SOCIAL SOLIDARITY AND PERSONAL RESPONSIBILITY IN HEALTH REFORM

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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 cycle today. Several states have adopted reform laws to make insurance available to most of their residents.1 Presidential candidates are offering their own proposals for the nation’s health care system.2 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.3 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.4 Thus, insurance has come to stand for health care.5


4. See generally, INSTITUTE OF MEDICINE, COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, COVERAGE MATTERS: INSURANCE AND HEALTH CARE (2001). Here I use the concept of insurance rather liberally to include government health benefit programs, such as Medicare, 42 U.S.C. §§ 1395 et seq., Medicaid, 42 U.S.C. §§ 1396 et seq., and the State
Yet buying health 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.\(^6\) Health reform proposals reflect different philosophies about who should be responsible for certain health conditions—society at large, employers, or the individual herself. Current health insurance reform proposals borrow from both camps, combining provisions promoting social solidarity with provisions based on actuarial fairness.

This essay argues that amalgamating reforms that serve inconsistent goals can perpetuate, rather than resolve, conflict. Part I suggests that joining social insurance with commercial indemnity insurance provisions forges a contract for traditional indemnity coverage plus discretionary personal services—an “insurance + services” contract—which pulls the system in opposite directions, forcing insurers to act as both insurers and service providers. Part II examines a recent example of the service side of this insurance + services contract—coverage of so-called “wellness programs,” which offer rewards for 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 suggests that such programs are likely to disadvantage those most in need of social assistance.

I conclude that the use of commercial insurance to provide access to care encourages reforms based on actuarial fairness instead of social solidarity. In the context of rising health care costs, the renewed emphasis on personal responsibility for health may unravel the social solidarity that

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Children’s Health Insurance Program (SCHIP), 42 U.S.C. §§ 1397aa et seq., which also finance care.


prompted reform in the first place, especially for certain disfavored conditions or groups. These reforms may return 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

When Senator Ron Wyden (D-OR) proposed federal legislation to cover all Americans with insurance in December 2006, he was hoping to break “60 years of gridlock on a desperately needed overhaul of the nation’s health care system.” Like several recent state reforms, his proposal offered both universal coverage and more personal responsibility in making health care choices. Yet, 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.

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. The difficulty of reconciling these opposing views of health care and the purpose and function of insurance has undoubtedly stymied agreement on reform.

Recent trends in health insurance in the United States reflect both of these competing views. On one hand, there are several 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 slowly declining proportion of nonelderly Americans. This decline has been offset by expansions in state Medicaid


12. See, e.g., Norman Daniels, Just Health Care (1985) (arguing that health care is special because it promotes equality of opportunity within the meaning of Rawls’ theory of justice); Institute of Medicine, Committee on the Consequences of Uninsurance, Insuring America’s Health (2004); Proposal of the Physicians’ Working Group for Single-Payer National Health Insurance, 290 JAMA 798 (2004).


and SCHIP programs, but those public programs risk future cutbacks. Recognizing these trends, 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.


18. The Employee Retirement Income Security Act, 29 U.S.C. §§ 1001 et seq. Section 514(a), codified at 29 U.S.C. § 1144(a), generally preempts state laws that require private employers to provide health benefit plans for their employees, Standard Oil Co. v. Agsalud, 633 F.2d 760 (9th Cir. 1980), aff’d mem., 454 U.S. 801 (1981) (holding that ERISA preempted Hawaii’s Prepaid Health Care Act requiring employee benefit plans with prescribed health coverage), as well as reforms that alter the benefit structure or administration of such plans, Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 97 (1983) (a state law relates to an ERISA plan "if it has a connection with or reference to such a plan."). Two recent lower court decisions found that ERISA preempts employer pay-or-play legislation in Maryland, Retail Industry Leaders Association v. Fielder, 475 F. 3d 180 (4th Cir. 2007), and the city of San Francisco, Golden Gate Restaurant Ass’n v. City & County of San Francisco, No. C 06-06997 (N.D. Cal. Dec. 26, 2007), stay granted pending appeal, No. 07-17370 (9th Cir. Jan. 9, 2007). But see N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995) (surcharges imposed on commercial health plans for hospital bills not preempted, because they do not preclude uniform benefits or administrative practices).


20. See Robert S. Galvin & Suzanne Delbanco, Between A Rock and A Hard Place: Understanding The Employer Mind-Set, 25(6) HEALTH AFF. 1548 (Nov./Dec. 2006) (arguing that employers are looking for ways to get out of the health benefits business but reluctant to have government control costs); Jonathan Cohn, What’s the One Thing Big Business and the Left Have in Common?, N.Y. TIMES MAGAZINE 45, April 1, 2007
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 a commercial insurance product covering specified losses, rather than a mechanism for financing universal access to care. 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. Health savings accounts are popular among some employers, because they make employees responsible for a portion of their health care expenses. A recent innovation, wellness coverage, offers discounted


22. This picture can be complicated by managed care practices, such as preferred provider networks and referral requirements, that limit services covered by claims. See generally MICHAEL MORRISEY, HEALTH INSURANCE 131-145 (2007).


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. These programs can expand personal responsibility beyond 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, Veterans and military health benefit programs that are not formal insurance plans.

The concept of social solidarity embodies goals of mutual aid and support. The idea is that we are all in this together, and no one should be abandoned. Such aspirations inspired early mutual aid societies to create insurance systems. Where people are considered to be equally and randomly at risk for all types of 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. 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

25. See Part II infra.

26. See Robert J. Blendon et al., Americans’ Views of the Uninsured: An Era for Hybrid Proposals, HEALTH AFF. w3-405, Aug. 27, 2003, at, http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.405v1/DC1 (reporting on public opinion surveys finding ambivalent views).

27. The concept of social solidarity may have originated with Émile Durkeim and his 1893 book, THE DIVISION OF LABOR IN SOCIETY, describing social cohesion.


30. See generally IN SEARCH OF RETIREMENT SECURITY: THE CHANGING MIX OF SOCIAL INSURANCE, EMPLOYEE BENEFITS, AND INDIVIDUAL RESPONSIBILITY (Teresa Ghilarducci et al. eds., 2005); STRENGTHENING COMMUNITY: SOCIAL INSURANCE IN A DIVERSE AMERICA (Kathleen Buto et al. eds., 2004); Western European countries have well-
for universality of coverage and community rating. Most systems bar medical underwriting that excludes 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, 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. States 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, at least during the child-bearing years. Many states also prohibit premium discrimination on the basis of genetic information.

The federal Health Insurance Portability and Accountability Act (HIPAA) prohibits certain group health plans from discriminating in eligibility or premiums on the basis of health status factors, such as medical condition and claims experience. More general anti-discrimination laws also foster social solidarity. For example, the federal Americans with Disabilities Act prohibits discrimination solely on the basis of disability in employee health insurance. Title VII of the Civil Rights Act of 1964

known social insurance systems, with most using either a Bismarck model or a Beveridge model. Because they were created before private commercial health insurance developed a significant market, commercial insurers adapted their products to the goals of the government program. In contrast, American commercial health insurance established a strong commercial market largely independent of social insurance programs. See Richmond & Fein, supra note 6.

31. 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).


35. 29 U.S.C. § 1182. See note 81 infra and accompanying text.

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 and increase substantially among the elderly.

**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 distinct products and pricing.

Commercial insurers may use medical underwriting and risk rating to classify people. Medical underwriting, used primarily in individual and small group policies in the United States, avoids insuring specific individuals or groups for non-fortuitous risks. They must have their own

38. But see Part II infra, discussing discounted premiums for participating in wellness programs.
39. See Centers for Disease Control and Prevention & The Merck Company Foundation, State of Aging and Health in America 2007 Report, at 5 (2007) (reporting that the “cost of providing health care for one person aged 65 or older is three to five times greater than the cost for someone younger than 65”), available at http://www.cdc.gov/aging/saha.htm; Christine Borger et al., Health Spending Projections Through 2015: Changes on the Horizon, 25 HEALTH AFF. w61 (2006). But see Uwe E. Reinhardt, Does the Aging of the Population Really Drive the Demand for Health Care?, 22(6) HEALTH AFF. 27, 34-35 (2003), (arguing that research shows that a gradually increasing elderly population is not likely to cause disproportionate national cost increases, and that labor and administrative costs may play more important roles in raising costs).
41. Medical underwriting may include investigating an applicant’s medical history, using information submitted on the application, medical claims, and prescription drug use. Insurers can deny the application entirely, refusing to cover the person. More commonly,
personal resources to pay for their most likely health problems. For coverage of other risks, actuarial fairness aligns premium rates with the risk profile of the person or group. 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. 42 Coverage limits, which restrict the number of covered services, such as inpatient hospital days or specialist visits, can also discourage unnecessary care and claims. 43 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 covered loss. While a broken limb or heart attack presents an unmistakable need for medical care, other health conditions are more ambiguous. What, if any, care is needed can often be debated, making the insurer’s risk more difficult to calculate. 44 Moreover, the cost of care varies significantly around the country. 45 Such concerns may not be unique to health insurance, but are undoubtedly more intense in assessing health insurance claims.


44. Examples include disputes over what services are “medically necessary” or “experimental.” Peter D. Jacobson et al., Defining and Implementing Medical Necessity in Washington State and Oregon, 34 INQUIRY 143 (1997); Mariner, Can Consumer-Choice Plans Satisfy Patients?, supra note 24 at 537-38 (collecting studies).

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.\textsuperscript{46} State laws and market demand, however, have introduced exceptions to the fortuity principle in many health insurance policies. The result 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.\textsuperscript{47} Statutory requirements for insurance coverage are generally based on concerns that many people, especially in 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.\textsuperscript{48} Moreover, preventive services typically cost less than treatment for the disease they prevent.\textsuperscript{49} These are sound rationales for encouraging prevention, but they do not fit insurance well.

\textsuperscript{46} 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). \textit{Eric Mills Holmes & Mark S. Rhodes, 1 Appleman on Insurance} §1.4 (2d ed. 1996) (“The fortuity principle is central to the notion of what constitutes insurance. The insurer will not and should not be asked to provide coverage for a loss that is reasonably certain or expected to occur within the policy period.”); \textit{George J. Couch, 2 Couch on Insurance 2d} § 2:7 (rev. ed. 1984) (“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.”); \textit{Lee R. Russ & Thomas F. Segalla, 7 Couch on Insurance} §101.2 (3d ed. 1997 & Supp. 1999) [hereafter “Couch”] (“In general, the loss must occur as a result of a fortuitous event, not one planned, intended, or anticipated.”). \textit{See also} Stephen A. Cozen & Richard C. Bennett, \textit{Fortuity: The Unnamed Exclusion}, 20 Forum 222 (1985) (noting that the fortuity principle is so essential to insurance that it does not explicitly appear in the text of insurance policies).


\textsuperscript{48} The alternative to requiring everyone to obtain or pay for their own preventive services would undoubtedly provoke a public outcry, especially in light of the individual’s well-settled right to refuse medical treatment of any kind. \textit{See George J. Annas, The Rights of Patients} 277-8 (3d ed. 2004).

\textsuperscript{49} \textit{But see} Pieter H. M. van Baal et al., \textit{Lifetime Medical Costs of Obesity: Prevention No Cure for Increasing Health Expenditure}, 5(2) PLoS Medicine e29 (2008)
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 and HSAs are the current paradigm

50. See, e.g., SCA Servs. Inc. v. Transportation Ins. Co., 419 Mass. 528, 532, 646 N.E.2d 394, 397 (1995) (explaining that a risk that the insured knows is likely to happen “ceases to be contingent and becomes a probable or known loss”). See generally 7 COUCH §102.9 (p. 102).

51. 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 Paul Fronstin & Sara R. Collins, The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Survey 2006: Early Experience with High-Deductible and Consumer-Driven Plans, EBRI ISSUE BRIEF No. 300 (Dec. 2006), available at www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3769.


53. See America’s Health Insurance Plans, HSAs and Account-Based Health Plans – An Overview of Preliminary Research, June 2006 (reporting 3.2 million people enrolled in HSA-qualified plans in January 2006), available at www.ahipresearch.org/pdfs/HSAsOverviewJun2006.pdf; and Melinda Beeuwkes Buntin et al., Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality, HEALTH AFF. Web Exclusive w516, w518 (Oct. 24, 2006) (reporting 2.9 million enrolled in HRAs in January 2006). Together, the 6.1 million may account for “about 3 percent of the commercial insurance market”. Id. at w518. But see Fronstin & Collins, supra note 51 (finding 1.3 million nonelderly adults enrolled in consumer-directed health plans); Gary Claxton et al., Health Benefits in 2006: Premium Increases Moderate, Enrollment in Consumer-Directed Health Plans Remains Modest, 25 HEALTH AFF. Web Exclusive w476
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.\footnote{Mariner, \textit{Can Consumer-Choice Plans Satisfy Patients?}, supra note 24. See also Alain C. Enthoven, \textit{Employment-Based Health Insurance Is Failing: Now What?}, \textit{Health Aff.} May 28, 2003, at 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.”), at http://content.healthaffairs.org/cgi/reprint/hltaff.w3.237v1.pdf; and Vanessa Fuhrmans, \textit{Health Savings Plans Start to Falter}, \textit{Wall Street J.} D1, June 12, 2007 (reporting 2.7 million enrolled in 2006, and lower satisfaction with such plans among participants).} Although there is as yet little data about how most individuals spend their account funds, it is likely that most are spent on preventive care and less expensive, less costly, discretionary medical services, such as treatment for colds and influenza.\footnote{See Buntin, \textit{Consumer-Directed Health Care}, supra note 53 at 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, \textit{Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans} (2006) (younger and higher income federal employees joined CDHPs in the Federal Employees Health Benefits Program).}

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 choosing 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 this economic 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.\footnote{See, e.g., Herzlinger, supra note 6; Clark C. Havighurst, \textit{Health Care Choices}, supra note 11; Joseph P. Newhouse, \textit{Medical Care Costs: How Much Welfare Loss?}, 6(3) \textit{J. of Economic Perspectives} 321 (1992).} Here, the 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.

Some economists concerned about national health expenditures object to generous insurance policies on the ground that they buy too much care.57 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.58 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.59 Thus, the economic argument against buying too much care supports the idea of social solidarity in ensuring access to


59. For arguments that health care is special in this sense, see supra note 12. Although an insurance policy may be a consumer product, the insurer’s purchase of services to pay an insurance claim differs from the consumer/patient’s direct purchase of services. The latter may come into play for the deductible amount in a high-deductible plan or HRA. See Sara R. Collins, Consumer-Drive Health Care—Why It Won’t Solve What Ails the United States Health System, 28 J. LEGAL MED. 53 (2007) (summarizing studies finding that higher cost sharing discourages people from getting care, with people with incomes lower than $50,000 twice as likely to avoid or delay care as those in other plans).
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care for everyone.60 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 one of 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 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, such that individuals should shoulder the burden themselves.61 Yet there has been little debate about what principles ought to govern classifying particular health conditions as either an individual responsibility or a social responsibility.

60. See Clark C. Havighurst & Barak D. Richman, Distributive Injustice(s) in American Health Care, 69 Law & Contemp. Prob. 7, 38-39 (2006) (arguing that the goal of reducing consumer demand for health services might have been better met by capping the “tax subsidy” or issuing government vouchers).

61. 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 Joel F. Handler & Ellen Jane Hollingsworth, The Deserving Poor (1971); Charles E. Rosenberg, The Care of Strangers 23 (1987).
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. When offered as part of a health insurance plan, such programs fall on the services side of the insurance + services contract, 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 called by a disease management company may get cash prizes. The specific conditions for which financial differences are allowed offer some insight into what we hold people personally responsible for.

First adopted by a small (now growing) number of employee group health plans, wellness programs are intended to keep employees healthy and productive and to reduce health insurance costs. It is not clear which goal takes precedence. Private employers who support health goals may also need to see a financial return in order to sustain wellness programs. 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 that employers who monitor their employees’ health may be overreaching.


63. Patty Enrado, ROI on Health Management Programs Difficult to Measure, Healthcare IT News, June 22, 2007 (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 http://www.healthcareitnews.com/story.cms?id=7321.


Public health agencies generally support programs for smoking cessation, screening for diseases, losing weight, and regular physical exercise for general health goals. However, such groups are not responsible for offering or regulating insurance. State Medicaid and commercial insurance reform laws that allow financial incentives for wellness programs might have been adopted for either health or financial goals.

Whether wellness programs can justify themselves with cost savings remains to be seen. Estimates of financial savings are often based on general population data. Research on the costs and savings from specific preventive measures is limited. Recent reports find that most interventions produce little or no reduction in total health care spending, while many increase costs. Some well constructed health promotion programs that positively engage individuals and some specific preventive


67. 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). However, the Medicaid program does not charge premiums to enrollees, so the legislature may consider alternative mechanisms for encouraging compliance.

68. See Paul Fronstin, Can “Consumerism” Slow the Rate of Health Benefit Cost Increases?, EBRI ISSUE BRIEF, No. 247, July 2002 (reporting that 10% of the population accounted for 58% of health expenditures).

69. See generally PREVENTION EFFECTIVENESS: A GUIDE TO DECISION ANALYSIS AND ECONOMIC EVALUATION, 2d ed. (Anne C. Haddix et al. eds., 2003).

measures, like immunizations, can save medical expenses. However, the promise of broader wellness programs 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 private health plans, about 17 percent of participants change plans every year. This weakens the financial incentive to offer wellness programs, unless competing plans have similar programs.

While wellness programs may produce better health, one probably ought not to expect financial miracles. 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


72. Peter J. Cunningham & Linda Kohn, Health Plan Switching: Choice or Circumstance?, 19(3) HEALTH AFF. 158, 159 (2000) (also finding that more than 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).

73. Since patients change physicians less often than they change health plans, wellness programs might improve their results by rewarding physicians (instead of patients) who educate their patients about prevention and manage medical conditions well. See, e.g., Massachusetts Blues Expanding Incentives for Preventive Care, Disease Management, 11(1) BNA’s HEALTH CARE POLICY 22 (Jan. 6, 2003) (describing providing information to primary care physician groups about their patients, such as mammograms conducted, and paying higher fees to groups that provide preventive services).

74. Targeting particular conditions may have unintended consequences. See, e.g., Steven E. Nissen & Kathy Wolski, Effect of Rosiglitazone on the Risk of Myocardial Infarction and Death from Cardiovascular Causes, 356 NEW ENGL. J. MED. 2457 (2007) (meta-analysis of studies, concluding that a drug widely used to treat type 2 diabetes may slightly increase the risk of myocardial infarction and death from cardiovascular disease); ‘Diabulima’: Some Diabetic Girls Skip Insulin in Dangerous Effort to Lose Weight, APA OnLine, June 17, 2007, available at http://psycport.apa.org/showArticle.cfm?xmlFile=ap%5F2007%5F06%5F17%5Fap%2Ewone%2Dstream%2DEnglish%5FPD8PQO2HG0%5Fnews%5FFap%5Forg%5Fap%2Eanpa%2Eew%2Exml &provider=Associated%20Press.
cannot guarantee good health or immortality. Nor do they affect the cost of care that is provided, which continues to rise. Indeed, there is some evidence that the lifetime costs are greater for healthy people than for smokers or obese people. The best that may be hoped for is disease compression—postponing debilitating illness to very short period before death at a ripe old age.

Wellness Programs within Health Insurance Plans

The key difference between indemnity insurance and wellness programs is how risk information is used. Insurers typically use risk data to set rates. A risk-rated insurance policy would base the premium on the individual’s risk factors or, in the case of a group policy, on the group’s overall risk. A wellness program uses risk data to selectively modify rates for individuals who are already in the risk-rated 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 based on their personal health risks.

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: $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 program 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, as discussed below, wellness programs have joined preventive services as an exception to the fortuity principle in many health insurance plans. However, unlike coverage of preventive care, wellness program coverage costs participants different amounts depending upon their behavior. The specific conditions for which financial differences are set offer some insight into what we hold people personally responsible for.

Discrimination on the Basis of Health Factors and the HIPAA Wellness Exception

The tension between rewarding wellness and banning discrimination based on health risks may be reflected in the fact that it took the federal government more than a decade to issue final HIPAA regulations governing group health plan wellness programs. 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


81. Dept. of Treasury, Dept. of Labor, Dept. of Health and Human Services, Nondiscrimination and Wellness Programs in Health Coverage in the Group Market; Final Rules, 71 FED. REG. 75013 (Dec. 13, 2006). The final rules add parallel provisions to regulations implementing the Internal Revenue Code, the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq., and HIPAA requirements for certain small group and individual plans added to the Public Health Service Act. Id.
disease prevention.”

Health factor is broadly defined and includes health status (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. Forms of discrimination include rules imposing waiting periods, coverage exclusions and limits, benefit restrictions, premium contributions, and cost-sharing mechanisms (such as coinsurance, co-payments, and deductibles), as well as exclusions from participation in a plan. The final regulations, issued in December 2006, attempt to reconcile the exception for wellness programs with the general prohibition against discrimination on the basis of any health factor. The difficulty of doing so can be seen in the examples of acceptable programs described in the regulations and discussed below.

A wellness program (defined as “any program designed to promote health or prevent disease”) will qualify for the exception if “none of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor” as long as “participation in the program is made available to all similarly situated individuals.” Among the rule’s examples of acceptable wellness programs are those that reimburse all or part of fitness center membership fees or smoking cessation programs; provide rewards for participating in diagnostic testing programs (and do not base rewards on test outcomes) or monthly health education seminars; and waive co-payments or deductibles for prenatal care or well-baby visits.

Nonetheless, programs that do base rewards on an individual satisfying a health-related standard can still qualify for the exception if they meet four criteria: (1) the value of the reward is not more than 20 percent of the

82. 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.”).

83. 29 U.S.C. § 1182 (a).
84. 29 C.F.R. § 2590.702.
85. Id.
86. 29 C.F.R. § 2590.702 (f)
87. 29 C.F.R. § 2590.702 (f)(1).
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.88 Even this exception to the exception has its own exception. Individuals cannot be required to meet the health standard if to do so is “unreasonably difficult due to a medical condition” or “medically inadvisable.”89 Such individuals must be given “a reasonable alternative standard.”90

The rules’ examples indicate that it should be easy to qualify for these exceptions, even if the program requires participants to achieve specific health targets. Two examples approve wellness programs that require patients to obey a physician’s recommendations in order to qualify for discounts. In one example, a wellness program offers a 20 percent premium discount to employees who achieve a cholesterol count under 200. The plan offers to “work with” employees who are unable to achieve that goal. One employee, “D”, begins a diet and exercise program, but his physician determines that D cannot lower his cholesterol below 200 without taking prescription medication. The plan “accommodates D by making the discount available to D, but only if D follows the advice of D’s doctor regarding medication and blood tests.”91 The rules conclude that this program qualifies for the exception and is permissible.

A second example describes a 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 rules approve a result in which the “plan agrees to make the discount available to E if E follows the physician’s [unspecified] recommendations.”92

It is hard to argue that these examples do not discriminate on the basis of a health factor. The conclusion that they are not discriminatory appears to rely on the assumption 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

88. 29 C.F.R. § 2590.702 (f)(2).
89. 29 C.F.R. § 2590.702 (f)(2)(A).
90. Id.
91. 29 C.F.R. § 2590.702 (f) Example 3.
92. 29 C.F.R. § 2590.702 (f) Example 4.
as a general condition of employment, some employers are refusing to hire smokers on the ground that they have higher health insurance claims than non-smokers. The same reasoning could be applied to similarly costly conditions, such as obesity. Conditions like hypertension are not likely to be considered disabilities for purposes of the Americans with Disabilities Act to preclude employers from not hiring individuals with those conditions. Nonetheless, they are certainly considered health conditions for purposes of wellness programs.

One might argue that these examples simply involve eligibility for rewards (in the form of discounts) that would not otherwise be available. The distinction between rewards and penalties, however, is often in the eye of the beholder. Moreover, some programs do impose penalties. The HIPAA rules approve the example of a wellness program that imposes an explicit financial penalty—a surcharge of 20% of the premium—on participants who do not certify that they have not used tobacco products in the past year. The surcharge can be avoided if a participant is addicted to nicotine and participates in a smoking cessation program.


94. See Truls Ostbye, Obesity and Workers’ Compensation: Results from the Duke Health and Safety Surveillance System, 167 ARCHIVES OF INTERNAL MEDICINE 766 (2007) (finding that obese workers had higher medical costs and worker compensation claims than non-obese employees).


97. 29 C.F.R. § 2590.702 (f) Example 5.

98. One might ask what counts as addiction and how long a participant will be allowed to avoid the surcharge in practice. The majority of smokers enrolled in smoking cessation programs fail to quit. Leatherman et al., The Business Case for Quality, supra note 71 at 21 (describing quitting rates of 25 to 30% among smokers in a well regarded smoking cessation program). See also H.A. Tindle et al., Cessation among Smokers of “Light” Cigarettes: Results from the 2000 National Health Interview Survey, 96 AM. J. PUB. HEALTH 1498 (2006) (finding that 53% of smokers quit, while 37% of light cigarette smokers quit).
Much of the justification for these programs depends on the idea that rewards and penalties are equally available to “all similarly situated individuals.” Yet rewards are available only to people who do not have the health condition at issue and to people who conform to the program’s requirements.99 Thus, they function as 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 the statutory prohibition against discrimination. In effect, therefore, wellness programs reintroduce the very risk rating that legislation aimed at social solidarity initially forbade.

**Implications for Social Solidarity**

In addition to introducing selective personal responsibility into insurance pools, the focus on wellness programs’ ability to save costs has two disadvantages. First, as noted above, such programs may not save significant sums, especially if healthy people cost more in the long run. More importantly, it discounts improved health and wellbeing as valuable for their own sake. This may discourage independent initiatives to promote health unless they prove financially rewarding.

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. Although employers and insurers may take short-terms health care costs into account, government may pay closer attention to total lifetime costs of all benefits.100

Current wellness programs target risk factors for chronic diseases, which account for about three-quarters of the costs of medical care in the

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99. After non-smokers took up smoking to get paid for stopping, one employer was quoted as saying, “It was not our intention to encourage people to start smoking. It was aimed at people who already had a bad habit.” M.P. McQueen, *Wellness Plans Reach Out to the Healthy*, WALL ST. J. at D1, March 28, 2007.

In 2004, 62 percent of adult respondents, age 50 to 64, reported having at least one of six chronic conditions (hypertension, heart disease, cancer, diabetes, arthritis, or high cholesterol). National data for the same year show that the percentage of adults with three or more chronic conditions was 7 percent for those age 45 to 54, and 36 percent for those over 75 years of age. Because the incidence of chronic conditions increases with age, older adults face higher medical costs. Moreover, the percentage of adults between 45 and 75 years of age with chronic conditions rose as their income declined.

Type 2 diabetes, a current target of wellness programs, is expected to generate rising costs, accounting for almost 92 billion dollars in public and private health care spending in 2003. About 6.5 percent of Americans over age 20 have diabetes, which is now the sixth leading cause of death in the U.S. The federal government pays about 61 percent ($77 billion) of national health care expenditures for diabetes treatment, most through Medicare ($61 billion). In general, chronic diseases and disabilities are more prevalent among populations who are low income, uninsured, or

101. See Catherine Hoffman, Dorothy Rice & Hai-Yen Sung, Persons with Chronic Conditions: Their Prevalence and Costs, 276 J. AM. MED. ASS’N 1473 (1996) (reporting that 76% of direct medical care costs in the U.S. are for chronic conditions); Martin Sipkoff, Health Plans Begin to Address Chronic Care Management, MANAGED CARE MAG., Dec. 2003, 24, 25 (reporting approximately 78% of health care spending is on behalf of individual’s with chronic conditions).


104. Id. at 42.


108. Id. at 21.
covered by Medicaid or Medicare (including the elderly), than among those
with commercial insurance. This suggests that government has a larger
financial stake in reducing the cost of diabetes and other chronic conditions
than the private sector. The Centers for Medicare and Medicaid and
presidential candidates are already emphasizing disease prevention over
expanding insurance coverage. If these efforts do not reduce costs,
government may consider more direct measures to ensure compliance with
health standards, such as mandatory participation in wellness programs.

Wellness programs also depart from social solidarity by targeting risk
factors that are more prevalent among disadvantaged populations than
among those of higher socio-economic status. Health status is strongly

109. Services for people with disabilities account for a disproportionately large share of
Medicaid spending. Anna Sommers & Mindy Cohen, Medicaid’s High Cost Enrollees: How
Much Do They Drive Spending? 6, 8 (The Kaiser Family Foundation, Kaiser Commission
on Medicaid and the Uninsured, Issue Paper 7490, March 2006), available at
www.kff.org/medicaid/upload/7490.pdf (3.4% of all Medicaid enrollees were
institutionalized and accounted for 31.6% of expenditures; non-institutionalized enrollees
with disabilities represented 14.2% of enrollees and 30.6% of expenditures).

110. See Linda Blumberg & John Holahan, Government as Reinsurer: Potential
Impacts on Public and Private Spending, 41(2) INQUIRY 130 (2004). See also Ron Z.
Goetzel et al., Can Health Promotion Programs Save Medicare Money?, 2(1) CLINICAL
INTERVENTIONS IN AGING (2007) (concluding that well-designed health promotion programs
for older people could save Medicare money). But see The Care of Patients with Severe
Chronic Illness: A Report on the Medicare Program by the Dartmouth Atlas Project (John E.
Wennberg & Elliott S. Fisher eds., 2006) (finding that Medicare could reduce chronic care
costs by up to 30% by reducing the variability and inconsistency of services provided),

111. Centers for Medicare and Medicaid Services, Senior Risk Reduction
Demonstration,
pdf (experimental program of health promotion services for Medicare beneficiaries) (last
visited Mar. 1, 2008); Joshua T. Cohen et al., Does Preventive Care Save Money? Health
Economics and the Presidential Candidates, supra note 70; David S. Broder, A Route to
Better Care, WASH. POST at B7, June 3, 2007 (describing the candidates’ statements). See
also West Virginia Medicaid Member Agreement,
www.wvdhhr.org/bms/oAdministration/bms_admin_WV_SPA06-02_20060503.pdf (tiered
benefit packages based on compliance with health goals).

(city fire department’s mandatory fitness program, requiring employees to submit to blood
draws to check cholesterol levels, was an unconstitutional search under the Fourth Amendment).
See generally SYLVIA N. TESH, HIDDEN ARGUMENTS: POLITICAL IDEOLOGY
AND DISEASE PREVENTION POLICY 46 (1988) (arguing that state laws targeting individual
conduct were prompted by a need to reduce health care costs or to lower mortality rates);
DEBORAH LUPTON, THE IMPERATIVE OF HEALTH: PUBLIC HEALTH AND THE REGULATED BODY
correlated with income. Chronic conditions are more common among lower income populations. Diabetes disproportionately affects African Americans, Hispanics, Native Americans, and Alaska Natives. Smoking is also more prevalent among lower income groups. 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. For example, smoking moved from a relatively common habit to pariah status in a few decades. The fact that obesity is now called an epidemic suggests little public tolerance for the overweight. Diabetes,
once considered out of anyone’s control, also appears to be moving into the realm of personal responsibility. One might ask whether wellness programs will target other health risk factors, such as job stress and shift work.121

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 is “evidence of insurability,” which is defined to include “(i) conditions arising out of acts of domestic violence; and (ii) participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.”122 Victims of domestic violence may be encouraged to seek medical care (and obtain help) if they are not charged higher premiums. It is not clear whether sports enthusiasts use less medical care or less costly care than people with chronic diseases.123 One might suspect that their exclusion from risk calculations 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 if 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 most 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.124 Of course that would return the entire enterprise to classifications based on health risks.

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122. 26 C.F.R. § 54.9802-1(f); 29 C.F.R. § 2590.702(f); 45 C.F.R. § 146.121(f).

123. See, e.g., List of Top 10 Summer Sports with Most Injuries Provides Warning for Olympic Enthusiasts, MEDSCAPE MED. NEWS, Sept. 1, 2000, http://www.medscape.com/viewarticle/412143 (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).

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. There is a remarkable lack of empathy for people who are believed to be personally responsible for their medical conditions. For example, when asked to choose among seven options for reducing health care costs, 41 percent of people in a Sacramento (California) Healthcare Decisions discussion group chose “requir[ing] patients to pay higher rates if they do not follow medical advice that will keep them healthier.” Similar attitudes can be seen in the policies of private organizations that refuse to hire individuals who smoke or are overweight. It is not clear whether such attitudes reflect assumptions that such behaviors and conditions generate higher costs of care or prejudice against certain behaviors and conditions. In either case, they encourage segmenting the population on the basis of health risks not only in insurance pools, but also in society at large.

III. CONCLUSION

The peculiarly American mix of entitlement and personal 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 serious discussion of the role of insurance in defining responsibility for health. Is insurance a way to spread specific risks or a mechanism for financing health care for all? 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

125. Marjorie Ginsburg, *Rearranging the Deck Chairs*, HEALTH AFF. Web Exclusive w537, w539 (Oct. 24, 2006), available at http://content.healthaffairs.org/cgi/reprint/25/6/w537 (the 3 options with more support were: restricting coverage of treatment that is not effective or is not critical for basic functioning and longevity, and limiting the use of expensive care with little benefit.).
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, like redlining. 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 government services and benefits. In the absence of a defensible 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, then efforts to insert personal responsibility for health into social insurance reforms may presage the 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, the role of insurance may be converted from risk spreading into 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 a strong incentive to bring younger, healthier people into its risk pool to spread the costs of the population it finances. That case would produce a final paradox: efforts to increase personal responsibility may ultimately yield a form of government-sponsored social insurance.