⁶ National Conference of State Legislatures, *Health Reform: State Examples* (Mar. 22, 2010), <http://www.ncsl.org/default.aspx?tabid=17691>.

³⁷ Health Insurance Portability and Accountability Act, 29 U.S.C. § 1182 (West 2008).

also prohibit or limit risk rating on the basis of gender, at least in group policies. However, San Francisco's Attorney General has sued the insurance commissioner for permitting health insurers to use gender rating in individual insurance policies.⁴⁰ If, as reported, women use more medical services than men,⁴¹ then it would be actuarially fair to charge women higher premiums than men, as many states permit.⁴² This actuarial fairness argument is regularly invoked to justify higher premiums for the elderly, smokers and others with above average health risks.⁴³ If the goal of a reformed health system is to treat everyone the same, however, then actuarial fairness is irrelevant.

Insurance companies already function solely as payment intermediaries rather than conventional insurers for tens of millions of Americans in employee group health plans. In 2008, 55% of employees with health insurance participated in employer-sponsored plans that are fully or partially self-insured (up from 49% in 2000).⁴⁴ Insurance companies do not issue insurance policies to such plans. The employer bears the financial risk of loss (hence the term "self-insured"), and typically hires an insurance company or other third-party-administrator to administer the plan (collect contributions and pay claims) for a fee.

Insurance companies also perform administrative services for government benefit programs, Medicare in particular.⁴⁵ Medicare is not a conventional insurance system, despite its title, Health Insurance for the Aged and Disabled.⁴⁶ Rather, it is a statutory entitlement program, with benefits, premiums and provider payments authorized by statute and specified by regulations. Although Medicare must calculate needed funds based on risk, it does not engage in underwriting practices, such as excluding high risks. Rather, it automatically covers retirees over 65 years of age, as well as disabled

³⁸ *Id.* See Deborah S. Hellman, *Is Actuarially Fair Insurance Pricing Actually Fair?: A Case Study in Insuring Battered Women*, 21 HARV. C.R.-C.L. L. REV. 355, 355-56 (1997).

³⁹ Genetic Information Nondiscrimination Act, 42 U.S.C. § 2000ff (West 2008).

⁴⁰ Nathan Olivarez-Giles, *California Health Insurers Discriminate Against Women, Lawsuit Contends*, L.A. TIMES, Jan. 28, 2009, at C1.

⁴¹ Cameron A. Mustard et al., *Sex Differences in the Use of Health Care Services*, 338 NEW ENG. J. MED. 1678, 1678 (1998); Paul D. Cleary et al., *Sex Differences in Medical Care Utilization: An Empirical Investigation*, 23 J. HEALTH & SOC. BEHAV. 106, 106 (1982).

⁴² Jane Slater, *Colorado Women Pay More for Insurance Than Men*, THE DENVER CHANNEL, Oct. 19, 2009, <http://www.thedenverchannel.com/health/21343272/detail.html>; Barbara Barrett, *N.C. Lets Insurers Charge Women More*, McCLATCHY, Oct. 12, 2009, <http://www.mcclatchydc.com/staff/story/76996.html>.

⁴³ See Deborah Stone, *The Struggle for the Soul of Insurance*, 18 J. HEALTH, POL. POL'Y & L. 287, 287-88 (1993).

⁴⁴ *Employer Health Benefits 2008 Annual Survey*, *supra* note 12, at 154-55.

⁴⁵ 42 U.S.C. §§ 1395 et seq. (2006).

⁴⁶ THEODORE MARMOR, ET AL., *AMERICA'S MISUNDERSTOOD WELFARE STATE: PERSISTENT MYTHS, ENDURING REALITIES* 178-79 (1990). However, Medicare beneficiaries may pay a premium for Part B (physician services), and purchase a Medicare Advantage health plan from a private insurer under Part C in lieu of traditional Medicare Parts A and B coverage, and also purchase a prescription drug coverage plan from a private insurer under Part D.

individuals, in a national pool of nearly 45 million Americans.⁴⁷ The federal government also pays directly for care for 7.8 million veterans enrolled in the Veteran Affairs health care system and a large fraction of the 9 million military personnel, dependents and retirees for whom the Department of Defense is responsible.⁴⁸ State-based Medicaid and SCHIP programs, which together cover more than 61 million people,⁴⁹ do enroll some beneficiaries in private health plans, but pay providers directly for most care. These government benefit programs pay for health care for about 40% of Americans.⁵⁰ They also account for more than half of total health care expenditures.⁵¹

These examples indicate that a growing percentage of the health insurance business lies not in risk-bearing indemnity insurance, but in providing administrative services for government benefit programs and private self-funded plans. Although the profit margin for administrative service contracts may be lower than for risk-bearing insurance policies, the former may prove to be a more relevant and reliable business model for the health insurance industry's future.

IV. PAYING FOR CARE v. SPREADING RISK

Health insurers have moved away from conventional indemnity insurance practices, even in their own health plans.⁵² Fewer than eleven million Americans bought individual health insurance policies in 2006,⁵³ down from 16 million in 1999.⁵⁴ Most employees and their dependents with health insurance are in employer-sponsored plans, most with some form of managed

⁴⁷ TOTAL NUMBER OF MEDICARE BENEFICIARIES, KAISER FAMILY FOUNDATION STATE HEALTH CARE FACTS (2009), <http://www.statehealthfacts.org/comparemaptable.jsp?ind=290&cat=6>.

⁴⁸ INST. OF MED., COMBATING TOBACCO USE IN MILITARY AND VETERAN POPULATIONS 34 (2009).

⁴⁹ Centers for Medicare & Medicaid Services & Center for Medicaid and State Operations, *Trends in Medicaid Persons Served and Vendor Payments: Fiscal Years 1975-2005*, available at www.cms.hhs.gov/MedicareMedicaidStatSupp/downloads/08Fig13.3.pdf; TOTAL MEDICAID ENROLLMENT, KAISER FAMILY FOUNDATION STATE HEALTH CARE FACTS (2009), <http://www.statehealthfacts.org/comparemaptable.jsp?ind=198&cat=4>; KAISER COMM'N ON MEDICAID AND THE UNINSURED, SCHIP TURNS 10: AN UPDATE ON ENROLLMENT AND THE OUTLOOK ON REAUTHORIZATION FROM THE PROGRAM'S DIRECTORS 5 (2007), available at www.kff.org/medicaid/upload/7642.pdf.

⁵⁰ MARMOR, *supra* note 46, at 179.

⁵¹ Thomas M. Selden & Merrile Sing, *The Distribution of Public Spending for Health Care in the United States, 2002*, HEALTH AFF. w349, w353, w357 (2008) (public spending on health care for the non-institutionalized civilian population averaged 56% of total spending; adding institutionalized civilians raises public spending to more than 64% of the total).

⁵² See Michelle M. Doty et al., *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*, THE COMMONWEALTH FUND, 6-7, (2009), available at http://www.commonwealthfund.org/-/media/Files/Publications/Issue%20Brief/2009/Jul/Failure%20to%20Protect/1300_Doty_failure_to_protect_individual_ins_market_ib_v2.pdf.

⁵³ Press Release, Agency for Healthcare Research and Quality, Nearly 11 Million Americans Have Individual Health Insurance Policies, But Some Only for a Short Time, (Jan. 7, 2009).

⁵⁴ Jon Gabel et al., *Individual Insurance: How Much Financial Protection Does it Provide?*, HEALTH AFF., Apr. 7, 2002, <http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.172v1/DC1>.

care. About 8% of employees work for employers that offer conventional indemnity insurance.⁵⁵ Although the Department of Labor classified 76% of the workers in private industry with health benefits as covered by "indemnity" insurance in 2005, it found only 7% had traditional indemnity insurance policies that allow choice of provider without payment restrictions.⁵⁶ The rest were in plans organized as PPOs [Preferred Provider Organizations] and HDHP/HsAs [High deductible health plans/health savings accounts], which are gaining market share, while an additional 24% were in prepaid plans like HMOs, which are declining. More recent surveys suggest that only 2% of all workers are enrolled in conventional indemnity plans.⁵⁷

The world of health benefits is making conventional insurance models obsolete. Instead of insurance policies, we have health plans, which perform two distinct financial functions: risk spreading for unanticipated health problems; and paying for routine or regular health services. The risk spreading function of health insurance remains for unpredicted medical problems. Yet, the financial need for risk spreading is largely confined to illnesses and injuries that are expensive to diagnose or treat. In contrast, the payment function operates like a service contract to pay for routine health care visits, such as regularly scheduled physical examinations and dental cleanings.⁵⁸ The addition of the service contract function to insurance policies is a welcome, but striking departure from insurance jurisprudence, which has prized the risk spreading function of insurance above all other possible purposes.⁵⁹

Two premises underlie risk spreading. First, risks should be predictable for a population; that is, the probability of a harm (loss) occurring in a population should be ascertainable. Second, risks should be unpredictable for an individual; that is, whether it will occur to a particular individual should be uncertain.⁶⁰ Uncertainty for the individual is embedded in the fortuity principle, the assumption that insurance is designed for losses that a specific individual cannot expect to incur (beyond the general possibility for all others similarly situated).⁶¹ Although actuaries are skilled at estimating the percentage of a given population that is likely to experience glaucoma, for example, in any given year, the risk of glaucoma for a particular individual is

⁵⁵ *Employer Health Benefits 2008 Annual Survey*, *supra* note 12, at 58.

⁵⁶ U.S. DEP'T OF LABOR, NATIONAL COMPENSATION SURVEY: EMPLOYEE BENEFITS IN PRIVATE INDUSTRY IN THE UNITED STATES, 2005 6 (May 2007), *available at* <http://www.bls.gov/ncs/ebs/sp/ebbl0022.pdf>.

⁵⁷ *Employer Health Benefits 2008 Annual Survey*, *supra* note 12, at 65.

⁵⁸ *Social Solidarity*, *supra* note 1, at 209.

⁵⁹ VAUGHAN & VAUGHAN, *supra* note 30, at 41. *Compare* Griffin Sys., Inc. v. Washburn, 505 N.E.2d 1121 (Ill. App. Ct. 1987) (finding that a "mechanical service contract" covering automobile parts repair services was an insurance policy), *with* Griffin Sys., Inc. v. Ohio Dep't of Ins., 575 N.E.2d 803 (Ohio 1991) (finding the same company's similar contract to be a service contract and not insurance).

⁶⁰ *See* SCA Serv. Inc. v. Transp. Ins. Co., 646 N.E.2d 394, 397 (Mass. 1995) (finding that the basic purpose of insurance is to protect against fortuitous events, not known certainties). *See generally*, JEFFREY W. STEMPEL, *STEMPEL ON INSURANCE CONTRACTS* (3d ed. 2006 & Supp. 2008); PETER J. KALIS ET AL., *POLICYHOLDER'S GUIDE TO THE LAW OF INSURANCE COVERAGE* (1st ed. 1997 & Supp. 2008).

⁶¹ *See* Joan T. Schmit, *A New View of the Requisites of Insurability*, 53 J. RISK & INS. 320, 325-26 (1986); JEFFREY W. STEMPEL, *INTERPRETATION OF INSURANCE CONTRACTS: LAW AND STRATEGY FOR INSURERS AND POLICYHOLDERS* 27 (1994).

considered insurable only if the individual has no specific knowledge that s/he has or will soon have the disease. Decades of court decisions confirm that policyholders who know they are about to suffer a loss or who bring one about are not entitled to the benefits of insurance.⁶² The known loss doctrine precludes coverage of a loss that has already occurred or one that the policyholder reasonably expected to occur.⁶³ The federal Court of Appeals for the Fourth Circuit described the doctrine as inherent in the concept of insurance: “[t]he known loss doctrine seeks to prevent the concept of an insurable risk from becoming a mere fiction when the insured knows there is a substantial probability that it has suffered or will suffer a loss covered by the policy.”⁶⁴ As Thomas Morawetz notes, “in a world that is perfectly ordered, controlled, and determined, insurance has no meaning.”⁶⁵

Yet, today's health plans do provide benefits for predictable expenses. Many plans pay for preventive services, such as immunizations, mammograms, cholesterol screening, and annual physical examinations, and the 2010 Act requires coverage of certain preventive services.⁶⁶ In the conventional sense of insurance, these are not insurable risks, because they are expected events, controlled and scheduled by the patient.⁶⁷ For sound reasons of public policy, however, states have required health insurers to pay for many such services as mandated benefits, and many insurers have done so voluntarily in response to consumer demand.

It has become nearly impossible for insurers to spread risk solely by increasing premiums to cover rising health care costs, which now exceed 2 trillion dollars.⁶⁸ They need to control their expenditures, but their options are limited.⁶⁹ Two – reducing payments to providers and reducing administrative costs and profit margins – do not appeal to those who would lose income.⁷⁰ The remaining options, which are traditional insurance tools,

⁶² M. Elizabeth Medaglia et al., *The Status of Certain Nonfortuity Defenses in Casualty Insurance Coverage*, 30 TORT & INS. L.J. 943, 943 (1994) (finding that the principle that insurance covers only fortuitous losses is universally recognized).

⁶³ See, e.g., *Stonehenge Engineering Corp. v. Employers Ins. of Wausau*, 201 F.3d 296, 301-02 (4th Cir. 2000); *U.S. Liability Ins. Co. v. Selman*, 70 F.3d 684, 690-91 (1st Cir. 1995); *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 607 N.E.2d 1204, 1210 (1992); 7 LEE R. RUSS & THOMAS F. SEGALLA, *COUCH ON INSURANCE* §§ 102.8-102.9 (3d ed. 2009).

⁶⁴ *Stonehenge Engineering Corp.*, 201 F.3d at 301-02. See also *U.S. Liability Ins. Co.*, 70 F.3d at 690 (“[T]he presence of risk runs to the very essence of an insurance contract. Where there is no risk of loss – as where a loss has already occurred before a policy takes effect – insurance ceases to serve its socially useful function of risk-spreading.”).

⁶⁵ Morawetz, *supra* note 11, at 4.

⁶⁶ The 2010 Act, §§ 1001 (adding § 2713 to the Public Health Service Act), 1302(b)(1)(I), 1301(b)(1)(J). Dental and eye care are typically covered by separate policies from general health insurance, but do cover preventive examinations.

⁶⁷ See 1 ERIC MILLS HOLMES & MARK S. RHODES, *APPLEMAN ON INSURANCE* § 1.4 (2d ed. 1996); RUSS & SEGALLA, *supra* note 63, § 101.2.

⁶⁸ Andrea Sisko et al., *Health Spending Projections Through 2018: Recession Effects Add Uncertainty to the Outlook*, HEALTH AFF. W346, W346 (Feb. 24, 2009), <http://content.healthaffairs.org/cgi/reprint/28/2/w346>.

⁶⁹ Peter S. Hussey et al., *Controlling U.S. Health Care Spending - Separating Promising from Unpromising Approaches*, 361 NEW ENG. J. MED. 2109, 2110 (2009).

⁷⁰ The 2010 Act and earlier federal reform proposals have been criticized for failing to significantly alter payment structures for health care services to reduce costs. See, e.g., Theodore Marmor et al., *The Obama Administration's Options for Health Care Cost Control: Hope Versus Reality*, 150 ANNALS OF INTERNAL MED. 485, 488 (2009). Massachusetts

run contrary to the goals of reform: excluding people with higher risks of illness from coverage or charging them actuarially fair, but very high, possibly unaffordable premiums; excluding coverage of preexisting or expensive conditions or treatments; and capping coverage amounts.

Instead of using conventional insurance techniques, therefore, insurers must try to manage their costs by either limiting or discouraging the use of unnecessary or overly expensive covered services. Pre-authorization requirements for specialty care and specific treatments and caps on the number of covered treatments or visits are examples of limiting techniques. Discouragement techniques include cost sharing: co-insurance, deductibles, and co-payments. These management techniques are intended to keep covered losses within bounds by influencing the behavior of people enrolled in a health plan, but they are admittedly blunt tools.⁷¹

Management techniques are sometimes viewed as ways to reduce moral hazard – the possibility that once insured, a person has less incentive to prevent a loss (or avoid health care services).⁷² But, moral hazard is less likely to affect a person's behavior with respect to health care than it can with respect to other types of insurance, like fire or automobile insurance, because the policyholder suffers the loss physically as well as financially. Instead, moral hazard is more likely to affect policyholder decisions about elective and preventive services, where the patient has more control and can behave more like a consumer than a patient.⁷³ In other words, moral hazard arises more naturally on the service-contract side of a health plan than on the risk-spreading indemnity side.

Paradoxically, while health plans manage risk on the risk-spreading side of the policy by *limiting* the use of services, they manage risk on the service-contract side of the policy by *encouraging* the use of services. Patients are supposed to avoid using some services, like MRIs, while consumers are encouraged to use others, like immunizations, regularly. If insurers responded to moral hazard in conventional ways, they would discourage policyholders from voluntarily using too many elective services. Moreover, as Tom Baker makes clear, insurers face their own moral hazard,⁷⁴ since they have a financial incentive to retain as much of the premiums as possible by

deferred efforts to control health care costs until after implementing its 2006 health insurance reform law. See 2006 Mass. Acts 58. A later Massachusetts law created a Special Commission to study cost control. 2008 Mass. Acts ch. 305, § 44 (2008). The Special Commission's 2009 recommendations for payment reforms have not received notable support from providers. See MASSACHUSETTS OFFICE OF HEALTH AND HUMAN SERVICES, RECOMMENDATIONS OF THE SPECIAL COMMISSION ON THE HEALTH CARE PAYMENT SYSTEM 49-52 (July 16, 2009), available at http://www.mass.gov/Eoohhs2/docs/dhcfp/pc/Final_Report/Final_Report.pdf.

⁷¹ CAROL A. HEIMER, REACTIVE RISK AND RATIONAL ACTION: MANAGING MORAL HAZARD IN INSURANCE CONTRACTS 13 (1985) (noting that co-insurance and deductibles are methods to "further unbalance incentives in a situation in which the insurers have selected policyholders whose incentives are already skewed against loss").

⁷² Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531, 533 (1968).

⁷³ Wendy K. Mariner, *Can Consumer-Choice Plans Satisfy Patients? Problems with Theory and Practice in Health Insurance Contracts*, 69 BROOK. L. REV. 485, 491-95 (2004) (distinguishing the roles of patients and consumers).

⁷⁴ Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237 (1996).

paying fewer benefits.⁷⁵ Here again, health plans diverge from the conventional model of insurance.

Before the 2010 Act endorsed coverage of prevention, health plans began to cover an increasing number of preventive and disease management services.⁷⁶ The federal government encouraged group health plans to adopt this service coverage by exempting most "wellness programs" from HIPAA's prohibition against discrimination on the basis of a health factor.⁷⁷ Although these programs are often described as reducing the need for more expensive medical care in the future,⁷⁸ the evidence on cost saving is mixed.⁷⁹ Too few preventive services save money in the long run.⁸⁰ The best reason for encouraging prevention programs is to improve people's health, not to reduce covered losses.⁸¹

It makes sense to pay for prevention if one thinks of the risk of disease in terms of health status instead of financial loss.⁸² Health plans that pay for preventive services are simply financing disease prevention and health promotion. Thus, coverage of preventive services has moved health plan operations further from conventional insurance and closer to functioning as health care payment plans. Furthermore, to the extent that these efforts succeed, Medicare, not insurance, may ultimately pay for the care that is needed at the end of longer, healthier lives.⁸³

⁷⁵ Eric D. Beal, Comment, *Posner and Moral Hazard*, 7 CONN. INS. L.J. 81, 83 (2005).

⁷⁶ *Employer Health Benefits 2008 Annual Survey*, *supra* note 12, at 174, 182-85.

⁷⁷ Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75013, 75014 (Dec. 13, 2006). The 2010 Act continues the exemption. The 2010 Act, § 1201 (adding Public Health Service Act § 2705(j)).

⁷⁸ Larry Cohen et al., *Reducing Health Care Costs Through Prevention 1* (Prevention Inst. and The Cal. Endowment, Working Paper, Aug. 2007), www.preventioninstitute.org/documents/HE_HealthCareReformPolicyDraft_091507.pdf.

⁷⁹ Matthew G. Marin & Jessica Nutik Zitter, *Expenditures Associated with Preventive Health Care*, 39 PREVENTIVE MED. 856, 861 (2004); Sheila Leatherman, et al., *The Business Case for Quality: Case Studies and an Analysis*, 22 HEALTH AFF. 17, 21 (2003); Steven G. Aldana, *Financial Impact of Health Promotion Programs: A Comprehensive Review of the Literature*, 15 AM. J. HEALTH PROMOTION 296 (2001); Reed Abelson, *Medicare Finds How Hard It Is to Save Money*, N.Y. TIMES, April 7, 2008, at A1.

⁸⁰ LOUISE B. RUSSELL, IS PREVENTION BETTER THAN CURE? 109-12 (1986); Joshua T. Cohen et al., *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 NEW ENG. J. MED. 661, 662-63 (2008); Pieter H. M. van Baal et al., *Lifetime Medical Costs of Obesity: Prevention No Cure for Increasing Health Expenditure*, PUB. LIBRARY OF SERVICE, Feb. 5, 2008, <http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0050029>. See David Hilzenrath, *Misleading Claims about Safeway Wellness Incentives Shape Health-care Bill*, WASH. POST, Jan. 17, 2010, at G1 (finding that, contrary to earlier reports, Safeway's health insurance premiums increased after its wellness program took effect).

⁸¹ Louise B. Russell, *Preventing Chronic Disease: An Important Investment, But Don't Count on Cost Savings*, 28 HEALTH AFF. 42, 42-43 (2009).

⁸² Pre-2010 reform bills also required coverage of preventive services. See, e.g., H.R. 3962, 111th Cong. §§ 112, 222(b)(8), 222(b)(10) (2009); S. 1679, 111th Cong. §§ 101, 362, 367 (2009); S. 1796, 111th Cong. §§ 1901, 2001-2005 (2009); H.R. 3200, 111th Cong. § 122(b)(8) (2009).

⁸³ Sean Keehan et al., *Health Spending Projections Through 2017: The Baby Boom Generation is Coming to Medicare*, 27 HEALTH AFF. w145 (2008), <http://content.healthaffairs.org/cgi/reprint/27/2/w145>.

V. USING ACTUARIAL EXPERTISE WITHOUT UNDERWRITING

There is ample historical precedent for using the expertise of actuaries and insurance claims administrators in contexts beyond conventional commercial indemnity insurance. Insurance policies have been viewed as devices for thrift,⁸⁴ self-help,⁸⁵ mutual aid,⁸⁶ investment,⁸⁷ gambling,⁸⁸ and even defying the will of God,⁸⁹ in the United States and elsewhere.

The perspective of William Beveridge, the founder of Britain's national health insurance system, has special resonance for American health reform.⁹⁰ Beveridge conceived of social insurance as a thrift mechanism, and the government needed this thrift to reduce the number of people receiving "poor relief."⁹¹ Beveridge distinguished between "compulsory thrift" to pay for necessities and "voluntary thrift" for everything else.⁹² Since necessities must be available to everyone, he argued, the state is a proper party to organize their provision.⁹³ To cover everyone, of course, contributions had to be compulsory, which only the state can require. Social insurance financed by compulsory fees provides protection against financial risks in the same way that that police departments financed by taxes provide protection against property damage and bodily injury.⁹⁴ However, people were free to purchase voluntary indemnity insurance for non-necessities in the private market.

Many Western European countries adopted "social insurance" schemes for health care before commercial insurers had secured much of a market in private policies.⁹⁵ Governments could incorporate insurers into the new national health system to act as financial facilitators or administrators of a public program, rather than risk-bearing entrepreneurial vendors of

⁸⁴ Pat O'Malley, *Imagining Insurance: Risk, Thrift, and Life Insurance in Britain, in* EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 97, 98 (Tom Baker & Jonathan Simon eds., 2002).

⁸⁵ Carol Weisbrod, *Insurance and the Utopian Idea*, 6 CONN. INS. L.J. 381, 390, 409-10 (2000).

⁸⁶ Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371, 377 (2003); *Struggle*, *supra* note 43, at 290-92.

⁸⁷ Geoffrey Clark, *Embracing Fatality through Life Insurance in Eighteenth-Century England*, in EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 80, 90 (Tom Baker & Jonathan Simon eds., 2002).

⁸⁸ GEOFFREY CLARK, *BETTING ON LIVES: THE CULTURE OF LIFE INSURANCE IN ENGLAND, 1695-1775* 34, 40-53 (1999); VIVIANA A. ROTMAN ZELIZER, *MORALS AND MARKETS: THE DEVELOPMENT OF LIFE INSURANCE IN THE UNITED STATES* 67-72, 79-81, 86-89 (1979). See generally Timothy Alborn, *A License to Bet: Life Insurance and the Gambling Act in the British Courts*, 14 CONN. INS. L.J. 1 (2008); R. Merkin, *Gambling by Insurance: A Study of the Life Assurance Act 1774*, 9 ANGLO-AM. L. REV. 331 (1980).

⁸⁹ Brian J. Glenn, *God and the Red Umbrella: The Place of Values in the Creation of Institutions of Mutual Assistance*, 10 CONN. INS. L.J. 277, 292 (2004).

⁹⁰ See JOSÉ HARRIS, *WILLIAM BEVERIDGE: A BIOGRAPHY* (1977).

⁹¹ *Id.* at 102, 172, 256-58, 463-64.

⁹² WILLIAM BEVERIDGE, *SOCIAL INSURANCE AND ALLIED SERVICES* 8 (The MacMillan Company, 1942); *Imagining Insurance*, *supra* note 84, at 105-06.

⁹³ HARRIS, *supra* note 90, at 172, 392, 396-99.

⁹⁴ Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 CONN. INS. L.J. 11, 14-16, 18 (1999).

⁹⁵ See generally THE EVOLUTION OF SOCIAL INSURANCE 1881-1981 (Peter A. Kohler & Hans F. Zacher eds., 1982) (detailing how social insurance developed in Germany, France, Great Britain, Austria and Switzerland).

commercial policies.⁹⁶ Health insurance entities, whether private or public, developed within a more or less carefully regulated sphere to serve a public function.⁹⁷ This approach, which varies from country to country,⁹⁸ takes advantage of insurers' actuarial expertise, while tailoring the companies' business operations to the national program's goals. Although companies are profitable, their national health program activities are more ministerial than entrepreneurial.⁹⁹

In contrast, health insurance in the United States grew up largely independently in the private sector and has deep roots in the entrepreneurial ethos of private enterprise.¹⁰⁰ Blue Cross and Blue Shield began with an indemnity insurance model (yet avoiding regulation as an insurer),¹⁰¹ while employer-based groups like Kaiser Permanente created prepaid service models.¹⁰² In the absence of a national health program, most private health plans grew to mimic conventional lines of commercial indemnity insurance. This may explain some industry resistance to reforms that look more like social insurance. Yet, as more recent history shows, private health insurance companies do much more than sell conventional indemnity insurance.¹⁰³ Private insurers now administer government benefits, as well as self-insured employee group health plans, resembling Western European practice. Many of the health benefit programs that we call insurance today are insurance in name only.

All health care programs, including private plans and social insurance schemes, must determine what kind of care should be available to all: what to pay for; how to price it; what sources of revenue to use; what limits to put on which services; and how to encourage the most appropriate care.¹⁰⁴ These

⁹⁶ See RICHARD A. KNOX, *GERMANY: ONE NATION WITH HEALTH CARE FOR ALL* 54-56 (1993); TIMOTHY B. SMITH, *CREATING THE WELFARE STATE IN FRANCE, 1880-1940* 130-38 (2003). See also DEBORAH STONE, *THE SAMARITAN'S DILEMMA: SHOULD GOVERNMENT HELP YOUR NEIGHBOR?* 274-79 (2008).

⁹⁷ See generally ROWENA JACOBS & MARIA GODDARD, UNIV. OF YORK CENTRE FOR HEALTH ECONOMICS, *SOCIAL HEALTH INSURANCE SYSTEMS IN EUROPEAN COUNTRIES: THE ROLE OF THE INSURER IN THE HEALTH CARE SYSTEM: A COMPARATIVE STUDY OF FOUR EUROPEAN COUNTRIES* (2000), available at www.york.ac.uk/inst/che/pdf/op39.pdf (describing the health insurance programs in Germany, Switzerland, France and the Netherlands, including the history of these programs, how they are financed, and the health status of the populations in these nations).

⁹⁸ For a succinct comparison of systems, see THOMAS S. BODENHEIMER & KEVIN GRUMBACH, *UNDERSTANDING HEALTH POLICY: A CLINICAL APPROACH* 163-79 (5th ed. 2009).

⁹⁹ This does not insulate such systems from cost pressures. See, e.g., Paul Clay Sorum, *France Tries to Save Its Ailing National Health System*, 26 J. PUB. HEALTH POL'Y 231, 239 (2005); Jere A. Wysong & Thomas Abel, *Universal Health Insurance and High-Risk Groups in West Germany: Implications for U.S. Health Policy*, 68 MILBANK Q. 527, 530-31 (1990); Laurence J. Kotlikoff & Christian Hagist, *Who's Going Broke? Comparing Growth in Health Care Costs in Ten OECD Countries*, (Nat'l Bureau of Econ. Research, Working Paper No. 11833, 2005) at 8-11, 17.

¹⁰⁰ RICHMOND & FEIN, *supra* note 13, at 30-42.

¹⁰¹ ROBERT CUNNINGHAM III & ROBERT M. CUNNINGHAM JR., *THE BLUES: A HISTORY OF THE BLUE CROSS AND BLUE SHIELD SYSTEM* 93-97 (1997).

¹⁰² RICKEY HENDRICKS, *A MODEL FOR NATIONAL HEALTH CARE: THE HISTORY OF KAISER PERMANENTE* 1-3, 28 (1993).

¹⁰³ See Part IV *supra*.

¹⁰⁴ See generally Henry J. Aaron & Paul B. Ginsburg, *Is Health Spending Excessive? If So, What Can We Do About It?*, 28 HEALTH AFF. 1260 (Sept./Oct. 2009) (analyzing the causes of

decisions depend on predictions of the population's medical needs and the providers and services needed. Insurance companies with expertise in estimating needs and costs, as well as administering payments, can play a role in this process, whether or not they act as risk-bearing gatekeepers.

It must be recognized that private insurers cannot be expected to accept everyone who applies for coverage regardless of health status, provide comprehensive care including preventive services, and also keep premiums relatively affordable unless everyone is in the aggregate insurance pool. Without universal participation, healthy people would rationally wait to purchase insurance until they needed it, as adverse selection predicts, and premiums prices would rise to meet the costs of caring for those who need care. After COBRA and the Health Insurance Portability and Accountability Act of 1996 required insurers to provide post-employment coverage to qualified employees,¹⁰⁵ the General Accountability Office found that insurers "discouraged individuals from applying for coverage or charged them rates 140 to 600 percent of the standard premium."¹⁰⁶ Thus, the goal of keeping premiums affordable depends on requiring participation by virtually everyone in the population or allowing government to convert the system into one of complete or partial social insurance. If the American system seeks to enable private insurers to provide coverage, it must require participation by all those who do not now have health benefits in some form.

VI. CONCLUSION

A majority of the Congress and the public support health care payment plans that look almost nothing like conventional indemnity insurance: health plans that accept all people regardless of health status, cover both existing and future medical conditions, and pay for preventive as well as acute care services.¹⁰⁷ In reality, these plans are a very different species of insurance, one that uniquely combines elements of risk spreading insurance and service payment commitments. Legislators who believe that everyone should have insurance cannot achieve universal coverage without eliminating most conventional insurance practices and transforming the very meaning and function of health insurance. A more transparent approach to reform would make explicit that health plans constitute a valuable, separate species of insurance designed primarily to finance socially beneficial health services by spreading the cost of care.

Recognizing health insurance as a separate species of insurance has several advantages. It more accurately reflects how we use health plans today – as vehicles to pay for care – and mutes opposition to reform that is based

high health care spending in the U.S., including consumer demand for health care and health insurance coverage, and economic incentives for overtreatment).

¹⁰⁵ Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. 99-272; Health Insurance Portability and Accountability Act, 42 U.S.C. § 300gg-41 (2010).

¹⁰⁶ U.S. GEN. ACCOUNTING OFFICE, HEALTH INSURANCE STANDARDS: NEW FEDERAL LAW CREATES CHALLENGES FOR CONSUMERS, INSURERS, REGULATORS 2 (1998).

¹⁰⁷ PAUL FRONSTIN ET AL., EMPLOYEE BENEFIT RESEARCH INST., THE 2009 HEALTH CONFIDENCE SURVEY: PUBLIC OPINION ON HEALTH REFORM VARIES; STRONG SUPPORT FOR INSURANCE MARKET REFORM AND PUBLIC PLAN OPTION, MIXED RESPONSE TO TAX CAP 6 (2009), http://www.ebri.org/pdf/briefspdf/EBRI_IB_7-2009_HCS_091.pdf.

solely on the assumption that only conventional indemnity insurance is real insurance. In addition, it embraces coverage of both acute and preventive care, avoiding disputes over what counts as an insurable risk, and focuses on calculating costs without imposing controversial underwriting practices. Most important, it should allow us to proceed with the real work of designing a reasonable benefit package. Policy makers can think more clearly about what care should be available to all and how to pay for it.

To be sure, treating health insurance as a distinct species of insurance will require adjusting some traditional statutory and legal doctrines that underpin insurability, coverage, and contract interpretation.¹⁰⁸ Adapting legal principles to innovative relationships is a familiar challenge to law, however, not a significant obstacle. Health insurance plans can occupy a conceptual space between conventional insurance and consumer transactions, which serves its real role as financing health care.

¹⁰⁸ For perspectives on issues that will require fresh thinking, see Mark L. Movsesian, *Are Statutes Really "Legislative Bargains"? The Failure of the Contract Analogy in Statutory Interpretation*, 76 N.C. L. REV. 1145 (1998); Susan Randall, *Freedom of Contract in Insurance*, 14 CONN. INS. L.J. 107, 108 (2008); Peter Nash Swisher, *A Realistic Consensus Approach to the Insurance Law Doctrine of Reasonable Expectations*, 35 TORT & INS. L.J. 729 (2000).

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