SOLUTIONS FOR THE UNINSURED: FEDERAL, STATE, AND LOCAL INITIATIVES

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I. INTRODUCTION
Currently forty-six million Americans have no health insurance and “[i]n 2007, fifty-seven million Americans had difficulty paying their medical bills, up fourteen million from 2003.”¹ These fifty-seven million citizens carried with them an average of two thousand dollars worth of medical debt.² While no one can deny the effects of being uninsured in our health care system, this dilemma has implications beyond those who cannot afford health insurance. As of 2007, half of American hospitals operated at a loss due in part to underpayments.³ If the United States does not solve this problem, our market forces will cause many of these hospitals to go out of business. When a hospital shuts down, those who can afford health care begin to take a hit.

Both state and federal governments have made attempts at universal health care coverage. Hawaii established the Prepaid Health Care Act in 1975 that sought to cover all Hawaiians through employer mandates and subsidies for the poor.⁴ In 1993, former First Lady Hillary Clinton spearheaded an attempt at universal coverage, but saw the program crushed by Congressional and special interest group opposition.

After a spike in health care costs, starting in the mid-1990s, state and local governments began to take steps to provide health insurance to their residents in the absence of any genuine federal effort to provide coverage for the uninsured. What is the result? States and localities around the country are implementing health insurance programs, behaving as our Founders intended, namely; like the engines of experimentation in government. However, certain realities are making it clear that state and local responses are inadequate to deal with some of the problems our current system faces. Furthermore, certain aspects of federal law, particularly the Employment Retirement Income Security Act (ERISA) and an IRS tax benefit make reform at the federal level necessary. This paper will explore the changes to health insurance taking place at the federal, state, and local levels, and conclude with a brief outlook on possible solutions taking shape today for the millions of uninsured Americans.

II. FEDERAL INITIATIVES
A. Medicare
Medicare is the federal government’s health insurance program for: “(1) people aged 65 or older; (2) people under age 65 with certain disabilities; and (3) people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).”⁵ In 1965, Medicare was created through amendments to the Social Security Act.⁶ Due to the time period Medicare was enacted, its benefits tend to mirror the Blue Cross and Blue Shield plans in place in the 1960s, focusing on hospital and physician services.⁷

Medicare was originally split into two parts: Part A covered hospital insurance and Part B covered medical insurance. Eligible Medicare members do not pay out-of-pocket coverage for hospital insurance. The majority of members choose to enroll in the optional Part B of Medicare and paid a premium of $96.40 in 2009.⁸ Enrollees in Medicare have the choice to enroll in the original Medicare plan or any one of the Medicare Advantage plans run by private insurers.⁹

The Medicare Modernization Act of 2003 (MMA) created Part D of Medicare, a prescription drug benefit program. This represented one of the largest increases in entitlement spending since the enactment of Medicare and Medicaid in the 1960s. At the time the MMA passed, two-thirds of Medicare beneficiaries were already receiving prescription drug coverage from their previous employers, Medicaid, or their enrollment in a Medicare+Choice plan.¹⁰

Part D essentially was designed “as a form catastrophic coverage.”¹¹ Enrollment in Part D, like Part B, is voluntary, and it is private companies – not the federal government – that provide the drug benefit portion of the insurance policy.¹² Coverage under the plan is limited. Each beneficiary pays a monthly premium of thirty-five dollars, an annual deductible of $250, and is still responsible for a portion of their overall drug costs.¹³ As of 2005, “beneficiaries [were] responsible for 25% of their drug costs between $250 and $2,250, 100% between $2,250 and $5,100, and 5% of their drug costs of $5,100 and over.”¹⁴ The monthly premium

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payments are waived for low income Medicare beneficiaries whose incomes are below 135% of the federal poverty level, while limiting their cost-sharing responsibilities to no more than five dollars per prescription.15

MMA presented a dramatic change in treatment of Medicare beneficiaries. Breaking with thirty years of social insurance policy, the MMA provided a means-testing analysis that charged wealthier recipients more.16 Prior to this change, all Medicare recipients paid the same for their Part B premiums regardless of income.17 Under the changes embodied in the MMA, individuals “with adjusted gross incomes over $80,000 ($160,000 for joint filers) paid higher premiums for the same Part B benefit,” and those with incomes below 135% of the poverty line paid substantially lower premiums.18 While both sides of the political aisle have pushed for means-testing in the past, there are some who believe this could be an eventual deathtrap for any form of universal health care. As the argument goes, since participation in Part B is voluntary, wealthy Americans will eventually choose not to participate in Part B, leaving poorer and usually less healthy individuals to foot the program’s bill.19

The MMA also amended provisions of Medicare with an aim towards privatization, under the assumption that market forces could help reduce the rising costs of the entitlement program. The MMA renamed Medicare+Choice as “Medicare Advantage.” Medicare Advantage is the private option counterpart to the original Medicare plan. The problem with relying on the private sector to rein in costs is that the enactment of Medicare+Choice did not decrease costs: “[I]n 2003, Medicare paid private health plans participating in Medicare+Choice an average of four percent more than the average cost of a Medicare beneficiary under fee-for-service.”20 In 2005, Medicare Advantage did not deliver the cost-saving advantage many hoped it would. Instead, Medicare was paying 6.6% more for each of the five million beneficiaries enrolled in a private program than those enrolled in the original Medicare plan.21

One of the problems inherent in attempting to privatize health insurance is the reality of the marketplace surrounding health care. A book review of The Health Care Mess: How We Got Into It and What It Will Take to Get Out by Julius B. Richmond and Rashi Fein, provides insights into the realities of the health care market. The authors explain that the normal forces of supply and demand do not operate the same in the health care system.22 Richmond and Fein assert that after World War II, an increase in funding for the National Institutes of Health forced medical schools to become dependent on the federal government for research and training physicians.23 The American Medical Association (AMA) successfully blocked attempts at government financing for delivery of care to patients, leaving personal care in a private market setting, representing the demand side of the medical system.24 Academic medicine, coupled with a growing pharmaceutical and medical device industry, represented the supply side of the medical system.25 This left the supply side unresponsive to changes in demand. While changes in demand should have brought about a decrease in cost, the supply side of medicine continued to “pump out more and more expensive therapies and procedures, with the attitude that more is better. . . while the AMA was standing guard against socialism, it got blindsided by capitalism.”26 The result was a system that could not keep up with the rising costs of care.27 As legislatures work to reform health care, it is important to balance the need for government regulation while retaining a responsive supply and demand system.

B. Medicaid

Medicaid, which was enacted with Medicare in 1965,28 accounts for one in every six health care dollars spent in the U.S.29 The 2009 Congressional Budget Office (CBO) estimate predicts that Medicaid will provide health insurance to “nearly 68 million children, parents, pregnant women, seniors, and people with disabilities.”30 Medicaid is paid for in part through matching funds by the federal government, but is not administered by the federal government. Instead, each state sets up its own guidelines and is responsible for administering the program.31 Medicaid sends its payments directly to each beneficiary’s health care provider and, depending on the states’ rules, individuals may be required make co-payments.32

There are some general guidelines for these state-run programs. Medicaid categorizes individuals into ‘need’ groups, some which are required to be covered under state plans.33 The three most common groups include: special groups, the medically needy, and the categorically needy.34 Special groups include, but are not limited to, qualified working disabled individuals, Medicare beneficiaries, women with cervical or breast cancer, and people with tuberculosis.35 The medically needy consist of individuals who make too much money to be considered categorically needy.36 If a state decides to enroll this class of individuals, Medicaid requires that it cover pregnant women through a sixty-day postpartum period, children under age eighteen, certain newborns for one year, and certain blind persons.37 The categorically needy represent the following groups:

Families who meet states’ Aid to Families Dependent Children (AFDC) eligibility requirements in effect on July 16, 1996; pregnant women and children under age 6 whose family income is at or below 133% of the Federal poverty level; children ages 6 to 19 with family income up to 100% of the Federal poverty level; caretakers (relatives or legal guardians who take care of children under age 18 (or 19 if still in high school); Supplemental Security Income (SSI) recipients (or, in certain states, aged, blind, and disabled people who meet requirements that are more restrictive than those of the SSI programs); and individuals and couples who are living in medical institutions and who have monthly income up to 300% of the SSI income standard (Federal benefit rate).38

As the economy worsens, an increasing number of people are beginning to fall into these groups. Hence, the need for an effective and efficient Medicaid system, like all other aspects of health care, is growing.

C. Consolidated Omnibus Budget Reconciliation Act

In 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions.39 The law amended portions of ERISA, the Internal Revenue Code, and the Public Health Service Act. COBRA provides health insurance to employees who lose coverage when their employment is terminated.40 The law requires certain employers to allow employees to remain temporarily covered under the employer’s health insurance program after termination, and to notify employees of the availability of COBRA continuation.41 An individual covered by COBRA will experience a spike in health care costs since employers usually only pay part of the health insurance premiums.42 Under COBRA continuation, the newly unemployed are required pay pay the remaining premium payments,
but this cost is still notably lower than purchasing individual health insurance.43

There are three basic elements that determine COBRA applicability: plan coverage, qualified beneficiaries, and qualifying events. First, only employers who provide coverage to twenty or more employees, part-time (counted as a fraction equal to the part-time employee’s hours worked divided by a full time employee’s hours) and full-time, during “more than 50 percent of its typical business days in the previous calendar year...” are required to participate.44 All employees and their dependents who were covered by an applicable group health plan, as well as certain retired employees, are considered qualified beneficiaries.45 There are various qualifying events for employees, their spouses and children. Qualified beneficiaries are eligible for COBRA continuation if they are “voluntarily or involuntarily terminate[d] . . . for reasons other than gross misconduct,” or there was a reduction in the number of hours of employment that would, without COBRA continuation, cause the individual to lose health coverage.46

After an employee is terminated, he or she has a sixty day period in which to apply for care, which is measured from the later of either the coverage loss date or the date the COBRA election notice was provided.47 Generally, COBRA allows beneficiaries to remain on their employer’s group plan for a maximum of eighteen months. However, if another qualifying event occurs during this period, the individual may be able to extend coverage for a maximum of thirty six months.48 The COBRA regulations do not prohibit group plans from continuing to cover employees beyond the established COBRA periods.49

When the American economy began to decline in late 2008, high unemployment rates forced Congress to take a close look at COBRA’s continuation policy. COBRA did not provide a safety net for many recently terminated individuals because they were required to pay high premiums previously subsidized by their employer. American workers were finding “themselves in a ‘Catch-22’ of whether to elect COBRA in light of its costs or risk trying to get insurance in the individual market.”50 The American Recovery and Reinvestment Act of 2009 (ARRA) benefited recently unemployed individuals faced with this Catch-22 predicament. The ARRA extends a sixty-five percent subsidy of COBRA continuation premiums for a period of nine months for individuals involuntarily terminated between September 1, 2008 and December 31, 2009.51 Another provision covers workers who were involuntarily terminated between September 1, 2008 and February 17, 2009, but originally decided against enrolling in COBRA.52 These former employees were given an extra sixty days to enroll in COBRA in order to take advantage of the subsidy.53 While the subsidy is not taxable for the year received, individuals with an adjusted gross income above $125,000 ($250,000 for joint filings) are obliged to repay the government, in whole or in part, through tax return cuts.54 Under these changes, qualifying employers must subsidize the premium payments of former employees.55 The ARRA allows companies to recoup some of these payments by “offsetting its payroll tax deposits or claiming the subsidy as an overpayment at the end of the payroll quarter.”56

The ARRA goes a long way in achieving COBRA’s mission to protect employees in between jobs, but with continuing unemployment, Congress and the Administration will face new difficulties when the nine month COBRA grace period runs out. Unless those individuals covered under the ARRA’s COBRA extension find employment, these Americans will soon join the ranks of the uninsured. The uncertain economy increases the pressure to reform health care.

D. Children’s Health Insurance Program

The Children’s Health Insurance Program (CHIP), formerly known as the State Children’s Health Care Insurance Program (SCHIP), is jointly financed by the federal and state governments and is administered by the states.57 Specifically, “[w]ithin broad federal guidelines, each [s]tate determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures.”58 SCHIP began insuring children in 1997 through its inclusion in the Balanced Budget Act.59

The law attempts to encourage states to provide health coverage for children of families that do not qualify for Medicaid, but also cannot afford to purchase private health insurance.60 In its first ten years of existence, SCHIP has allocated approximately twenty billion dollars to the states,61 and has so far covered over five million children.62 In order to provide this coverage, states receive what is known as an ‘enhanced’ federal match. This enhanced match is greater than what a state receives through Medicaid.63 However, the law caps the match rate for states that provide coverage for those families with incomes greater than 300% of the poverty line.64

Since the law’s enactment, states are responsible for determining SCHIP income eligibility levels.65 As private insurers began to increase the cost of health coverage, states responded accordingly to cover more families by raising the eligibility levels and requiring families to pay a share of the premiums based on income levels.66 The Bush Administration pushed back in 2007 in a letter issued by the Center for Medicare and Medicaid Services (CMS) to state health officials, demanding limitations on a state’s ability to set its own income eligibility standards.67 The letter, dated August 17, 2007, burdened states with “additional requirements . . . states must meet in order to cover children under SCHIP plans, including plans that CMS had previously approved.”68 As a result, tens of thousands of children were denied health care coverage.69 CMS issued a second letter to the states on May 7, 2008, restating the policy set forth in the August 17, 2007 letter.70

The law’s mandate extended for only ten years and its reauthorization was a subject for debate during the 2007 Congressional session. The Bush Administration and the Democratic Congress reached an impasse while debating the terms of any new enactment of SCHIP. As such, they extended the law’s 1997 version through March of 2009, after the nation’s next election cycle.71 After the 2008 elections, Democrats in Congress planned to make reauthorization of SCHIP one of its first priorities. After quick passage through both the House and Senate, President Barack Obama, on February 4, 2009, signed into law the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Calling it a “down payment on my commitment to cover every single American,” the reauthorization would “provide health care to millions of children across the country and [will go] into effect on April 1, 2009.”72 The signing of CHIPRA into law ensures financing for CHIP through fiscal year 2013.73 Although the major health coverage program for low-income children is Medicaid, with about twenty nine million enrollees,74 currently, seven million children are enrolled in
CHIP, with the CBO estimating 4.1 million children will join the program by 2013.75

For uninsured children whose parents are not poor enough to qualify for Medicaid but not rich enough to afford insurance, this program will ensure that their health care needs are met for the immediate future. President Obama issued a memorandum to CMS on February 4, 2009 – the day CHIPRA was signed into law – directing CMS to disregard President Bush’s prior directives. In essence, states have more flexibility, or at least as much flexibility as they did prior to the Bush Administration’s directives to determine income eligibility levels for their families. With this dual plan of action by the Obama Administration, and the program’s general popularity, universal health insurance for children is creeping closer to reality in America.

E. Tax Exemption for Non-Profit Hospitals

The IRS, through § 501(c)(3) of the IRC, grants non-profit hospitals a tax break that some estimates predict decreases tax revenues by twenty billion dollars.76 The public policy, generating free care for the poor, was reflected in the regulation’s original language which required that the hospital be, “operated to the extent of its financial ability for those not able to pay for the services rendered.” The IRS, from the enactment of this tax break in the 1950s until 1969, used a ‘charity care’ analysis in determining whether a hospital was qualified to receive the tax benefit.77 In 1969, the IRS abandoned the ‘charity care’ standard in issuing Revenue Ruling 69545, in favor of a ‘community benefit’ standard.78

The original language of § 501(c)(3) represented a way to cover uninsured indigents through the tax code. By changing the analysis from whether the hospital was providing ‘charity care’ to whether it was providing a ‘community benefit’, it is less clear what exactly the federal government is subsidizing. Non-profit hospitals pushed for this change, not because they were overburdened by the requirement to provide free care, but because they believed that the Medicare and Medicaid systems would eliminate the need for non-profits to provide services free of charge.79

Since the ‘community benefit’ standard was enacted nearly forty years ago, the health care sector has undergone major overhauls. This raises tough questions. What exactly is the federal government subsidizing in providing this tax relief? If the public policy behind § 501(c)(3) is to provide care for the indigent, what benefit is it providing to said population? Medicaid provides health insurance to the indigent, but forty-six million Americans are still uninsured. Additionally, the media has reported accounts of non-profit hospitals charging more for services rendered for the uninsured than those with health insurance.80 Uninsured patients are “cross-subsidiz[ing]” the deep discounts that hospitals negotiate with private health insurers to provide care for insured patients.”81 Law suits brought on behalf of these patients have failed to establish a real basis for legal relief.82

Today, although it is difficult to differentiate between for-profit and non-profit hospitals, only one is subsidized by the taxpayers.83

[T]he vagueness of the existing federal community benefit standard and its historically lax enforcement mean that we do not really know what or how much beneficial conduct flows from the tax exemption and its foregone revenue, or whether that conduct is closely related to improving access and health outcomes for the uninsured or other groups.84

This reality has caused some to call for reforming § 501(c)(3). Some reformers call for a return to the ‘charity care’ analysis, accompanied with strict enforcement.85 This is exactly the approach the Texas legislature took by requiring hospitals to account for the ‘charity care’ they provide.86 Problems still exist with this approach. Specifically, measuring and accounting for charity care would cause administrative headaches and discourage hospitals from providing current benefits to the community not amounting to ‘charity care’. Meanwhile, a return to a pre-Medicare analysis may not help the uninsured get access to health care.87

Other models call for a flexible tax exemption to measure the variety of ways a hospital could provide community benefits, or even the outright repeal of § 501(c)(3) in favor of tax credits that could be applied to both for-profit and non-profit hospitals.88 The former would require hospitals to set up a robust accounting system for the community benefits it provides, while the latter may bankrupt non-profit hospitals that rely heavily on the IRS subsidy.89 I.R.C. § 501(c)(3) essentially is IRS-created health policy. Any federal attempt to provide coverage for the uninsured must take into consideration the tax code’s effect on coverage.

III. STATE INITIATIVES

As health care costs continue to eat away at our nation’s savings, (or perhaps more accurately, our debt-financed assets) over twenty states have attempted to fix the problem. Maine and Massachusetts have taken the lead in setting up comprehensive plans intended to eventually provide its residents with universal health care coverage. California is in the process of attempting to draft a comprehensive plan, but its struggles demonstrate the limits of state power during these troubling economic times. Although budget problems are currently choking off any new spending initiatives in California, Governor Schwarzenegger has supported the President’s push for health care reform this year.90

A. Maine Takes the First Step

Maine became the first state since Hawaii in 1975 to pass a comprehensive health care statute with the goal of providing its citizens access to health care by 2009.91 The Dirigo Health Reform Act established an independent executive agency “to arrange for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees and dependents, and individuals on a voluntary basis. Dirigo Health Agency is responsible for monitoring and improving the quality of health care in this State.”92 This Act has “contribute[d] to a reduction in uninsured adults to one of the lowest rates in the nation.”93

The Dirigo Health Agency oversees the DirigoChoice health plan, the state’s public sponsored option, and the Maine Quality Forum, which “promotes quality of care initiatives.”94 DirigoChoice can serve as health insurance for small businesses and individuals alike.95 The program is currently only available for small employers with two to fifty employees, sole proprietors, and individuals.96 Some benefits of DirigoChoice include no pre-existing condition restrictions, discounts from twenty to eighty percent off the monthly cost of health care depending on income and family size, reductions in deductibles and annual out-of-pocket expenses
depending on discount level, routine preventive care, inpatient/outpatient services, prescription drug coverage, maternity care, child care, childhood immunizations, emergency care, mental health services, no deductible for preventive care or prescription drugs, smoking cessation education programs, domestic partner coverage, extensive provider network, out of network coverage (at greater out of pocket cost), and no referral requirement to see a specialist.97 DirigoChoice represents one of the most expansive forms of insurance coverage available.

People earning less than 300% of the federal poverty level are eligible for a sliding scale subsidy for DirigoChoice. As of 2007, DirigoChoice had a “maximum deductible of $1,250 and lower sliding-scale deductibles and premiums available to people below 300 percent of the federal poverty level.”98 The plan may suffer from its voluntary aspects. Employers that do not provide health insurance to their employees may voluntarily pay a fee covering sixty percent of their employees’ premiums.99 As of December 2, 2006, only 13,290 residents of Maine had enrolled in DirigoChoice, even though Maine had approximately 130,000 uninsured citizens.100

Maine’s health care initiative will be funded by employer and individual contributions, general state funds, Medicaid, and the recovery of bad debt and charity care. Nevertheless, the results are nowhere close to the program’s initial goals. When DirigoChoice was created, the government estimated that 31,000 people would enroll by the end of 2005.101 According to a New York Times article published on April 30, 2007, only 18,800 people had signed up for DirigoChoice. Such paltry numbers in comparison to the state’s original high hopes has forced Maine’s leadership to attempt reform again.

Premiums have become too expensive for many individuals. Prices are increasing instead of decreasing because many of the people who signed up for this voluntary program have significant medical costs. The program lacks enough enrollees to bring down costs because healthy people do not yet see the need for such comprehensive coverage.102 To cure this problem, Governor Baldacci laid out proposals that would require people to have insurance, employers to offer insurance, or subject both to financial penalties if they fail to abide.103

Some critics want to see the program scale back its comprehensive coverage. Jim McGregor, Executive Vice President of the Maine Merchants Association argued that, “[i]t’s a Cadillac policy, and we ought to be trying to fund a Ford Escort policy.”104 While Mr. McGregor’s concerns reflect a pragmatic approach, Maine has utterly rejected such a tactic. In fact, Maine’s State Health Plan for 2008-2009 indicates a desire to maintain the same comprehensive program while still attempting to make strides in other areas such as oral care.105 Maine’s plan to tackle rising costs while still delivering improved health care is to implement an integrated care model that consists of two steps: “(1) the design and implementation of a Patient Centered Medical Home (PCMH) pilot; and (2) the continuation of the work of the Maine Center for Disease Control (CDC/DHHS) and MaineCare to raise awareness and inspire action on addressing the relationship between depression and the prevention and treatment of chronic diseases.”106

Maine faces substantial obstacles in making the plan available to all its residents. Certain cost-cutting measures implemented by the plan mean lower costs to insurers.107 Rather than allow the insurers to collect these savings, the state decided to charge insurers for these savings.108 In 2005 and 2006, Maine charged insurers $43.7 million and $34.3 million, respectively, for alleged cost savings to the insurance companies.109 The insurance companies complained that they owed much less, but lost in state court.110 The case is now on appeal and the financing strategy has been scrapped in favor of imposing lower-cost surcharges.111 This incident underscores the battle states will face in attempting to dictate the profit of insurers. Furthermore, Maine’s large rural, poor, and elderly populations have significant health needs and many businesses are not large enough to afford voluntary payments to employees for health insurance.112 Insurance companies no longer find it profitable to do business in Maine where Anthem Blue Cross Blue Shield controls a vast portion of the marketplace.113 If Maine does not figure out how to tackle this problem soon, the lack of competition could make it difficult to keep costs low.114

B. The Massachusetts Mandate

On April 12, 2006, Massachusetts passed the most comprehensive attempt at universal health care in our nation’s history. The plan includes an individual mandate that requires every person to obtain health care coverage or risk tax penalties.115 The Massachusetts Health Care Reform Plan (the plan) subsidizes individuals with income levels between 300% of the poverty level, with some expansions to MassHealth, an existing program for poor adults and children.116 The law also contains a controversial measure with regards to the ERISA. The plan requires employers who neglect to provide coverage for individuals to pay an annual fee of $295 per uninsured employee to the state. These measures have been challenged in the courts under the allegation that such state provisions are preempted by ERISA.117 More litigation on this issue is likely to follow.

Massachusetts, through a quasi-governmental entity known as the Commonwealth Insurance Connector (Connector), provides six different subsidized insurance programs.118 The Connector works as the central nerve system through which individuals purchase a plan from one of these six programs.119 The six plans were chosen “based on their ability to provide comparable services similar to what would be purchased on the open market and are portable upon a change in employment.”120 Beneficiaries of the program pay subsidized premiums based on a sliding-scale means test (akin to the changes adopted to Medicare through the MMA) up to three hundred percent of the federal poverty level.121 Fully subsidized premiums are available only to those enrollees with income less than 100% of the federal poverty level.122

The six health insurance programs cover a wide array of services including “inpatient and outpatient care, mental health and substance abuse treatment, vision care, dental care, hospice care, emergency care, and certain rehabilitation services.”123 At conception, the plan was expected to cost 1.2 billion over its first three years, but it experienced a budget shortfall of $153 million as of April, 2008.124 The system is funded through a “complex scheme involving Medicaid expansion to cover children, a Medicaid 1115 waiver, and the mandate schedule.”125 As a result of the shortfall, Massachusetts Governor Deval Patrick’s request of $869 million is almost double the amount originally planned for the 2008-2009 fiscal year.126

These financing shortfalls should not be overlooked as mere growing pains. Instead, they reflect the necessity for a program that accurately
predicts the actual amount of uninsured individuals. Former Massachusetts Governor Mitt Romney, who signed the plan into law, originally thought there were 400,000 uninsured individuals in Massachusetts.\textsuperscript{127} In 2008, this figure increased to 650,000 as uninsured citizens came “out of the proverbial woodwork to buy insurance rather than face tax penalties.”\textsuperscript{128} The state was forced to foot the bill for the premium because the majority of these previously unaccounted for individuals were poor.\textsuperscript{129} Furthermore, Massachusetts already had in place a “free-care” pool to pay hospitals for treating the poor. With the plan, legislators assumed the state would save anywhere between $500 and $600 million due to a decline in uncompensated hospital care.\textsuperscript{130} Those savings never came to fruition.

Even acknowledging its shortcomings, the health care solution enacted by the Massachusetts legislature still represents the best attempt at providing universal coverage to its citizens. As of 2008, 340,000 formerly uninsured residents have signed up for insurance programs either through a private insurance company or through the Connector.\textsuperscript{131} As more residents sign up, cost control issues are expected to decline. If costs can somehow be reigned in, the program may achieve its goal of universal health coverage for the residents of Massachusetts.

C. California Tries to Follow Suit

Governor Arnold Schwarzenegger, on January 8, 2007,\textsuperscript{132} unveiled what would be the largest attempt at health insurance coverage since the creation of Medicare and Medicaid in 1965.\textsuperscript{133} The program faces the daunting task of providing insurance to 6.5 million uninsured Californians.\textsuperscript{134} Governor Schwarzenegger’s plan revolves around three main elements: (1) prevention, health promotion, and wellness; (2) coverage for all Californians; and (3) affordability and cost containment.\textsuperscript{135}

The Governor began promoting the first element of this plan in his acting days. He intends to incentivize healthy behavior such as gym memberships and weight management programs.\textsuperscript{136} In addition, the plan proposes to reduce premiums for participation in healthy activities.\textsuperscript{137} These incentives are “linked to a health risk assessment and follow-up doctor visits.”\textsuperscript{138} The Governor proposes additional measures to address two preventable causes of high health care costs. The proposed plan seeks to develop a diabetes treatment model and implement what is known as ‘evidence-based’ measures to reduce medical errors.\textsuperscript{139}

The Governor’s second goal is to provide health coverage for all Californians. To achieve this result, he has proposed an ambitious five-part plan:

(1) Expansion of the Medi-Cal and Health Families programs to cover all uninsured children with family incomes below 300% of the federal poverty level; (2) mandated purchase of health insurance by all legal adult residents of California and expanded medical coverage for undocumented persons in California; (3) provision of payment assistance for lower-income adults through a state purchasing pool; (4) a mandated minimum level of coverage with a $5,000 deductible plan and maximum out-of-pocket costs of $7,500 per person ($10,000 per family); and (5) a “pay-or-play” mandate requiring all employers with 10 or more employees to provide health coverage or pay a 4% payroll contribution to the cost of coverage, as well as a contribution to the state health plan of 4% gross revenues by hospitals and 2% of gross revenues by physicians.\textsuperscript{140}

With the fifth element in his plan raising ERISA questions discussed below, the Governor may have to rethink the viability of this plan.

The Governor introduced a complex system of cost-saving measures and mandates on provider spending. These measures include: (1) a set of tax breaks for contributions to Health Savings Accounts; (2) a mandate that forces patient care to account for eighty five percent of every dollar a health plan, insurer, or hospital receives from premiums and health spending; (3) an expansion of electronic submission of documents between insurers and beneficiaries; (4) universal electronic prescriptions by 2010; and (5) incentives for quality health care through pay-for-performance measures.\textsuperscript{141} Whether these provisions would successfully fund an insurance plan for millions of uninsured Californians remains to be seen.

Concerns about the financial health of Governor’s Schwarzenegger’s proposal are well-founded. The most recent plan, the Health Care Security and Reduction Act (HCSRA), proposed to finance health coverage through: (1) an employer contribution based on the size of payroll and number of uninsured employees; (2) expected contributions from counties totaling one billion dollars; (3) a raise in cigarette tax to $1.75 per pack; and (4) a mandated four percent contribution from hospital revenues into a state-controlled fund.\textsuperscript{142} However, California’s Legislative Analyst’s Office, an independent state agency, found that “by the fifth year, the program’s costs would exceed revenues by $300 million, and by as much as $1.5 billion a year further down the road.”\textsuperscript{143} The state Senate committee did not pass HCSRA because it was deemed too expensive.\textsuperscript{144}

California’s budget shortfalls, exacerbated by the economic recession, forced the legislature to put universal health care on the backburner. Although Governor Schwarzenegger remains committed to providing Californians with universal health care, he faces an uphill battle. California is an example of a state not having the financial capacity to deal with a major health care overhaul during times of economic hardship. Obliging states to fund large entitlement programs, such as universal health care, creates long-term problems for state budget-planners, especially when the economy is not producing tax revenue to pay for such programs.

D. Problems with Employer Mandates: Preempted by ERISA?

On January 12, 2006, Maryland successfully overrode the governor’s veto, and passed the Fair Share Health Care Fund Act (the Act).\textsuperscript{145} Employers with at least 10,000 workers that spend less than eight percent on non-profit payroll (less than six percent for-profit payroll) on health insurance cost are required to contribute to the state Medicaid program.\textsuperscript{146} In early 2005, prior to passage of the Act, the Retail Industry Leaders Association (RILA) challenged the Act on its constitutionality and preemption by ERISA. ERISA contains a preemption clause that states, “ERISA shall supersede any and all State laws insofar as they relate to any ERISA-covered employer benefit plan.”\textsuperscript{147} The preemption clause ensures that only one set of regulations governed employee benefit plans.\textsuperscript{148} In Shaw v. Delta Air Lines, Inc., the Supreme Court declared that “a law ‘relates to’ an ERISA plan if it has either ‘reference to’ or ‘connection with’ such a plan.”\textsuperscript{149}
The United States District Court in Maryland, in a July 19, 2009 decision, determined that the Act was constitutional but preempted by ERISA because it had a “connection with” an ERISA plan. The court essentially looked at two criteria: the objectives of ERISA and the effect of the state law on ERISA plans. The court reasoned that the ERISA preemption clause was intended to avoid a multiplicity of regulations and concluded that, “[T]he intended effect of the Act is to force the employer to increase its contribution to its health benefit plan, which is an ERISA plan, and the actual effect of the Act will be to coerce [the employer] into doing so.” The court’s decision was affirmed in the Fourth Circuit.

The Fourth Circuit’s decision sent shockwaves through state legislatures, as states have either attempted to pass employer “Pay-or-Play” laws or at least debated the possibility. The Massachusetts Pay-or-Play provision, if challenged, will probably be preempted by ERISA due to the fact that it “mandates employer health care financing.”

With states struggling to find ways to pay for health insurance programs, this is yet another indication of the need for federal intervention in health care. The issue has not gone unnoticed on Capitol Hill. Senator John Kerry of Massachusetts “said he wanted to require employers to provide insurance to their employers.” Bringing to fruition Senator Kerry’s hopes would go a long way to cure the ERISA-created hassle for state programs trying to effectuate change in our health care system.

IV. LOCAL INITIATIVES

While much attention is drawn to the debate over universal health care at the state and national level, local initiatives are also emerging. The following is a brief look at local initiatives taking place in California and Maryland. The county-level programs in California stress coverage for children. Howard County, Maryland is beginning its attempt to provide health coverage for the uninsured at all ages.

A. Californians Take the Lead at the County Level

In California, as many as twenty-five counties operate what is known as a Children’s Health Initiative (CHI). CHI has two basic goals: (1) increasing outreach to uninsured children eligible for state-provided health insurance programs; and (2) developing a new insurance program known as Healthy Kids for children who would otherwise be ineligible for the state-administered programs. California, the nation’s largest state, has suffered immensely from a drop in employer-based coverage, increasing poverty rates, and rising immigration. These factors have forced a shift of responsibility in financing health insurance for families.

The California Medical Association reported that in 2007, twenty percent of Californians were uninsured, a remarkable 6.6 million people (the largest uninsured population of the states), sixteen percent of whom are children aged zero to eighteen. An estimated two-thirds of these children are eligible for existing programs, but have not yet enrolled in Medicaid or SCHIP (entitled Medi-Cal and Healthy Families, respectively). The remaining third fail to qualify because their family’s income does not qualify or, more commonly, the family has undocumented immigration status. These facts underscore the need to fulfill the two goals of California’s local initiatives: to educate the public of existing programs and to provide insurance for those who fall through the current system’s cracks. The existing state programs have “restrictions on providing assistance to undocumented families, and child health advocates sought alternatives to ensure that the estimated 200,000 or so ineligible children without coverage could obtain care.”

In 2001, Santa Clara County launched the first CHI and Healthy Kids programs, followed closely by Alameda, San Francisco, and San Mateo Counties. The program was launched in only six months, using a mix of public and private funding. Currently, twenty-six counties operate Healthy Kids programs. Other counties offer CalKids benefits. Furthermore, children appear to be faring better as a result of government insurance displacing employer-based coverage. For example, “[P]ublic program expansions have more than offset major decreases in employer-based coverage, resulting in an estimated net decrease of 117,000 uninsured children between 2001 and 2003.”

The rapid pace of growth for these programs spurred further efforts to both consolidate resources and vary approaches. Regional efforts to consolidate county programs are underway and three CHIs have initially opted to utilize CaliforniaKids, a nonprofit private insurance plan for undocumented immigrant children aged two to eighteen. CaliforniaKids is available statewide, offering primary coverage and subsidized premiums to qualified children.

Although CaliforniaKids has served more than 62,000 children statewide, Marin County hopes to leave CaliforniaKids behind and aims to offer a Healthy Kids program. The Healthy Kids program, run by CHIs, has been successful in enrolling more than 85,000 children whose immigrant status precluded them from...
coverage under federal and state insurance programs.\textsuperscript{171} Furthermore, these county-wide initiatives enrolled countless more children in the state-run health insurance programs to ensure that California inches “closer to universal coverage for children.”\textsuperscript{172}

B. Howard County, Maryland

Howard County, Maryland attempted to build a low-cost health care program to serve its estimated 15,000 uninsured adults.\textsuperscript{173} The program launched on October 1, 2008.\textsuperscript{174} Healthy Howard, as the program is called, “offers care for as little as $50 a month.”\textsuperscript{175} Although applicants inundated the program when it first went online, most were denied because they were eligible for state or federal programs and were consequently directed to those programs. This is a sign that information is not being disseminated regarding government-sponsored health insurance at the federal or local level.\textsuperscript{176} As a result, approximately 109 of the 1,500 uninsured but eligible individuals were receiving health care through Healthy Howard.\textsuperscript{177} Howard County is ready to take some bold marketing steps to attract the uninsured to the program. These steps include “plans to increase outreach efforts to local college students and small businesses. They are even resorting to cold cash – offering some nonprofit community groups $20 for each person they help recruit for the program.”\textsuperscript{178}

V. THE AMERICAN RECOVERY AND REINVESTMENT ACT, THE OBAMA ADMINISTRATION, AND CONGRESS: HOPE FOR THE FUTURE?

A. The American Recovery and Reinvestment Act (ARRA)

President Obama kept his campaign promise by signing the ARRA into law. The ARRA provides $19.2 billion to support the development of health information technology (HIT).\textsuperscript{179} The ARRA also goes a long way to address long-term cost-containment issues, such as HIT and research in best practices. The AARA sets aside ten billion dollars for the National Institutes of Health; two billion dollars for Community Health Centers with $1.5 billion of that amount allotted for construction, renovation, equipment and HIT, and $500 million for operations; and $1.1 billion for Comparative Effectiveness Research.\textsuperscript{180} Another $500 million was set aside to expand the primary care work force, with $300 million going to the National Health Service Corp. and $200 million allotted for primary care training programs contained within the Public Health Services Act.\textsuperscript{181} Furthermore, the ARRA provides an additional $500 million to the Indian Health Service for renovation, HIT, and health services. Another $338 million will go to “Medicare spending to block payment reductions for teaching hospitals and hospice providers and to make technical corrections for long-term care hospital payments.”\textsuperscript{182}

While the ARRA went a long way to place a ‘down payment’ on health reform, the steps taken were mostly to counteract the economic recession while the task of true health care reform remains with Congress. This could prove to be a tough fight. As of this paper’s publication date, five Congressional panels have passed comprehensive health reform bills.\textsuperscript{183} While this represents a significant step forward towards passing legislation, Congress must still reconcile some of the more contentious issues – a public option and an individual mandate being two of the major ones – before the proverbial ‘mission accomplished’ flag can fly above Washington.

The plan President Obama touted on the campaign trial would cost approximately $1.2 trillion over ten years.\textsuperscript{184} but would not guarantee coverage to all Americans. The Lewin Group, a leading consulting and health policy analysis firm, estimates that in order to cover all Americans the cost will be between $1.5 and $1.7 trillion dollars over ten years.\textsuperscript{185} This price tag has drawn criticism from Republican lawmakers.\textsuperscript{186} It will be difficult, but not impossible, to pass a major overhaul of our health care system. The President, through the ARRA, asked Congress to place $634 billion into a reserve for health care reform.\textsuperscript{187} However, Congress has yet to appropriate this money into such a fund.

B. Health Care Reform Legislation

As President Obama has called upon Congress to provide a health care proposal, many commentators are expecting a tough political fight.\textsuperscript{188} In recent years, several proposals have floated around Congress. In April of 2007, the late Senator Edward Kennedy (D-Mass.) and Congressman John Dingell (D-Mich.) introduced the “Medicare for All” bill, which included an individual mandate and the offering of Medicare to those under sixty-five during a five year phasing-in process.\textsuperscript{189} Those ages fifty-five and sixty-five and children under the age of twenty-five would be eligible for coverage.\textsuperscript{190} Enrollees would then be able to choose any of the private insurance plans available to federal employees through the Federal Employee Health Benefit Program (FEHBP). The estimated cost is $600 billion per year paid for by payroll taxes and general revenues.\textsuperscript{191}

Representative Pete Stark (D-Calif.) proposed “AmeriCare” as an alternative, while Senator Ron Wyden (D-Ore.) introduced the “Healthy Americans Act” in 2006.\textsuperscript{192} Stark and Wyden’s proposals claimed to cover nearly all Americans.\textsuperscript{193} Stark’s proposal will turn Medicare into the primary source of insurance coverage for all Americans. The AmeriCare proposal estimated that administrative costs of health insurance would decline by seventy-four billion in 2007.\textsuperscript{194} Stark’s proposal underscores what many believe a single-payer system would accomplish by slashing the administrative costs associated with private health insurance. Wyden’s proposal, on the contrary, would set up regional purchasing pools called Health Help Agencies.\textsuperscript{195} People would purchase private insurance in these large regional groups that were estimated to cut administrative costs by fifty-seven billion in 2007.\textsuperscript{196}

While neither of these proposals became law, they underscore the debate on Capitol Hill. Some liberal Democrats urge for the creation of a single payer system, while moderate Democrats and Republicans are pushing for more personal choice in order to supplement and encourage participation in the private health insurance market. With five Congressional bills having passed their respective committees, a number of options still linger that could find themselves into the final draft. The Senate Finance Committee balked at a public option and chose instead to propose a system of consumer-driven cooperatives established with six billion federal dollars.\textsuperscript{197}

The jury is still out on whether cooperatives can successfully compete with the private insurance market to force down costs. In the rural west, insurance cooperatives have existed for quite some time with success – notwithstanding Republican Senator Orrin Hatch’s characterization of cooperatives “as another way of saying a government plan.”\textsuperscript{198} Cooperatives are completely member-owned.\textsuperscript{199} In Idaho, “a consumer-
governed, nonprofit health care provider — Group Health Cooperative of Puget Sound — offers extensive [health] coverage at some of the lowest premiums in the nation.200 Cooperatives are also a uniquely American solution to health insurance. Many western Americans purchase “their tents, sleeping bags and bikes from the nation’s largest consumer co-op, REI, founded in Seattle in 1938, now with 3.5 million active members. It’s consistently rated one of the best places to work in the United States.”201 Whether “co-ops” can assuage both Republican desires for there not to be a public option and the Democratic desire to create some entity that can keep the insurance industry honest is difficult to foresee.

What could be the most intriguing aspect to this battle is how Democrats decide to try and pass health care reform. The Democratic Party holds a significant majority in the House, such that initiatives like a public option are sure to come out of House bills. Liberal Democrats, such as Portland, Oregon Representative Earl Blumenauer, continue to hope for a public option claiming: “[i]t would be very hard for me to [vote for a bill without a public option].”202 However, Republican opposition in the Senate remains committed to seeing the government stay out of the insurance business.203 Olympia Snow, the lone Republican senator from Maine, who voted in support of the Senate Finance Committee’s bill, may turn out to be the key determinant of any final bill.204 Her continual insistence that a final bill not include a government sponsored insurance option – coupled with Blue Dog Democrats’ similar instincts and the desire to have the appearance of bi-partisan support – underscore the difficulty of reconciling bills coming out of the House and Senate.

The ARRA barely passed muster in the Senate, and health reform will be an even harder fight tempting Democrats to use a process called ‘reconciliation’ to pass major health care reform. If Congress takes the normal route, Democrats risk a Republican filibuster unless they can count on Arlen Spector’s allegiance to his new party. Reconciliation would erase the need for sixty ‘yea’ votes, and allow health reform to pass by a simple majority. Reconciliation is more properly termed ‘budget reconciliation’ and would place any health reform proposal in a budget resolution that only requires a simple majority vote in the Senate.205 Reconciliation is still an available option and “the Obama administration has made it clear that they will push something through, using reconciliation if necessary, and in effect put Democrats who don’t go along on the spot.”206

If Democrats can pass health care reform through the reconciliation process there will undoubtedly be little concessions made to the Republican Party. Such a proposal would most likely include a public health insurance plan to compete with the private market, and perhaps a program mandated employers to provide a minimum amount of health coverage.207 Senator John D. Rockefeller IV, a Democrat from West Virginia, hopes to see a public option in any final legislation while Senator John Kerry hopes to push through an employer mandate to provide health insurance for their employees.208

Senators are allowed, under current rules, to attack provisions of a reconciliation piece that are “merely incidental to budgetary concerns, [but] nobody is quite sure how the Senate parliamentarian would rule on such items as tighter regulation of private insurers or creation of a new public plan to improve the coordination of care.”209 Democrats may attempt to establish a bill that allows for the normal Congressional procedures with a clause that would eventually bring the proposal into the reconciliation process if Democrats and Republicans cannot agree on a bill.210 One concern with the reconciliation process is the divisive affect it may have on the country. The Republican base would certainly feel cheated, and the President’s goal of bringing the country together may never come to fruition. Conservatives may forever hold a grudge against the President for his failure to reign in a Democratic Congress unwilling to compromise, ferociously attacking any further attempts at reform in other fields. Either way, the fight for health care reform is under way.

VI. CONCLUSION

A. Universal Coverage for Children a Far Easier Task

Providing coverage for children seems to be a more feasible goal than providing coverage for all Americans. This makes sense in light of the American value of self-reliance. In order to create a universal health care system, the public will have to accept the fact that the government, not the individual, will be the guarantor of health care. The public seems more willing to accept a government initiative to ensure health care for children because children lack the self-reliance necessary to provide health insurance for themselves.

The ease with which Congressional Democrats passed the reauthorization of SCHIP (now known as CHIP) is a telling sign that America is getting used to the idea of universal health care. However, comparing a program that provides insurance to children, who

"The public seems more willing to accept a government initiative to ensure health care for children because children lack the self-reliance necessary to provide health insurance for themselves."
have no control over their parents’ income, to a true universal system of health care may not be warranted. There still seems to be a general fear of an all-powerful federal program governing something as private as a person’s health care. Perhaps, as more and more people experience the benefits of CHIP, we can expect the nation to turn the corner and warm to the idea of universal health care.

B. Facets of a Solution

1. Make the Public Aware of the Health Care Coverage Available

All levels of government seem to be failing when it comes to community outreach and education. In 2006, twelve million non-elderly uninsured Americans were eligible for existing state or federal health programs, but failed to enroll.21 The government should take note of the problems created by failed outreach. Arkansas currently offers coverage through small businesses but the program enrolls a mere 5,000 people while having the capacity to accommodate ten times as many.212 Massachusetts currently imposes a tax penalty on 167,000 individuals because of their failure to enroll in either a private or public insurance program. In Maryland, Healthy Howard has only been able to enroll 109 out of an estimated 13,500 uninsured constituents.213 If outreach programs do not address these inadequacies, any initiative is bound to fail to provide health coverage to the uninsured.

2. Fix the Tax Code

The tax break created under IRC § 501(c)(3) was enacted before the existence of Medicare and Medicaid and needs reevaluation. While the language was amended to reflect these federal health insurance programs, the IRS has still failed to rationalize the change in light of the public policy concerns behind the subsidy. The original policy goal was to provide medical care for those who could not afford it. While Medicare and Medicaid provide health insurance for a large portion of the population, millions still slip through the cracks. There are forty-six million uninsured Americans who cannot afford health care. The tax benefit provided to non-profit hospitals would more accurately address public policy concerns if the benefit were granted according to the hospital’s provision of medical services to the uninsured at a discounted rate.

The twenty billion dollar subsidy for non-profit hospitals is still merely “a drop in the bucket in terms of the amount needed to address the access problems faced by the insured.”214 Any change to IRS rulings or enforcement policy would not substantially address the health care problems we face as a nation. Still, every little bit helps. As Congress and the Administration lay out their plans for reform, it is important that they address a myriad of potential areas for reform, including the tax code.

3. Get Everyone in the Pool

To spread risk and decrease per-capita costs of health insurance, the healthy and young need to jump into the insurance pool. Outreach programs will not force young, healthy individuals to allocate monthly rent money for a benefit they cannot foresee using. Hence, some sort of mandate may be necessary. In Massachusetts, the individual mandate had more success than Maine’s original coverage plan, forcing the Maine legislature to consider implementing an individual mandate.

While during the presidential election campaign then Senator Hillary Clinton (D-NY) supported an individual mandate on the campaign trail, President Obama shied away from such a federal declaration. Instead, the President believes we can provide affordable health care to all through cost cutting measures such as: allowing more generic drugs and drugs from other developed countries to enter the American marketplace, subsidizing the costs of catastrophic care for insurers, preventing insurers from overcharging doctors for their medical malpractice insurance, requiring large employers who do not provide health coverage to pay into a worker’s health care savings account, requiring insurance companies to cover pre-existing conditions, providing a small business health insurance tax credit so they can also provide insurance to their employees, and promoting initiatives such as investments in HIT and quality of care.215

4. Health Care Reform Does Not Need to Completely Overhaul the System

Whether the President’s program would be enough to bring substantial numbers of the uninsured into the risk pool remains uncertain. Massachusetts Governor Patrick, after experiencing frustrations with rising premium costs even with an individual mandate, told reporters prior to the 2008 election, “[T]he next administration in Washington should give serious consideration to a single-payer universal health care solution.”216 Such a solution would no doubt lower administrative costs in the future, but at what cost?

Currently there are a myriad of ways in which Americans get their health care, ranging from Veterans benefits, Medicare, Medicaid, employer-sponsored plans, and private insurance. In a New Yorker piece...
entitled Getting There From Here: How Should Obama Reform Health Care?, Atul Gawande takes the reader through a history of universal health care developments around the world. Contrary to popular beliefs, universal health care reform in countries like Great Britain, France, Switzerland, and Australia did not come about with drastic changes to the systems already in place. Instead, each country merely built around and expanded the pre-existing insurance programs. The plan that President Obama proposes seems to do just that by providing a mix of tax benefits and incentives for employer-sponsored health insurance, as well as the possibility of expanding existing federal programs. With the addition of a few cost-containing measures such as investments in the quality of care, preventive care, and HIT, change could be right around the corner.

C. Federalism is Working like the Founders Planned, Now Its Time for Washington to Take Action

In the health care context, federalism is working out as planned: experimental, slow and painful – at the expense of millions of uninsured Americans. States and localities are initiating programs for universal health care while Congress debates how such a system would work. The results are mixed. Local initiatives in California seem promising and reflect a truly American solution with a combination of private and public funding. This cannot be mistaken for a belief that local solutions can rescue the almost fifty million Americans without health insurance. Historically states and localities were the first to enact fair labor standards at the start of the twentieth century. It was not until after numerous court battles, the Great Depression, and the election of Franklin Roosevelt that a national plan was created to provide some sort of safety net and floor for employees’ wages.

When comparing the current economic situation to the crisis that precipitated the New Deal, there are some stark differences. First, states and localities are not waiting for the federal government to solve their problems. Akin to the early years of the twentieth century, states are taking the lead in ensuring a safety net exists. This time the target is health care, not fair labor standards. Furthermore, ERISA represents a legal tug of war between the states and the federal government. Prior to the New Deal, Supreme Court decisions made it very difficult for the federal government to enact national workers’ rights laws. Although we face almost the opposite problem today – with federal courts denying states the power to mandate employer contributions to health coverage programs – both court challenges underscore the need for federal action. With regard to the enactment of fair labor standards, too many states were not willing to enact their own workers’ rights laws. Today states are unable to fully incorporate employers into a health insurance solution due to ERISA preemption. This dramatically weakens states’ abilities to provide coverage to the uninsured, as employer provided health care represents one of the largest facets of American health insurance.

The current economic recession, like the Great Depression, is increasing the number of uninsured citizens in America. Since the federal government is one of the few players that can access the capital needed to provide health insurance to those forty-six million uninsured, it only makes sense for it to take responsibility for the costs and risks associated with a government administered health insurance program. As the benefits and drawbacks of such a system battle each other in the marketplace of ideas, federalism seems to be doing its job. It is unclear how these debates will be resolved, but one thing is certain: history and the realities of the day point in the direction of a federal solution.

2 Id.
3 Id.
8 Medicare General Enrollment and Eligibility, supra note 5.
10 Rick Mayes, Medicare and America’s Health care System in Transition: From the Death of Managed Care to the Medicare Modernization Act of 2003 and Beyond, 38 J. HEALTH L. 391, 417 (Summer, 2005).
(MedicareChoice is now referred to as Medicare Advantage; regardless of the name, this is Medicare Part C).
11 Id. at 417.
12 Id.
13 Id.
14 Id.
15 Id. at 418.
16 Mayes, 38 J. HEALTH L. at 418.
17 Id.
18 Id.
19 Id. at 419 (citing to Bruce C. Vladeck, *The Struggle for the Soul of Medicine*, 32 J.L. Med. & Ethics 410, 413 (2004)).
20 Id.
21 Id. at 419-20.
23 Id.
24 Id.
25 Id.
26 Id. at 551-52.
27 Id. at 551.
30 Id.
32 Id.
34 Id.
35 Id. at 2.
36 Id. at 1.
37 Id.
38 Id.
41 Id.
42 Id.
43 Id.
44 Id.
45 Id.
47 Id.
48 Id.
49 Id.
50 *House Dems Incllude COBRA Expansion, Subsidies as Part of Economic Stimulus*, 22 No. 2 COBRA GUIDE NEWS. 2 (Feb., 2009).
52 Id.
53 Id.
54 Id.
55 Id.
56 Id.
57 *See Centers for Medicare and Medicaid Services, supra* note 29. (CHIP is contained within Title XXI of the Social Security Act (42 U.S.C. §§ 1397aa-aj)).
58 Id.
61 *See National Conference of State Legislatures, supra* note 59.
62 *See Centers for Medicare and Medicaid Services, supra* note 31.
63 *See National Conference of State Legislatures, supra* note 31.
65 *See Presidential Memorandum – State Children’s Health Insurance Program, supra* note 55.
66 Id.
67 Id.
68 Id.
69 Id.
70 Id.
71 *See National Conference of State Legislatures, supra* note 59.
72 *See Centers for Medicare and Medicaid Services, supra* note 31.
73 Id.
74 *See Kaiser Commission on Medicaid and the Uninsured, supra* note 64.
75 Id.
77 Id. at 53-54.
78 Id. at 54.
79 Id.
80 Id. at 55-56.
81 Id. at 56.
84 Id.
85 Id. at 57.
86 Id.
87 Id.
88 Id. at 57-58.
94 *See National Conference of State Legislatures, supra* note 91.
95 Id.
97 Id.
98 *See Karen Davis, supra* note 93 at 3.
99 Id.
100 Id.
102 Id.
103 Id.
104 Id.
106 Id. at 39.
108 Id.
109 Id.
110 Id.
111 Id.
112 Id.
113 Pam Belluck, *supra* note 101.
Karen Davis, supra note 93, at 3.

Id.

Shelly K. Hubner, supra note 4, at 15.


Id.

Id.

Id.

Id. at 292.


Mark Douglas, supra note 118 at 292.

Id.

Id.

Id.


Id.

Id.

Id.

Mark Douglas, supra note 118, at 296.

Kim, supra note 132, at 39.

Id.

Id.

Id.

Id.

Id.

Id.

Id.

Id. at 17.

The “Pay or Play” initiatives refer to government attempts to mandate employer-sponsored healthcare. If employers refuse to “play” – i.e. sponsor healthcare for their employees – they will be forced to “pay” in the form of a tax.

Shelly Hubner, supra note 4, at 18.


Id. at 738.


Gregory Stevens, supra note 157.

Id.

Id.

California Children’s Health Initiative, supra note 156.

Id.

Id.