In the United States, calls to expand access to health care, when not simply ignored, typically result in bills or legislation to reform health insurance. We are in the midst of just such a transformation today. Several states have adopted reform laws to make insurance available to most of their residents. Presidential candidates are offering their own proposals for the nation’s health care system. Former Treasury Secretary Paul O’Neill even declared that health care should be a right, adding that wealthier people should help pay for those who will never be able to afford their own care. Most Americans cannot afford to pay for more than minor medical procedures out of their own pockets. Insurance is the vehicle that finances the rest. Thus, insurance has come to stand for health care.

Yet buying insurance is not the same thing as buying health care. Conflating the two can exacerbate disagreements about the responsibilities of government, business, and individuals for health and health care. Health reform proposals reflect different philosophies about who should be responsible for certain health conditions — society at large or the individual herself. Current health insurance reform proposals borrow from both camps, combining provisions

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based on actuarial fairness with provisions promoting social solidarity by prohibiting certain forms of risk rating and underwriting.

This essay argues that amalgamating reforms that serve inconsistent goals can perpetuate, rather than resolve, conflict. Part I suggests that combining commercial indemnity insurance and social insurance forges a contract for traditional indemnity insurance plus discretionary personal services — an “insurance + services” contract — which pulls the system in opposite directions. Part II examines a recent example of the service side of this insurance + services contract — coverage of so-called “wellness programs,” which base premiums, discounts or rewards on meeting specific standards of behavior. Often justified on grounds of actuarial fairness, they foster the idea that certain health conditions are matters of personal responsibility. Yet, there has been virtually no discussion of what principles ought to govern the choice of conditions targeted by wellness programs. Experience to date, however, suggests that such programs are likely to disadvantage those most in need of social assistance. In the context of rising health care costs, such personal responsibility provisions may unravel the social solidarity that prompted reform in the first place.7

I conclude that using commercial insurance to provide access to care encourages reforms based on actuarial fairness promote the view that health is each person’s personal responsibility. These reforms may return to us to the days before health insurance, and have the potential to undermine social solidarity beyond the insurance sphere.

I. Social solidarity and personal responsibility in health insurance

There are many explanations why the United States has never adopted a system for universal access to health care, much less national health insurance.8
Underlying much of the political disagreement are very different views about the nature of health care. At one end of a wide spectrum is the view a person is (or ought to be) responsible for her own health and pay for her own medical care like other ordinary consumer goods. At the other end are those who find health is somehow special so that society should be responsible for ensuring everyone access to care, regardless of ability to pay. Health reform proposals reflect these opposing views, and the difficulty of reconciling them undoubtedly has stymied agreement on reform. Without greater clarity about whether insurance should reflect social solidarity or personal responsibility, or which health conditions deserve social insurance coverage and which do not, gridlock is likely to continue.

Recent trends in health insurance in the United States reflect both these competing values. On one hand, there are signs that the country is moving toward universal health insurance coverage for reasons of social solidarity. Public opinion polls report that a large majority of Americans favor universal access to care. Health care is no longer affordable for most Americans without insurance. Employment-based health insurance covers a declining proportion of nonelderly Americans. This decline, however, has been offset by expansions in public (state) Medicaid and SCHIP programs. Several states have adopted or are considering legislation to increase insurance coverage. But state level reforms are limited by ERISA preemption, and recent proposals for national reform at the federal level suggest that momentum for universal coverage is building. Even employers may support reforms that include universal coverage.

At the same time, a competing trend has emerged favoring increased personal responsibility for health and health insurance. The beginning of the twenty-first century saw a return to more traditional indemnity health insurance following the late 1990’s backlash against managed care. Although most health insurance plans still include
procedures for managing care, most private insurance companies see their plans as commercial insurance products covering specified losses, and not as a mechanism for financing universal access to care.21 Continuing health care cost increases also put pressure on insurers, government, and employers to reduce the need for care, tie premiums to claims experience, and shift more costs onto insureds.22 Health savings accounts are popular among some employers, because they make employees responsible for a portion of their health care expenses.23 A recent innovation, wellness coverage, offers discounted premiums or rewards for employees who participate in programs to prevent health risks, such as smoking cessation programs, exercise programs, and blood pressure and cholesterol screening programs.24 These programs, however, expand the concept of personal responsibility from financial liability to responsibility for one’s own health status.

Social solidarity

Given the complexity of medicine and disease, there may be good reason to create health insurance structures that aim for both universality and some degree of personal responsibility in coverage. Nonetheless, those two goals pull insurance in opposite directions. This tension affects both private commercial insurance and public benefit programs, like Medicare, Medicaid or Veterans and military health benefits that are not formal insurance plans.

The concept of social solidarity embodies goals of mutual aid and support.25 The idea is that we are all in this together, and no one should be abandoned. Such aspirations inspired early mutual aid societies to spread and share financial risks.26 Where people are considered to be equally and randomly at risk for medical problems, it makes sense for everyone to chip in and make sure that, when injury or illness occurs, help is available to anyone who needs it.27 To
fulfill their responsibilities to their populations, governments often adopt social insurance systems to finance health care. The principle of mutual aid and support is evident in rules for universality of coverage and uniform premium rates. Most systems bar medical underwriting to exclude people from coverage and prohibit or limit segmented markets and risk classification. The defining feature is that people are not excluded or asked to pay more because of their own health status, health risks or medical claims experience.

Even in the absence of universal social insurance in the United States, state and federal laws move commercial insurance toward social solidarity goals. For example, laws requiring guaranteed issue preclude insurers from excluding certain people from the pool. State laws requiring coverage of specific services (mandated benefits) embody social policies about what coverage must be available to all (except self-insured employee group plans exempted under ERISA). Most state laws forbid charging higher premiums to women, even if women are more likely than men to use medical care on average. Many states also prohibit premium discrimination on the basis of genetic information.

The federal Health Insurance Portability and Accountability Act (HIPAA) prohibits certain group of health plans from discriminating in eligibility or premiums on the basis of health status factors, such as medical condition or claims experience. More general anti-discrimination laws also foster social solidarity. For example, the federal Americans with Disabilities Act prohibits discrimination in employee health insurance coverage solely on the basis of disability. Title VII of the Civil Rights Act of 1964 prohibits discrimination in employee benefits on the basis of race, color, religion, sex, or national origin. Employee group health plans generally offer the same premium rate to all employees, regardless of age, health status, or claims experience. Offering the same coverage for the same premium regardless of age is a significant example of solidarity, since health costs tend to increase with age.
Personal responsibility

Commercial insurance captures the concept of personal responsibility in efforts to achieve actuarial fairness. Here, the idea is that each person should pay for his own risks and no others. In contrast to social solidarity, the personal responsibility principle is that people are different and we should not be responsible for those who are different from us. Actuarially fair insurance policies classify and segregate insureds into groups according to the type and amount of risk they represent, with different coverage, exclusions, and premiums. In health insurance, this means that the market for insurance is segmented into multiple categories with multiple products.

Commercial insurers use medical underwriting and risk rating to classify people. Medical underwriting, used primarily in individual policies in the United States, avoids insuring specific individuals for predictable (non-fortuitous) risks. For coverage of other risks, actuarial fairness aligns premium rates with the individual’s level of risk. Other payments, like the cost-sharing devices of deductibles and co-payments, serve both to discourage unnecessary medical care (and claims) and to engage the insured in effectively “insuring” her own losses to some degree. Coverage limits, although strictly a matter of covered losses, can also serve to discourage unnecessary care and claims. For example, limits on services restrict the number of inpatient hospital days or physician office visits covered. Caps on paid claims, such as annual or lifetime limits on the dollar amount of health care expenditures covered, provide a ceiling on the insurer’s risk.

The complicated terms of commercial health insurance policies may be an inevitable consequence of the difficulty of determining what should count as a loss. While a broken limb or heart attack presents an unmistakable claim on the need for medical care, many health conditions are more ambiguous. What,
if any, care is needed can often be debated, making the insurer’s risk more difficult to calculate. Moreover, the cost of care varies significantly around the country, yet continues to rise everywhere. Such concerns may not be unique to health insurance, but are undoubtedly more intense in assessing health insurance claims. Indeed, health insurance may push the boundaries of insurable risks.

**Insurance policies and service contracts**

Fundamental to the concept of insurance is the premise that covered risks should be fortuitous — that is, unplanned and unanticipated. State laws and market demand, however, have crafted exceptions to the principle in many health insurance policies. The consequence may be confusion about what counts as an insurable risk.

The best known exception is coverage of preventive services, such as immunizations, disease screening (e.g., mammograms), dental cleaning, prenatal care, well baby visits, and annual physical examinations. There are undisputed social policy reasons for these exceptions; such services can prevent disease and keep people healthy. Requirements for insurance coverage are generally based on concerns that many people, especially low-income groups, would not obtain such services if they had to pay for them out of pocket. Insurance coverage encourages prevention by paying for it. Moreover, preventive services typically cost less than treatment for the disease. These are sound rationales for encouraging prevention, but they do not fit insurance well.

The use of insurance to achieve desirable public policy goals challenges the nature of commercial insurance. Preventive care is not a typical insurable risk, because it is predictable and under
the control of the insured. The specific services are explicitly paid for whenever the insured chooses to obtain them. Insurers can predict the cost of such coverage, but assume no risk, removing the agreement from the realm of insurance. Instead, the insurance payments to health providers function like assets of the insured to pay for a defined set of services. The result looks more like a service contract than an insurance policy.

Health reimbursement accounts (HRAs) expand the service contract concept beyond preventive care. A particular type of HRA, the health savings account (HSA), has become more attractive to individuals and employee group health plans since receiving favorable tax treatment. Although not yet widespread, HRAs are the current paradigm for so-called “consumer-directed” care, described as giving consumers more choice than they had with regular health insurance, primarily managed care plans. Both supporters and critics agree that such accounts are designed to make consumers more cost-conscious by forcing them to pay for a portion of their care. Although there is as yet little data about how most individuals spend their account funds, it is likely that most are spent in preventive care, as described above, as well as less expensive, acute medical services, such as treatment for a sprained ankle, which are more discretionary or less costly than hospitalizations. Shifting this kind of care out of the defined benefit package trims health plans of their coverage of some non-fortuitous risks. While there are limits on the type of care for which the funds can be used, HRA accounts move responsibility for seeking and paying for care back onto the individual.

Health reimbursement accounts embody the view of some health economists and policy analysts that health insurance is a personal financial asset that can be used to buy medical care at the consumer’s discretion, a view at odds with that of insurance
purists. In these commentators’ view, insurance distorts the market for health care by enabling, even encouraging, individuals to buy more care than they need, or at least more care than is economically efficient for the country. Their focus of analysis is the purchase of health care; insurance is merely a source of funds for payment.

In contrast, the traditional insurance industry view is that its product is a promise to pay only for specified losses. In this view, an insurance policy is not a cash equivalent to pay for whatever the insured chooses to buy. Therefore, HRAs, like coverage of preventive services, distort insurance. While health economists argue that consumers should be deliberate, rational purchasers of care, insurers expect to pay only for fortuitous losses. Pairing HRAs with defined benefit insurance policies couples very different conceptions of the function of insurance.

Economists concerned about national health expenditures object to generous insurance policies on the ground that they buy too much care. But, the reason we have insurance is to pay for losses that we could not otherwise afford. If health care is a consumer good, freely bought and sold in the marketplace, then it should not matter what resources consumers use to buy it. Wages, daddy’s trust fund, and health insurance are all cash equivalents. Moreover, if health care is a consumer good, who cares what people buy? Why not let the market determine what services people value? Of course, the main reason for objecting to unrestrained spending is that it raises the price of care so that not everyone can afford it. Yet unaffordability matters only if health care is something more than an ordinary consumer good, something that should be available to everyone regardless of ability to pay. Thus, the economic argument against buying too much care supports the idea of social solidarity in ensuring access to care for everyone. Paradoxically, however, the solution offered to rising health
care costs — making people responsible for more of their care — weakens social solidarity.

Summary

The exceptions to traditional indemnity insurance for insurable risks are usually justified on two grounds: cost (to society at large, government or private insurers, or employers who contribute to premiums); or social policy (to improve health, encourage “good” behavior or discourage “bad” behavior). In many cases, both reasons are intertwined, so that is difficult to disentangle one from another, as may be seen in the example of wellness programs discussed below. Adding exceptions for these reasons may make some sense in a universal social insurance system, where everyone is in the pool, to remove financial barriers to important services. Adding them to private insurance sold in the commercial market outside the context of a universal social insurance system, however, may simply widen the sphere of personal responsibility.

Neither social solidarity nor personal responsibility principles, by themselves, can explain or justify the package of health insurance reforms put forward today. Coverage of some conditions and services reflect social solidarity, while other provisions encourage personal responsibility and treat health care as a consumer good. Implicit in this division of reform provisions is the idea that some conditions are socially acceptable, such that all society ought to share (at least financial) responsibility for their prevention or consequences, while other conditions are socially unacceptable, so that individuals should shoulder the burden themselves. Yet there has been no significant debate about what principles ought to govern classifying particular health conditions as either an individual responsibility or a social responsibility.
II. The peculiar case of wellness programs

The most recent examples of allocating health conditions to the personal responsibility side of the equation are wellness programs. Although often offered as part of a health insurance plan, such programs function like service contracts, with the individual earning rewards for performing specific tasks (or incurring a loss for failing to do so). For example, those who get screened for hypertension or high cholesterol might receive a discount on their health plan premium. Those who attend regular exercise programs might avoid paying the plan’s deductible. Those who take medication as prescribed might have their drug co-payment waived. Those who fill out a personal health history and agree to be monitored by a disease management group may get cash prizes. Some employees welcome the programs, while others object that they are intrusive and unrelated to job performance or consider them a mechanism to get rid of the employees most likely to incur expensive medical claims. Even the Wall Street Journal worried in print that employers may be overreaching by monitoring employees’ health.

A wellness program uses risk data to selectively modify rates for individuals who are already in an insurance pool. In theory, it is the insured, instead of the insurer, who changes the rate—by complying with the program’s requirements. Generally, however, everyone in the group who does not have a particular risk factor, like smoking or diabetes, receives a discount or reward. The effect is to charge higher rates to individuals with specific health risks or behaviors. The specific conditions for which financial differences are allowed offer some insight into what we hold people personally responsible for.

A well-publicized example was the plan adopted by Clarian Health, an Indiana hospital system, to charge employees bi-weekly fees if they failed to meet target health standards, beginning in
2009. US$10 if BMI ≥ 30; $5 for blood pressure > 140/90; $5 for glucose levels > 120; $5 for low density lipoprotein Cholesterol > 130; $5 for smoking; and $5 for not completing a health assessment. After public opposition to its plan, Clarion made the plan voluntary and withdrew the penalties on those who fail to meet the targets. Instead, it will offer the same amounts as bonuses to those who voluntarily meet the targets. The effect, however, may be the same.

Laws forbidding medical underwriting and basing premium rates on individual health risks would seem to prohibit this result. Nevertheless, wellness programs have joined preventive services as an exception to the fortuity principle in many health insurance plans. The tension between rewarding wellness and banning discrimination based on health risks, however, may be reflected in the fact that it took the federal government more than a decade to issue final regulations under the federal Health Insurance Portability and Accountability Act. Like several health insurance reform proposals, the Act prohibits discrimination on the basis of health factors while simultaneously allowing group health plans to offer financial rewards for “adherence to programs of health promotion and disease prevention.” The regulations attempt to reconcile the exception for wellness programs with the general prohibition against discrimination on the basis of any health factor.

The difficulty of reconciling the two can be seen in examples of acceptable programs described in the regulations. Even programs that base rewards on an individual satisfying a health-related standard can qualify for the exception if they meet four criteria, which, judging from the examples, appears to be relatively easy to do. The regulations approve a hypothetical wellness program that waives the $250 annual deductible for participants who have a body mass index (BMI) between 19 and 26. Those who are unable to lose enough weight for medical reasons can earn the reward by walking 20 minutes a day 3 days a week. A
medical condition prevents individual E from meeting either standard. The regulations approve a result in which the “plan agrees to make the discount available to E if E follows the physician’s [unspecified] recommendations.”

It is hard to argue that this program does not discriminate on the basis of a health factor. The conclusion that it is not discriminatory relies on the idea that, if all else fails, health plans can force participants to follow a physician’s recommendations. Although it is doubtful that employers could require employees to obey their physicians as a general condition of employment, some employers are refusing to hire smokers because smokers in general have higher health insurance claims than non-smokers. The same reasoning could be applied to similarly costly conditions, such as obesity.

One might argue that wellness programs simply offer rewards that would not otherwise be available. However, some programs do impose penalties. More important, the distinction between rewards and penalties is often in the eye of the beholder. All these programs create incentives to conform to specific standards as a condition of employment or as a condition of obtaining insurance coverage. In principle, it is only the price of coverage, not coverage itself, that is conditional on compliance. Yet, if the costs of coverage depend on satisfying specific health standards, then costs are based on health factors. They are the same risk factors that insurers would ordinarily take into account in determining premium rates, absent a legal prohibition against discrimination. In effect, therefore, wellness programs reintroduce the very risk rating that legislation aimed at social solidarity initially forbade.

Wellness program goals

First adopted by a small (now growing) number of employee group health plans, wellness programs are intended either to
keep employees healthy and productive or to reduce premiums (or both). State Medicaid and commercial insurance reform laws that allow financial incentives for wellness programs may have been adopted for either health or financial goals. Private employers who support health goals, however, may need to see a financial return (or reduced costs) in order to sustain wellness programs.

Whether wellness programs can achieve better health or cost savings remains to be seen. Their promise may not be realized without a long-term investment. Set up costs are concentrated in the early years, with savings beginning years later when (and if) participants avoid expensive services. Full benefits to the insurer or employer depend on long-term enrollment by individual participants. In the United States, about 17 percent of participants in private health plans change plans every year. This weakens the financial incentive for any single plan to offer wellness programs, unless competing plans have similar programs.

One probably ought not to expect financial miracles from wellness programs. Unless such programs stave off illnesses that are more expensive than other diseases not targeted, they may simply shift the causes, not the costs, of illness. Preventive measures cannot guarantee good health or immortality. Nor do they affect the cost of care, including preventive care, that is provided, which continues to rise. Perhaps the best that may be hoped for is disease compression — postponing debilitating illness to very short period before death at a ripe old age.

Implications for social solidarity

In addition to introducing personal responsibility into insurance pools, wellness programs depart from social solidarity in at least two other ways. First, to the extent that they succeed in improving health and reducing costs, they may benefit the federal
government more than the private sector, further dividing the country along lines of coverage. Current wellness programs target risk factors for chronic diseases, which account for about three-quarters of the costs of medical care in the U.S.\textsuperscript{74} In general, chronic diseases and disabilities are more prevalent among populations who are low income, uninsured or covered by Medicaid or Medicare (including the elderly), than among those with commercial insurance.\textsuperscript{75} This suggests that government has a larger financial stake in reducing the cost of chronic conditions than the private sector.\textsuperscript{76} The Centers for Medicare and Medicaid and presidential candidates are already emphasizing disease prevention over expanding insurance coverage.\textsuperscript{77} If these efforts do not reduce costs, government may consider more direct measures to ensure compliance with health standards.\textsuperscript{78}

Another way in which wellness programs depart from social solidarity is by targeting risk factors that are more prevalent among disadvantaged populations than among those of higher socio-economic status. Health status is strongly correlated with income.\textsuperscript{79} Chronic conditions are more common among lower income populations.\textsuperscript{80} Diabetes disproportionately affects African Americans, Hispanics, Native Americans, and Alaska Natives.\textsuperscript{81} Smoking is more prevalent among lower income groups.\textsuperscript{82} Thus, the people most likely to be subject to wellness program requirements may be those who need insurance the most and can least afford higher costs. While such groups may benefit from the improved health promised by such programs, their circumstances raise questions about whether their participation is truly voluntary.

Risk factors that wellness programs target can be seen as conditions for which society holds individuals personally responsible. Such conditions change as science identifies new sources of risk and society alters its norms of behavior.\textsuperscript{83} For example, smoking moved from a relatively common habit to pariah status in a few decades.\textsuperscript{84} The fact that obesity is now called
an epidemic suggests little public tolerance for the overweight.85 Diabetes, once considered out of anyone’s control, also appears to be moving into the realm of personal responsibility. Significantly, however, wellness programs have not yet targeted other health risk factors, such as job stress and shift work.86

It is instructive to examine the conditions that are not (yet) considered suitable for personal responsibility. Among the health factors on which HIPAA prohibits discrimination are “participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.”87 It is possible that sports enthusiasts use less medical care or less costly care than people with chronic diseases.88 Nonetheless, one might suspect that their exclusion from risk rating is based more on social preference than on financial considerations. Making sure that victims of injuries are covered for medical care seems like simple justice, even when they assume the physical risk of injury. But, then, why single out other conditions, especially those that are less likely to be voluntarily assumed? The only plausible reason would be the comparative cost of coverage. Yet, if cost is the real reason, then any comparably expensive condition, regardless of how acquired, should be treated in the same manner. 89 Of course that would return the entire enterprise to classifications based on individual health risks.

The absence of empirical support for distinguishing among conditions on the basis of costs and savings suggests that wellness programs may rely on unstated, perhaps unrecognized, bias against disadvantaged groups of people.

III. Conclusion

The peculiarly American mix of entitlement and personable responsibility in today’s health reform proposals may be evidence
of our ambivalence about social solidarity and personal responsibility for health. It may also mask deep divisions in beliefs about whether society or the individual ought to be responsible for health. Trying to have it both ways may make it impossible to agree on sustainable reform.

What is missing from current health reform debates is any serious discussion of the role of insurance in defining responsibility for health. The use of market-based, private insurance to provide universal access to care has encouraged reforms based on actuarial fairness, which make everyone responsible for his own risks. A focus on medical care costs confuses the use of insurance with the purchase of consumer goods. Attempts to cabin the cost of medical services by selectively inserting elements of risk-based cost-sharing into insurance policies chip away at the general goal of universal coverage. Increased cost sharing encourages the belief that health is the personal responsibility of individuals, and not the responsibility of all society.

So far, increased cost sharing has been applied selectively. People are slotted into the actuarial fairness side of the equation ostensibly for reasons of public health or social costs. But, an underlying motivation may be prejudice against historically disenfranchised groups. Combining wellness programs with insurance tends to disadvantage those most in need of assistance, undermining social solidarity. In the long run, people may be excluded not only from affordable premiums, but also from jobs or eligibility for government services. In the absence of any explicit standard for selecting the conditions subject to higher payments, there is no principled limit to the scope of personal responsibility for one’s health. If the standard is cost, however, then efforts to insert personal responsibility for health into social insurance reforms may presage a return to an era in which everyone was responsible for his own costs. After all, the
original argument for coverage based on cost was actuarial fairness.

Alternatively, if services to prevent illness and promote health and fitness become an accepted part of health insurance coverage, insurance may be transformed from its indemnity function into the role of financing personal services. In such circumstances, it will be difficult to place any boundaries on the demand for services or their costs. If preventive measures push expensive illness to later ages, then the federal government will have even more incentive to bring younger, healthier people into its risk pool in to spread the costs of the population it finances. In that case, the initial effort to achieve actuarial fairness may ultimately yield a form of government-sponsored social insurance.

References


7 Stone, *supra* note 5 at 46 (“Insurance is a social institution that helps define norms and values in political culture, and ultimately shapes how citizens think about issues of membership, community, responsibility, and moral obligation.”).


Washington, D.C: American Enterprise Institute (analyzing the advantages and disadvantages of national health insurance).


Medicare & Medicaid Services. Available at http://cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopofPage


16 See *supra* note 1.


19 See Galvin, R. S. & Delbanco, S., 2006. Between a rock and a hard place: understanding the employer mind-set. *Health Affairs*, 25(6), p. 1548-1555 (arguing that employers are looking for ways to get out of the health benefits business but reluctant to have


24 See Part II infra.

25 The concept of social solidarity may have originated with Émile Durkeim and his 1893 book, The Division of Labor in Society, describing social cohesion.


29 See *e.g.*, 42 U.S.C. § 300gg-11 (guaranteed availability for employers in small group market and requirement to accept all eligible individuals in the small employer’s group).


Medical underwriting may include investigating an applicant’s medical history, using information submitted on the application, medical claims, and prescription drug use. Information is available from the Medical Information Bureau, Inc. (MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, (866) 692-6901, available at http://www.mib.com/). Insurers can deny the application entirely, refusing to cover the person. More commonly, insurers exclude coverage for specific medical conditions or increase premium rates to cover the conditions. They may also postpone coverage for pre-existing conditions. See Milliman, Individual Medical Underwriting Guidelines, and Small Group Medical Underwriting Guidelines (updated periodically).


Classic elements of an insurable risk are a measurable probability of loss (predictable within a defined population) and individual uncertainty of loss (the fortuity principle). Russ, L.R. & Segalla, T. F., 1997. Couch on insurance, 7 §102.8 (3rd ed. 1997 &
Supp. 1999) (“Implicit in the concept of insurance is that the loss occur as a result of an event that is fortuitous, rather than planned, intended or anticipated.”); Holmes, E. M. & Mark S. Rhodes, M.S., 1996. Appleman on insurance. 1 §1.4 (2nd ed. 1996) (“A basic principle of insurance law is that insurance will provide coverage only for fortuitous losses”); Keeton, R.E. & Widiss, A.I., 1988. Insurance law. § 1:3 (a) (1) (“Risk... is the very essence of insurance... It should relate to a possibility of real loss which neither the insured nor the insurer has the power to avert or hasten.”).


44 A health reimbursement account is a dedicated fund (from the employer and/or employee contributions) that can be used by a plan participant to pay certain medical expenses. For a description of such plans, see Fronstin, P. & Collins, S. R., 2006. The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Survey 2006: early experience with high-deductible and consumer-driven plans. EBRI Issue Brief, 300 (Dec. 2006) p. 1-48 (finding 1.3 million nonelderly adults enrolled in consumer-directed health plans). Available at www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3769.

45 The Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. 108-173, §101, 117 Stat. 2066 (2003), allows taxpayers to exclude from taxable income funds placed in an HSA, provided that it is coupled with a high deductible health plan (HDHP). See also Revenue Ruling 2002-41,
2002-28 I.R.B. 75 (employer’s contribution to HSA is not taxable if funds are used to pay certain medical expenses).


47 See, e.g., Mariner, W.K., 2004. Can consumer-choice plans satisfy patients?: problems with theory and practice in health insurance contracts. Supra note 23 at 497 (arguing that “consumer-directed” is a misnomer, because consumers have little control over plan design or premiums); Enthoven, A. C. Employment-based health insurance is failing: now what? Health Affairs, May 28, p. W3-237, W3-239. (“The popular ‘consumer-driven’ or ‘defined contribution’ models are no more than a cover for high deductibles, intended to make consumers cost-conscious shoppers.”). Available at http://content.healthaffairs.org/cgi/reprint/hltaff.w3.237v1.pdf.

48 See Buntin, M. B. et al., 2006. Consumer-directed health care: early evidence about effects on cost and quality. Supra note 46 at p. W519 (reporting on studies showing that people who enroll in high-deductible consumer-directed plans are healthier and have higher incomes than those who remain in more traditional plans); U.S. Government Accountability Office, 2006. Consumer-directed health plans: early enrollee experiences with health savings accounts and eligible health plans. Washington, DC: U.S. Government Accountability Office (younger and higher income
federal employees joined CDHPs in the Federal Employees Health Benefits Program).


52 It brings to mind the concept of the “deserving poor,” used to distinguish those who deserved charity or government benefits from those who did not. See Handler, J. F. & Hollingsworth, E. J., 1971. The deserving poor: a study of welfare administration. Chicago: Markham; Rosenberg, C. E.,


59 29 U.S.C. § 1182 (a) (prohibiting group health plans from conditioning eligibility on a health factor); 29 U.S.C. § 1182 (b)(1) (forbidding group health plans from requiring “any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor”); and 29 U.S.C. § 1182 (b)(2)(B) (providing that paragraph (1) shall not be
construed “to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.”).

The criteria are: (1) the value of the reward is not more than 20 percent of the premium for the participant (including both employer and employee contributions); (2) the program must be “reasonably designed to promote health or prevent disease”; (3) eligible individuals must be able to qualify for the reward at least once a year; and (4) the program must be available to all similarly situated individuals. 29 C.F.R. § 2590.702 (f)(2).

61 29 C.F.R. § 2590.702 (f) Example 4.


65 Simon, E., 2007. Survey: large firms to offer health care. The Washington Post, April 19. (reporting survey finding that 63% of

66 See, e.g., 2006 Mass. Acts 58, §54 (authorizing the Massachusetts Medicaid program to create wellness programs and to reduce MassHealth premiums or co-payments for “enrollees who comply with the goals of the wellness program”); §§ 76-79 (requiring community rating for commercial insurance without regard to health status but permitting premiums to vary based on wellness program usage, tobacco usage age, group size, industry, participation rate, geographic area, and benefit levels).

67 Enrado, P., 2007. ROI on health management programs difficult to measure. Healthcare IT News, June 22 (reporting that 70% of employers surveyed believe that programs must produce a financial return on investment greater than break-even to be acceptable). Available at www.healthcareitnews.com/story.cms?id=7321.


69 Cunningham, P. J. & Kohn, L., 2000. Health plan switching: choice or circumstance? Health Affairs, 19(3), p. 158-164, p. 158, 159 (also finding that more that 2/3 changed plans because they changed employment or their employer changed the plans offered; 16% switched to a less expensive plan and about 8% moved to a plan they liked better).


See Hoffman, C., Rice, D. & Sung, H-Y, 1996. Persons with chronic conditions: their prevalence and costs. JAMA. 276 (18) 1473-1479 (reporting that 76% of direct medical care costs in the U.S. are for chronic conditions); Sipkoff, M., 2003. Health plans


The CMS is to begin Senior Risk Reduction Demonstration, an experimental program of health promotion services for Medicare beneficiaries. See also Broder, D. S., 2007. A route to better care, Washington Post, June 3, B7 (describing the candidates’ statements). See also Department of Health and Human Services. Centers for Medicare & Medicaid Services, 2006. West Virginia Medicaid Member Agreement. Baltimore, Maryland: Centers for Medicaid and State Operations. Available at www.wvdhhr.org/bms/oAdministration/bms_admin_WV_SPA06-02_20060503.pdf (tiered benefit packages based on compliance with health goals).


SOCIAL SOLIDARITY AND PERSONAL RESPONSIBILITY IN HEALTH REFORM

87 26 C.F.R. § 54.9802-1(f)(ii); 29 C.F.R. § 2590.702(f)(ii); 45 C.F.R. § 146.121(f)(ii).


(listing the top 10 summer recreational activities, with number of injuries, and total costs of injury, including medical, legal and other costs: Basketball (1,633,905; $19.7 billion); Bicycles (1,498,252; $28.6 billion); Baseball (492,832; $6.6 billion); Soccer (477,647; $6.7 billion); Softball (406,381; $5.1 billion); Trampolines (246,875; $4.1 billion); Inline Skating (233,806; $4.2 billion); Horseback riding (196,260; $4.9 billion); Weightlifting (189,942; $2.7 billion); Volleyball (187,391; $2.1 billion).