GOING DUTCH: CAN HOLLAND SOLVE THE U.S. INSURANCE PROBLEM?

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Health care costs for the elderly have skyrocketed in recent years, forcing many states to consider how to provide care for their aging populations while keeping health costs under control. The elderly are particularly vulnerable to high health care costs because they use the system more than any other segment of the population, must pay significant out-of-pocket costs to make up for Medicare gaps, and must often survive on fixed incomes. This Note compares the health care systems of Massachusetts, Vermont, and that of Holland, the Netherlands, with an emphasis on how these systems address the needs of the elderly. Mr. Trame evaluates the ways in which each of these systems regulates insurance, negotiates price reductions, reduces the number of uninsured, and makes health care more accessible. While each of these systems is too new for their strengths to emerge completely, each incorporates important elements of much-needed reforms.

I. Introduction

The United States leads the industrialized world in one category that few Americans and even fewer politicians

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will brag about. By spending nearly $2 trillion, which equals approximately 16% of the U.S. gross domestic product,[1] Americans can claim to spend more money on health care than any other industrialized nation.[2] Despite this massive expenditure, many Americans currently lack any type of health care coverage. In 2006, forty-seven million Americans, or 15.8% of the U.S. population, were unable to or chose not to obtain health insurance.[3] To place this statistic into context, the total number of uninsured represents more than the aggregate populations of twenty-four of the fifty states.[4] The 2006 rates represent an increase of over two million Americans since 2005, which indicates that the problem is getting worse.[5] Rising health care costs and barriers to access can especially affect society's most vulnerable members, such as senior citizens,[6] who face disproportionately high costs with limited resources.[7]

Political leaders have recognized the significance of this problem. Many of the presidential candidates for the 2008 election made reducing the number of people without health insurance a central issue of the election and a top priority for their future administrations.[8]

1. AGENCY FOR HEALTHCARE RESEARCH & QUALITY, THE HIGH CONCENTRATION OF U.S. HEALTH CARE EXPENDITURES 1 (2006) [hereinafter HIGH CONCENTRATION] (using statistics collected in 2004 to determine total dollars spent as well as percentage of gross domestic product).

2. *See, e.g.*, Larry Grudzien, *The Great Vanishing Benefit, Employer Provided Retiree Medical Benefits: The Problem and Possible Solutions*, 39 J. MARSHALL L. REV. 785, 819 (2006).

3. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006, at 18 (2007).

4. Rick Mayes, *Universal Coverage and the American Health Care System in Crisis (Again)*, 7 J. HEALTH CARE L. & POL'Y 242, 246 (2004) (using the populations of the twenty-four smallest states).

5. *See* DENAVAS-WALT ET AL., *supra* note 3, at 18.

6. Throughout this Note, the terms *senior citizens* or *senior citizen* will be used to generally represent the population over fifty-five years of age. This designation takes into account the disparity in categories of reported statistics and reflects the shared concerns between those aged fifty-five to sixty-five and those over sixty-five. Because the age categories used in the statistics cited in the Note vary, this Note will generally highlight the age group represented in the statistics.

7. *See infra* Part II.D.

8. *See* Senator Hillary Clinton, 2008 Democratic Presidential Debate in Los Angeles, Cal. (Jan. 31, 2008) (transcript available at http://www.cnn.com/2008/POLITICS/01/31/dem.debate.transcript/) [hereinafter Senator Clinton]; Senator Barack Obama, 2008 Democratic Presidential Debate in Los Angeles, Cal. (Jan. 31, 2008) (transcript available at http://www.cnn.com/2008/POLITICS/01/31/dem.debate.transcript/) [hereinafter Senator Obama]; Former Governor Mitt Romney, 2008 Republican Presidential Debate at the Reagan Library (Jan. 30, 2008) (transcript available at http://www.cnn.com/2008/POLITICS/01/30/GOPdebate.transcript/) [hereinafter Former Governor Romney].

President Bush has also addressed the importance of increasing access to affordable health care for Americans without coverage.[9] Those advocating reform have proposed many different models, ranging from a purely market-driven approach to a federally administered system.[10] However, individual states may also drive reform much as they have driven innovation in other health care areas, such as the operation and delivery of Medicaid benefits, and their smaller populations may also reduce the scope of the possible reforms.[11] Two states in particular, Vermont and Massachusetts, passed legislation to address the growing number of uninsured within their state populations.[12] For these reasons, this Note will focus on state solutions to the problem, eliminating from consideration reforms targeted at larger populations, such as those in most European countries and Canada.

In order to analyze these plans and their likelihood of success, Part II of this Note will examine the current state of health care in terms of the current system and its accompanying problems, with a special emphasis on the unique needs of the senior citizen population. To examine possible means of solving the problem, Part III will provide an overview of three jurisdictions' response to the growing number of uninsured. In addition, Part III will examine Massachusetts's and Vermont's recently enacted legislation and consider an international response to similar health care problems in the form of the newly reformed health care system of Holland, in the Netherlands. These three jurisdictions also provide an interesting comparison because their populations range from very small to as large as some of the largest states. Finally, Part IV will illustrate that the Holland plan is the best reform model, given the unique needs of the senior citizen population.

9. *See* President George W. Bush, Remarks on Health Care, Address at Wendy's International, Inc. (Feb. 15, 2006) (transcript available at http://www.gop.com/News/NewsRead.aspx?Guid=f221132f-e061-4b24-9612-3c71bdedc4c5) [hereinafter President Bush].

10. *See* Carol S. Weissert, *Promise and Perils of State-Based Road to Universal Health Insurance in U.S.*, 7 J. HEALTH CARE L. & POL'Y 42, 46–50 (2004).

11. *See id.*

12. *See* Patricia Barry, *Coverage for All*, AARP BULLETIN, July–Aug. 2006, http://www.aarp.org/makeadifference/politics/articles/health_care_for_all.html (noting that the reform movements were even more surprising because of their bipartisan support).

II. Current State of U.S. Health Care

A. Current Health Care Costs and Sources of Growth

Currently, health care costs are astronomical and continue to grow, which significantly affects many Americans' ability to purchase insurance for themselves and their families. "In 2004, the United States spent $1.9 trillion, or 16% of its gross domestic product (GDP), on health care," and if these numbers are distributed evenly across the population, each person accumulated over $6000 in expenses.[13] In comparison, health care costs in 1980 were relatively paltry at $255 billion overall, 9% of the GDP and only $1106 per person.[14] Inflation is not the only factor fueling this growth, as the rate of health care cost growth significantly exceeds the rate of inflation.[15] In 2006, for example, health care costs grew at an annual rate of 7.7%, more than double the inflation rate.[16] The increasing number of bankruptcies caused by medical bills demonstrates the significance of these growing costs.[17] For example, in 1999, nearly 50% of nonbusiness bankruptcy filings, which amounted to nearly 600,000 individual filings, had a root cause related to medical bills.[18] The growing costs simultaneously make insurance for individuals more necessary yet more expensive to obtain. Because of this problem, many call for health care and insurance reform.[19]

To determine the best means of reducing both the growth of health care costs, and thereby the number of uninsured, one must recognize the multiple factors driving the increasing expenses. One of these factors is the cost and use of prescription drugs in medical treatment.[20] Prescription drug costs have annual growth rates of 9–10%.[21] In fact, the amount spent on prescription drugs doubled be-

13. HIGH CONCENTRATION, *supra* note 1, at 1. The total expenditure per person was $6280. *Id.*

14. *Id.*

15. *See id.*; Barry R. Furrow, *Access to Health Care and Political Ideology: Wouldn't You Really Rather Have a Pony?*, 29 W. NEW ENG. L. REV. 405, 407 (2007).

16. *See* Furrow, *supra* note 15, at 407.

17. *See* Mayes, *supra* note 4, at 244.

18. *Id.* (noting that the comparatively worse economic conditions have likely increased the number of medically related bankruptcy filings since the compilation of the statistics cited).

19. *See, e.g.*, *id.*

20. *See id.* at 266.

21. Wendell M. Harp, Comment, *America's Promise to Provide Health Care Access to the Elderly and the Medicare Modernization Act*, 50 HOW. L.J. 515, 521 (2007) (using statistics from the late 1990s).

tween 1990 and 2003 from $300 million to over $600 million.[22] At the same time, doctors increasingly prescribe more drugs, which exacerbates the problem of growing expenses.[23] As a result, people must have access to prescription drugs for treatment purposes, but cannot afford them without health insurance.

To make matters worse, the gradual aging of the population has further driven the growth in health care expenditures.[24] The number of Americans over sixty-five will reach seventy-two million by the year 2030,[25] as compared to thirty-six million in 2006.[26] The aging of the baby boomers drives this aging of the population.[27] Moreover, the average life expectancy continues to rise.[28] People who were sixty-five in the year 2000 live another 17.9 years on average, and people who were seventy-five in 2000 live another 11.3 years on average.[29] The greater number of senior citizens and their longer lifetimes significantly affects health care expenditures because senior citizens account for disproportionate percentages of health care costs and services compared to their relative population rates.[30] The combined effects of increases in prescription drug use and costs and the aging of the population increase the costs of health care. As a result, more people need health insurance to help pay for medical treatment.

B. Current State of Insurance

Consumers have a variety of choices when seeking health insurance. Generally, two broad categories exist: privately provided insur-

22. *See id.*
23. *See* Mayes, *supra* note 4, at 266.
24. *See* Joann Babiak, *Health-Care Access for the Elderly of Industrialized Nations: Fallen and Can't Get Up?*, 4 ILSA J. INT'L & COMP. L. 221, 222 (1997) (noting that public programs such as Medicare and Medicaid will face significant difficulties in ensuring adequate funding given the shrinking labor pools).
25. WAN HE ET AL., U.S. CENSUS BUREAU, 65+ IN THE UNITED STATES: 2005, at 1 (2005). In 2030, the seventy-two million Americans expected to be over the age of sixty-five will account for nearly 20% of the total U.S. population. *Id.*
26. DENAVAS-WALT ET AL., *supra* note 3, at 15 tbl.4.
27. WAN HE ET AL., *supra* note 25, at 2. The first baby boomers will turn sixty-five in 2011, an event expected to have a significant effect on the number of retirements. *Id.*
28. *See id.* at 36 (citing the reduction in mortality rates at both young ages and old ages as the cause of the increase in life expectancy).
29. *Id.* at 35.
30. *See* HIGH CONCENTRATION, *supra* note 1, at 1. The difference in health consumption rates for senior citizens compared to those in the general populations will be discussed *infra* in Part II.D.

ance and government-provided insurance.[31] The first of these categories, private insurance, usually involves the payment of premiums, deductibles, and possibly copayments, all directly to the insurer.[32] The category includes employment-based plans, in which employers may or may not give financial assistance in paying costs,[33] and individually purchased plans.[34] In 2006, nearly 68% of Americans, or over 200 million people, maintained health coverage through private insurance.[35] Specifically, about 60% of Americans received a health plan as part of their employment, while only about 9% of the population directly purchased insurance from a provider.[36] Furthermore, 75.3% of the population between fifty-five and sixty-four years of age as well as over 60.8% of people over sixty-five maintained privately provided insurance.[37]

Government-offered coverage similarly includes multiple subcategories, including Medicare for those over sixty-five, Medicaid for people with low income, military health care, and other programs made available by the state and federal governments.[38] The means of operation for these programs vary, but generally, the government wholly or partially subsidizes the coverage and administers coverage through private insurers.[39] These programs as a whole currently provide insurance for over 27% of the U.S. population, or 80 million Americans, including 19% of citizens between fifty-five and sixty-four and 94% of citizens over sixty-five.[40] Despite the seemingly large number of people covered by one of the current plans, many Americans still do not have any form of health insurance.

C. The Lack of Insurance: Its Sources and Effects

For several reasons, the number of uninsured Americans has increased significantly in recent years, and the effects of being unin-

31. *See* DENAVAS-WALT ET AL., *supra* note 3, at 18. These distinctions and categories are meant to be broad and are not meant to reflect all of the possible types of insurance coverage currently available.
32. *See id.* at 18.
33. *See id.* at 20 fig.7.
34. *See id.*
35. *Id.*
36. *Id.*
37. *Id.* at 66 tbl.C-3.
38. *Id.* at 18.
39. LAWRENCE A. FROLICK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 55–110 (2006).
40. *See* DENAVAS-WALT ET AL., *supra* note 3, at 66 tbl.C-3.

sured have grown more dramatic. In 2006, 15.8% of Americans, or nearly forty-seven million people, lacked health insurance, representing an increase over the 15.3% and less than forty-five million reported for 2005.[41] In that single year, the number of uninsured grew by over two million Americans.[42] Included in this growth is the number of older Americans without coverage: the number of uninsured between the ages of forty-five and sixty-four grew to over ten million, and those over sixty-five, to over 500,000.[43]

The uninsured typically share some characteristics. As could be expected, people with lower incomes are more likely to lack coverage than people with higher incomes.[44] For example, nearly 25% of people with annual income below $25,000 do not have insurance, as compared to less than 9% for people with annual income above $75,000.[45] Moreover, in comparison to the general population, young adults, minority groups, and people who work less have higher uninsured rates.[46] Further complicating the issue, the uninsured tend to be a fluid population, with individual people alternatively gaining and losing coverage.[47]

The combination of increases in insurance premiums due to growing health care costs, reduced employment-based benefits, and the rise of unemployment fuels the growth of the uninsured.[48] In response to the rapidly growing health care costs, insurers, like any other business, must adjust to the increasing price and raise the premiums and other out-of-pocket costs that consumers face.[49] As these costs rise, people with low income or who lack regular work attempt to go without insurance, resulting in the increased rates of uninsured individuals among these portions of the population.[50]

41. *Id.* at 20 fig.7.
42. *See id.*
43. *Id.* at 21 tbl.6.
44. *Id.*
45. *Id.*
46. *See* Mayes, *supra* note 4, at 248–49. Of all races, Americans of "Hispanic origin" faced the highest uninsured rates, at 34.1%, as compared to the lowest rate for "White, not Hispanic" Americans, at 10.8%. *See* DENAVAS-WALT ET AL., *supra* note 3, at 21 tbl.6. People between the ages of eighteen and twenty-four had the highest uninsured rates at 29.3%. *Id.* Finally, part time-workers and the unemployed had higher rates, 22.9% and 26.1%, respectively, than full-time workers (17.9%). *Id.*
47. *See* Mayes, *supra* note 4, at 249.
48. *Id.* at 247–48.
49. *See id.* at 247.
50. *See* DENAVAS-WALT ET AL., *supra* note 3, at 21.

Moreover, with the majority of the population relying at least in part on employment-based coverage,[51] changes in an employer's coverage or an individual's employment status seriously affects insurance coverage.[52] Faced with the increasing costs of health care, employers are increasing employees' costs as well as reducing the breadth of coverage available to current and retired employees.[53] In 2005, for example, only 33% of employers with more than 200 employees offered retiree medical benefits—half of the 66% offering plans in 1988.[54] When employers do offer coverage, they often shift the burden of any increase in insurance costs to the employee by increasing the amount of employee-paid copayments, premiums, and deductibles.[55] For example, a survey of future retirees in 2005 found that of their employers, 12% completely removed subsidized medical benefits, 71% increased required premium contributions, 24% raised deductibles, and 34% increased cost sharing for retirees.[56] As a result, employees must look elsewhere for coverage, which they may not be able to afford.[57] Further increasing the number of uninsured, the rise of unemployment rates has caused some workers to lose their jobs and therefore their coverage.[58] In concert, these factors combine to further fuel the growing number of uninsured.

This growth in the uninsured is significant because those without insurance suffer negative economic and physical health consequences.[59] The lack of coverage or gaps in coverage can lead to bankruptcy because of the high costs of medical treatment.[60] Even worse, the absence of insurance coverage negatively affects the health of the uninsured.[61] This lowered health is the result of the infrequent and

51. *See supra* Part II.B. Sixty percent of Americans had health insurance coverage through an employer in 2006. DENAVAS-WALT ET AL., *supra* note 3, at 63 tbl.C-3.

52. *See* John V. Jacobi, *Government Reinsurance Programs and Consumer-Driven Care*, 53 BUFF. L. REV. 540, 537 (2005); Mayes, *supra* note 4, at 247.

53. *See* Grudzien, *supra* note 2, at 791; Susan A. Channick, *Come the Revolution: Are We Finally Ready for Universal Health Insurance?*, 39 CAL. W. L. REV. 303, 304–05 (2003).

54. *See* Grudzien, *supra* note 2, at 785.

55. *See* Mayes, *supra* note 4, at 247.

56. *See* Grudzien, *supra* note 2, at 785.

57. *Id.* at 791.

58. *See* Mayes, *supra* note 4, at 247.

59. *See* Jacobi, *supra* note 52, at 540–42.

60. *Id.* at 540; Mayes, *supra* note 4, at 244.

61. *See* Jacobi, *supra* note 52, at 540–41.

disjointed care available to the uninsured.[62] For example, in 2001, only 21.4% of the uninsured visited a doctor, as compared to 73.1% of all Americans.[63] In addition, of the uninsured, only 2.6% had visited a hospital in 2001, and only 10.2% had received routine checkups.[64] In its most extreme form, a lack of insurance can result in fatalities: the reduced access to medical treatment results in an estimated 18,000 premature deaths each year.[65] Senior citizens are especially susceptible to these negative consequences.

D. The Special Concerns and Needs of Senior Citizens

When developing a means of reform, a reforming body must consider the unique needs of senior citizens because they represent a significant yet vulnerable segment of society and consume a disproportionately high percentage of health care costs.[66] Senior citizens remain an important challenge to any system of reform because they face increased costs from expensive ailments, frequent use of system resources, and limited income.[67] While it is true that Medicare covers nearly all people over the age of sixty-five,[68] private coverage and out-of-pocket expenses still account for 12% and 19%, respectively, of health care expenses for those over sixty-five.[69] In addition, Medicare has consistently faced significant funding problems that threaten its future viability and availability to senior citizens.[70] Finally, any system of reform could have a significant impact on the thirty-two million Americans between the ages of fifty-five and sixty-four who are

62. *Id.*

63. *See* SHAILESH BHANDARI, U.S. CENSUS BUREAU, HEALTH STATUS, HEALTH INSURANCE, AND HEALTH SERVICES UTILIZATION: 2001, at 11 tbl.5, 6 tbl.3 (2006). The general population includes those without insurance as well. *Id.*

64. *Id.* at 11 tbl.5.

65. *See* Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 546 (2006).

66. *See* HIGH CONCENTRATION, *supra* note 1, at 3. In 2006, there were over sixty-eight million people aged fifty-five and over, and nearly 300 million Americans in the total population. DENAVAS-WALT ET AL., *supra* note 3, at 15 tbl.4.

67. *See* Dorothy C. Rasinski-Gregory & Miriam Piven Cotler, *The Elderly and Health Care Reform: Needs, Concerns, Responsibilities and Obligations*, 21 W. ST. U. L. REV. 65, 66 (1993).

68. *See* DENAVAS-WALT ET AL., *supra* note 3, at 66 tbl.C-3 (noting that the government provided a form of insurance to nearly 95% of the population over sixty-five).

69. WAN HE ET AL., *supra* note 25, at 69.

70. *See* Mayes, *supra* note 4, at 252 (noting that Medicare and Medicaid, as well as other government insurance programs, would face significant difficulties if an attempt was made to expand the programs to cover more people).

not yet eligible for Medicare participation, but still face serious health care issues.[71] As a result, reform efforts remain an important issue for senior citizens.

Senior citizens frequently suffer from medical ailments that are among the most expensive to treat, including chronic conditions such as heart disease, asthma, diabetes, and hypertension.[72] These conditions significantly contribute to the rising costs of health care and place significant strain on the sick person's ability to afford health care.[73] On average, people with at least one chronic condition spend at least twice as much as a person without any chronic condition, and the disparity grows to fourteen times the average-person cost for those with more than five chronic conditions.[74] This is particularly problematic for senior citizens, whose incidence of chronic conditions is much higher than that of the general population.[75] Approximately 80% of senior citizens over sixty-five have been diagnosed with at least one chronic condition.[76] These expensive conditions contribute to the $11,089 in annual health costs for the average person over sixty-five, as compared to $3352 per person for the general population.[77]

Senior citizens are also more likely than the general population to need and use health care resources, such as doctor visits, hospital stays, and prescription drugs.[78] Over 57% of people over sixty-five visit a doctor at least four times annually, while less than 30.5% of the general population does so.[79] Similarly, people over sixty-five are four times more likely than the general population to spend at least thirty

71. *See* DENAVAS-WALT ET AL., *supra* note 3, at 66 tbl.C-3. This is especially important in this Note as the term "senior citizens" has been defined to include any person over fifty-five.

72. HIGH CONCENTRATION, *supra* note 1, at 7.

73. *Id.*

74. *Id.* This source does not provide different rates for senior citizens with at least one chronic condition and the general population with at least one chronic condition. *See id.*

75. *See id.*; Rasinski-Gregory & Cotler, *supra* note 67, at 75. For example, between 1998 and 2000, 11% of people between the ages of sixty-five and seventy-four faced a chronic condition of the heart. WAN HE ET AL., *supra* note 25, at 55 fig.3-16. In comparison, only 0.5% of people between the ages of eighteen and forty-four suffered from the same type of ailments. *Id.*

76. WAN HE ET AL., *supra* note 25, at 54. Around 50% of senior citizens have at least two chronic conditions. *Id.*

77. HIGH CONCENTRATION, *supra* note 1, at 3. For this statistic, the general population is limited to people between the ages of eighteen and sixty-four and does not include the costs for people over sixty-five. *Id.*

78. BHANDARI, *supra* note 63, at 6 tbl.3. The statistics cited from this source are based on information collected from 2001. *Id.* at 2.

79. *Id.* at 5 fig.2.

nights in a hospital during a single year.[80] Finally, senior citizens are more than twice as likely as the general population to take prescription drugs regularly.[81] Due to even more increased health-care-resource usage, senior citizens with preexisting conditions such as diabetes or heart disease may face higher insurance premiums or even coverage denials.[82]

Further complicating health care and insurance problems, many senior citizens live on fixed and limited incomes. Incomes are especially low for people over sixty-five, whose median income for 2006 was only $27,798, as compared to the national median of $48,201.[83] In addition, 3.4 million Americans over sixty-five are below the federal poverty line of $9669 for 2006.[84] Senior citizens' incomes are also largely fixed: Social Security payments represented at least half of the total income for 65% of the population over sixty-five.[85] Moreover, the Social Security Administration may reduce benefits in the future, as the growing number of beneficiaries will exhaust Social Security funds in 2042.[86] The growing cost of health care places an enormous burden on senior citizens due to their largely fixed and comparatively low incomes. Medical costs represent over 20% of senior income, resulting in 22% of people over sixty-five and 18% of people between fifty and sixty-four reporting difficulties in paying medical bills.[87]

In light of these difficulties, the most significant areas of reform for senior citizens are prescription drug prices, access to insurance and regular care, and the regulation of out-of-pocket expenses. Prescription drugs, among other factors, drive the rise in health care costs, motivating senior citizen advocates to argue for reform to en-

80. *Id.* at 6 tbl.3.

81. *Id.*

82. *See* Harold J. Krent et al., *Whose Business Is Your Pancreas? Potential Privacy Problems in New York City's Mandatory Diabetes Registry*, 17 ANNALS HEALTH L. 1, 26–28 (2008).

83. DENAVAS-WALT ET AL., *supra* note 3, at 5.

84. *Id.* at 11; U.S. CENSUS BUREAU, POVERTY THRESHOLDS 2006, at 1 (2007), http://www.census.gov/hhes/www/poverty/threshld/thresh06.html.

85. *See* WAN HE ET AL., *supra* note 25, at 97 fig.4-10. This statistic is based on information collected in 2001. *Id.* In addition, Social Security benefits represent at least 90% of all income for one-third of all Americans over sixty-five, and 100% of all income for 20% of those over sixty-five. *Id.*

86. *Id.* at 97. The exhaustion of funds is based on the aging of the population and the reduced ratios between active workers and people receiving benefits from the plan. *Id.*

87. Deanne Loonin & Elizabeth Renuart, *The Life and Debt Cycle: The Growing Debt Burdens of Older Consumers and Related Policy Recommendations*, 44 HARV. J. ON LEGIS. 167, 172 (2007).

sure necessary and affordable access to prescription drugs.[88] Moreover, in recognition of the problems caused by chronic conditions, it is necessary that senior citizens have access to insurance and regular care, which may reduce the physical and financial impact of these conditions.[89] Furthermore, reductions in out-of-pocket expenses are necessary to protect senior citizens' limited incomes.[90]

E. Calls for Reform

The significance and severity of the health care issues facing senior citizens and all Americans have not gone unnoticed by the American public nor its political leaders. Polls have shown that 74% of voting-age Americans support a program to provide coverage for the uninsured.[91] Moreover, the potential nominees for the 2008 presidential election and future political leaders of this country have expressed strong views on the importance of improved access to health insurance. Senator Hillary Clinton has said that universal health care is "a moral responsibility and right for our country."[92] Similarly, Senator Barack Obama stated that he believes that the United States has "a moral obligation to make sure that everybody has the opportunity to get health care in this country."[93]

Political interest in improving the status of the uninsured is not limited to the Democratic Party; indeed, President Bush has stated that "[t]o keep this country [economically] competitive, we need a health care system that provides Americans with high-quality care at

88. *See* William D. Novelli, Executive Dir. & CEO, AARP, Address at the American Medical Association 2003 National Advocacy Conference (Apr. 2, 2003); AARP.org, Health Care and Supportive Services, http://www.aarp.org/issues/policies/health_care/ (last visited Aug. 31, 2008).

89. *See* Novelli, *supra* note 88; AARP.org, *supra* note 88.

90. *See* Novelli, *supra* note 88.

91. Mark V. Pauly, *Conflict and Compromise over Tradeoffs in Universal Health Insurance Plans*, 32 J.L. MED. & ETHICS 465, 465 (2004).

92. Senator Hillary Clinton, *supra* note 8 (arguing for a universal system of health care delivery with a single-payer system and federal government administration and stating that a universal health care system should be a cornerstone of the Democratic Party).

93. Senator Barack Obama, *supra* note 8 (noting that growing costs have prevented many Americans from being able to afford health insurance and, by extension, health care, while attacking Senator Clinton's plan because of its use of individual mandates).

good prices."[94] Thus, political leaders on both sides of the aisle may now attempt to improve the current system. In fact, at least two domestic and one foreign jurisdiction have made significant reforms that attempt to curb the growing number of uninsured. This Note will now consider these reform efforts, made by Massachusetts, Vermont, and Holland, to determine if any of these proposals effectively address the issues of health care and insurance in America.

III. Recent Reforms to Health Care

In response to the rising costs and the number of uninsured, Holland, Massachusetts, and Vermont have enacted legislation to make it easier for people to obtain insurance.[95] Any reformer must evaluate these proposed solutions in reference to the current trends and problems facing health care. First, the reform must provide a means of reducing out-of-pocket costs, including prescription drug costs, in order to limit the escalating price paid by consumers, employers, and the government. Second, the reform should improve access to health care for the entire population, especially those with low income and other vulnerabilities. Finally, the plan should be administratively feasible while allowing some choice to the participants. The best of the proposed plans will have a positive impact on all of these issues.

A. Holland's Plan for Reform

Because Holland is similar in size to a large U.S. state and faced similar problems with its health care system as the United States, Holland's attempts to reform may serve as a possible model for the United States. With a population of 16.6 million,[96] the Kingdom of the Netherlands (Holland) would be the fifth largest state in the United States, between Illinois and Florida and considerably larger than both

94. President George W. Bush, *supra* note 9 (recognizing the difficulties that face American health care, including the growing costs, while advocating for the expansion and use of health savings accounts).

95. Gautam Naik, *Dutch Treatment: In Holland, Some See Model for U.S. Health-Care System; Private Insurers Compete, but All Get Coverage; Ms. Boël Sheds Pounds*, WALL ST. J., Sept. 6, 2007, at A1; Vermont.gov, Vermont's Health Care Reform of 2006, http://hcr.vermont.gov/health_care_reform_legislation (last visited Aug. 31, 2008).

96. Naik, *supra* note 95.

Massachusetts and Vermont.[97] Holland instituted a new system of health care in 2006 after years of its citizens (the "Dutch") facing problems similar to the current U.S. issues.[98] Consumers there had long faced rising prices, difficulties in securing quality coverage, and few health care and coverage choices.[99] As in the United States, Holland blamed the rise in costs on the growing use of prescription drugs,[100] the aging of the population, and the increased demand for health care.[101] Holland, too, maintained a system with a mix of private- and government-provided insurance.[102] Over the previous few decades, Holland had undergone at least three separate reforms in attempts to correct the issues.[103] Despite these efforts, the quality of health care appeared to the Dutch population to be deteriorating.[104]

To combat these problems, Holland implemented a multifaceted reform plan, the New Health Insurance Act (NHIA), on January 1, 2006.[105] The NHIA is consistent with Holland's belief that ensuring proper health care is a core governmental task.[106] In recognition of

97. *See* U.S. CENSUS BUREAU, STATES RANKED BY POPULATION: 2000, http://www/census.gov/population/www/cen2000/briefs/phc-t2/tables/tab01.pdf.

98. *See* Naik, *supra* note 95.

99. *See* MINISTRY OF HEALTH, WELFARE & SPORT, THE NEW CARE SYSTEM IN THE NETHERLANDS: DURABILITY, SOLIDARITY, CHOICE, QUALITY, EFFICIENCY 7, http://www.healthlaw.nl/healthcare_reform.pdf (last visited Aug. 31, 2008); Naik, *supra* note 95. For example, the country faced a serious challenge in the form of significant waiting lists for major operations, such as heart transplants, that were much longer than comparative lists for other European nations and the United States. *Id.*

100. Naik, *supra* note 95. Prescription drug costs had risen at rates as high as 9% prior to 2004. *Id.*

101. *See* MINISTRY OF HEALTH, WELFARE & SPORT, *supra* note 99, at 8 (noting that health demand is expected to continue to increase in the years to come and that new technology will develop).

102. Naik, *supra* note 95. The top third of the income brackets purchased insurance privately from insurers with or without help from their employers. *Id.* Civil servants and the elderly were insured through two separate schemes administered by the national government. *Id.* Finally, the majority of the population received insurance through a government-run system financed by taxes on the wages of the workers. *Id.*

103. *See* Jan-Kees Helderman et al., *Market-Oriented Health Care Reforms and Policy Learning in the Netherlands*, 30 J. HEALTH POL. POL'Y & L. 189, 193–94 (2005). These reforms included an attempt to establish universal care in the mid-1970s, an attempt to focus government resources on containing costs and reducing health care expenditures through an etatist policy movement during the 1980s and an attempt to introduce market-based competition from the late 1980s to the early 1990s. *Id.*

104. *Id.* at 201.

105. *See* MINISTRY OF HEALTH, WELFARE & SPORT, *supra* note 99, at 7.

106. *Id.* at 4.

this view, the central aim of the new system is to increase the quality and efficiency of the system while making insurance more affordable and therefore accessible for the entire population.[107] To achieve these ends, the NHIA places duties on four segments of society: individuals, employers, insurers, and the government.[108]

For individuals, insurance coverage is now compulsory, subjecting those who fail to comply to a government fine.[109] Moreover, individuals must pay an annual premium directly to the insurers.[110] The average citizen paid approximately $1500 in 2006.[111] Employees must also contribute 6.5% of their salary, with a cap of €2000, to a central fund.[112] Self-employed workers must pay an additional 4.4% of their income into the central fund.[113] The government may, however, reimburse a portion of the premium paid if the individual uses only a minimal amount of care during the year.[114] In return for these payments, the entire population, regardless of age or health, receives a standard health plan with the option to purchase additional protections.[115] In addition to the contributions made by individuals, the NHIA also requires employers to help fund the new system: each employer must reimburse the 6.5% of the employee's salary that the employee contributed to the central fund.[116]

The NHIA also places mandates on the insurance companies: to offer insurance in Holland, the insurance companies must meet certain requirements. The approved plans must offer basic coverage, as determined by law, and cannot offer different levels of coverage at the same price.[117] However, the companies may still set the premium levels for their plans.[118] In addition, the companies must accept any indi-

107. *Id.* at 8.
108. *Id.* at 7–15.
109. *Id.* at 8.
110. Naik, *supra* note 95.
111. *Id.* The government cited an average premium of €1028, which was actually below the expected premium cost of €1106 forecasted prior to enactment. *Id.*
112. *See* MINISTRY OF HEALTH, WELFARE & SPORT, *supra* note 99, at 16.
113. *See id.*
114. *Id.* Adults who use less than €255 worth of health care in any one year are eligible to receive part of their annual payment as a rebate. *Id.* This program is primarily designed to prevent people from unnecessarily using health care resources. *Id.*
115. *Id.* at 8–10.
116. *Id.* at 16–17.
117. *Id.* at 10.
118. *Id.*

vidual who seeks coverage, regardless of age or health.[119] To offset the burden of this requirement, a central fund, provided by contributions from employers, the state, and from individuals, compensates insurance companies when they accept individuals with greater health risks, such as diabetes or heart conditions.[120] The architects of the plan designed the central fund to equalize the burdens of risky and expensive patients across society.[121] Moreover, the insurers must allow individuals to switch coverage once per year and reimburse covered people who seek care outside of the network.[122]

The government also performs certain functions to ensure the efficacy of the new system. First, the state provides subsidies, called care allowances, for those with low incomes and pays the entire premium for those below the age of eighteen.[123] Moreover, the government performs administrative functions, such as publicizing the available health plans through a central network in order to inform the public about differences in the plans and reduce information deficiencies.[124] The government has also played a key role in reducing the total health care costs borne by the insurance companies and consumers by negotiating directly with prescription drug makers to secure a 40% reduction in prices.[125]

To achieve the program's stated goals of increased access and reduced costs, the architects of the NHIA allocated the rights and responsibilities of the stakeholders in the system to force competition among the insurers.[126] The insurance industry faces competition in two distinct ways.[127] Because the plan provides for individual flexibility in leaving programs, guaranteed acceptance, and improved information through government disclosure of plans, insurers must com-

119. *Id.* at 8.

120. *Id.* at 17 (noting that the compensation pool used to compensate insurance companies is funded by 50% employer contributions, 5% government funds, and 45% individual premiums). There are approximately thirty different diseases, such as diabetes and heart disease, that trigger the subsidies for the insurance companies that take on a patient with one of the diseases. *See* Naik, *supra* note 95.

121. Naik, *supra* note 95.

122. *See* MINISTRY OF HEALTH, WELFARE & SPORT, *supra* note 99, at 10–12.

123. *Id.* at 15. The care allowances, which are distributed to more than five million people, are based on a sliding scale that depends on the income level of the beneficiary. *Id.*

124. Naik, *supra* note 95.

125. *Id.*

126. *Id.* The stakeholders include insurance companies, health care providers, individuals, employers, and the government.

127. *See* MINISTRY OF HEALTH, WELFARE & SPORT, *supra* note 99, at 12.

pete with each other for customers, thereby driving costs down and improving service.[128] In addition, insurers can and must negotiate with health care providers to reduce costs because of the burden of accepting everyone, regardless of age or health.[129] The insurance companies' pressure then forces health care providers, such as doctors and hospitals, to reduce prices while improving care.[130]

Although the NHIA has achieved some short-term improvements since enactment, its future viability and success are still in doubt. Following its enactment, Holland has seen reductions in the growth of health care costs, including the costs of prescription drugs.[131] In addition, individual citizens' access to care has improved as waiting lists for procedures have dropped.[132] Despite these successes, there are still some critics. For example, a recent survey of Dutch labor union members found that 70% of the members believed that the system had actually hurt them financially.[133] Moreover, others have questioned whether market forces, such as health care provider and insurer competition, can effectively solve the health insurance problems.[134]

Despite these uncertainties, the plan enacted in Holland should result in significant benefits for senior citizens because it addresses many of their most important issues. The NHIA ensures meaningful access to health care for senior citizens because insurers cannot refuse to insure based on a preexisting condition or age.[135] Given the high percentage of senior citizens that suffer from preexisting conditions or that face difficulties in obtaining coverage because of their age, this component of the plan is especially important.[136]

Additionally, the risk equalization of the central fund spreads the burden of expensive conditions prevalent among senior citizens across multiple aspects of society.[137] As a result, the healthier segments of society subsidize senior citizens, who use a disproportionate

128. *Id.*
129. *Id.* at 12–14.
130. *See* Jost, *supra* note 65, at 580–81 (noting that these effects rely on the individual to make informed decisions).
131. Naik, *supra* note 95.
132. *Id.*
133. *Id.* Some argue that this perception is a result of the individuals having clearer information about the nature of their health care costs. *Id.*
134. *See* Helderman et al., *supra* note 103, at 208; Naik, *supra* note 95.
135. *See* MINISTRY OF HEALTH, WELFARE & SPORT, *supra* note 99, at 10.
136. *See* Krent et al., *supra* note 82, at 26–28.
137. *See* Jost, *supra* note 65, at 542–44.

percentage of health care.[138] Moreover, the system provides allowances to individuals with low incomes, including the disproportionately poor senior citizens.[139] These formal subsidies, as well as the informal subsidies of the risk equalization pool, allow senior citizens with low and fixed incomes to pay for quality coverage at lower rates.[140] The increased competition among the insurance providers further benefits senior citizens by driving costs down.[141] To take advantage of this competition, consumers must act rationally to switch coverage when a better plan is available.[142] Senior citizens are able to make these informed decisions because the government distributes the necessary information about the plans.[143]

The government also helps to control health care costs by negotiating price reductions directly from the drug manufacturers.[144] Reductions in prescription drug prices are extremely significant for senior citizens because senior citizens are twice as likely to purchase and use prescription drugs regularly.[145] Even with these cost reductions, the quality of care for senior citizens should not drop because the government mandates basic levels of coverage for all insurance plans.[146] Although Holland's system has many positive attributes that may make it an appropriate method of reform, Massachusetts and Vermont have offered competing models that may offer distinct advantages over Holland's plan.

B. Massachusetts's Plan for Reform

Like Holland, Massachusetts recognized that the government needed to take action to reduce the number of uninsured within its population.[147] In 2006, over 10% of Massachusetts's population, or 550,000 citizens, lacked health coverage.[148] Recognizing the problem, the government sought to reduce the number of uninsured by reduc-

138. *See* MINISTRY OF HEALTH, WELFARE & SPORT, *supra* note 99, at 15.
139. *Id.*
140. *See* Jost, *supra* note 65, at 542–44.
141. *See id.* at 580–81.
142. *See id.* at 581–82.
143. *See* MINISTRY OF HEALTH, WELFARE & SPORT, *supra* note 99, at 10.
144. *See* Naik, *supra* note 95.
145. *See* BHANDARI, *supra* note 63, at 6 tbl.3.
146. *See* MINISTRY OF HEALTH, WELFARE & SPORT, *supra* note 99, at 10.
147. *See* MASS. COMM. ON HEALTH CARE ACCESS & AFFORDABILITY, 184TH SESS., HEALTH CARE ACCESS AND AFFORDABILITY CONF. COMM. REPORT 1 (2006), *available at* http://www.mass.gov/legis/summary.pdf [hereinafter HEALTH CARE ACCESS].
148. *See id.*

ing costs and improving access to health care coverage for the entire population.[149] In pursuit of these goals, the State enacted a comprehensive program with three main components.[150] First, the program changed the insurance market by merging the small business and individual markets.[151] Second, the program imposed requirements on both individual citizens and employers.[152] Finally, the program created a new government agency to improve access and the quality of care.[153]

To implement these overall changes in furtherance of its stated purposes, the program created a new authority within the Department of Administration and Finance called the Commonwealth Health Insurance Connector (the "Connector") and charged it with several responsibilities.[154] The Connector's goal is "to facilitate the purchase of health care insurance products . . . at an affordable price by eligible individuals [and] groups."[155] The legislature designed the department to improve access to, as well as affordability of, health insurance for small businesses and individuals.[156] Under the statute, the Connector can only offer plans to eligible individuals and groups,[157] which the statute limits to state residents, employers with less than fifty employees, and private organizations such as unions or churches.[158] Effectively, the Connector changes the insurance market by merging the individual and small business pools, previously separated by the statute.[159] The Connector allows these smaller groups to improve their bargaining strength and risk-pooling advantages, thereby forcing insurance companies to reduce rates.[160]

Although the Connector serves a facilitation and overview function, private companies continue to actually provide and administer

149. *Id.* at 1–3.
150. *Id.*
151. *Id.*
152. *Id.*
153. *Id.*
154. *See* MASS. ANN. LAWS ch. 176Q, §§ 1–16 (LexisNexis Supp. 2007); Edward A. Zelinsky, *The New Massachusetts Health Law: Preemption and Experimentation*, 49 WM. & MARY L. REV. 229, 235–39 (2007).
155. Ch. 176Q, § 3.
156. Elizabeth A. Weeks, *Failure to Connect: The Massachusetts Plan for Individual Health Insurance*, 55 U. KAN. L. REV. 1283, 1290–91 (2007).
157. Ch. 176Q, § 4.
158. *Id.* § 1.
159. HEALTH CARE ACCESS, *supra* note 147, at 1.
160. *See* Weeks, *supra* note 156, at 1290.

the insurance plans.[161] However, the Connector does review the plans to determine if they meet certain requirements, such as not discriminating based on age or health status.[162] In addition, the Connector provides its seal of approval only for plans that provide sufficient value and quality for consumers.[163] The Connector also requires insurance companies to allow covered people to take their plans with them if they change jobs.[164]

Pursuant to statute, the Connector developed regulations that set out the necessary requirements for creditable coverage.[165] The statute defines *creditable coverage* to include certain per se categories such as Medicare coverage and plans that meet standards established by the Connector.[166] The plans must provide for certain benefits, including preventative care, a prescription drug plan, hospital visits, and outpatient services.[167] The statute and its enforcing regulations also impose cost ceilings on the insurance companies. For the period beginning January 1, 2009, plans for an individual may not exceed $2000 in deductibles, $250 in prescription drug deductibles, or $5000 in out-of-pocket but in-network costs and cannot place a maximum cap on benefits for covered services.[168] In addition, providers may not charge deductibles for doctor visits without providing three visits before a deductible applies.[169]

To reduce the number of uninsured, Massachusetts requires that every resident over eighteen purchase creditable coverage.[170] Former Governor Mitt Romney, who signed the legislation, described the mandate: "If somebody could afford insurance, they should either buy the insurance or pay their own way. . . . But they shouldn't be allowed to just show up at the hospital and say, somebody else should pay for me. And so we said: No more free riders."[171] An individual who does not maintain creditable coverages loses the personal exemption for state income taxes.[172] In the future, the State will charge the individual

161. Ch. 176Q, § 1.
162. *Id.* § 5(c).
163. *Id.* § 10.
164. HEALTH CARE ACCESS, *supra* note 147, at 1.
165. Ch. 111M, § 1.
166. *Id.* § 1.
167. 956 MASS. CODE REGS. 5.03(2)(a) (2007).
168. *Id.* 5.03(2)(c)–(f).
169. *Id.* 5.03(2)(h)(1).
170. Ch. 111M, § 2.
171. Former Governor Mitt Romney, *supra* note 8.
172. Ch. 111M, § 2(b).

a penalty of 50% of the cost of a plan that the Connector deems affordable to the person.[173] To avoid individual hardship, the statute exempts individuals from the coverage requirements if they can demonstrate that religious beliefs prevent them from having insurance,[174] or if the Connector certifies that they cannot afford coverage.[175] The Connector promulgates an affordability schedule each year to determine if a person is exempt from the individual mandate.[176]

To improve coverage rates further, the Connector administers a program to provide subsidies to people with low incomes.[177] The Commonwealth Care Insurance Program (Commonwealth Care) provides subsidies to individuals with incomes below 300% of the federal poverty level.[178] However, the subsidies do not apply to people who have qualified for another form of government-provided insurance, such as Medicare.[179] For people with incomes below 100% of the federal poverty level, the State pays the entire premium for insurance made available by the Connector, leaving the individual responsible only for copayments.[180]

To spread the burden of reducing the number of uninsured beyond individuals and the government, employers must conform to certain mandates or face economic penalties. First, any employer with more than ten employees must provide an opportunity for its employees to purchase health care using pretax dollars.[181] If an employer fails to meet this requirement, the statute subjects it to the "Free Rider Surcharge," equal to a certain percentage of the public funds used to provide care for the employees of the nonconforming employer.[182] Second, employers with more than ten employees that do not offer a group health plan must make a "Fair Share Contribution" to the State equal to $295 per employee.[183] The legislature designed the fee to offset the State's cost of providing insurance to the nonproviding em-

173. *Id.* § 2(b).
174. *Id.* § 3.
175. Ch. 176Q, § 3(a)(5).
176. 956 MASS. CODE REGS. 6.05(1) (2007).
177. Ch. 176Q, § 7.
178. Ch. 118H, § 3.
179. *Id.*
180. *Id.*
181. Ch. 151F, § 2.
182. Ch. 118G, § 18B (applying gradual percentages while exempting the first $50,000 in expenses).
183. Ch. 149, § 188.

ployer's employees.[184] This provision of the plan may, however, actually act as a disincentive for employers to provide insurance.[185] The $295 penalty is far less than the cost of actually providing insurance to employees, so a truly rational employer would choose to take the penalty.[186]

As Massachusetts only recently enacted its new system, little concrete data is available about the success of the program. By combining the purchasing power of individuals and small groups into a larger group with greater purchasing power, the State believes that the program will reduce insurance premiums for individuals by 24%.[187] In addition, Massachusetts estimates that within three years, 95% of the uninsured will have coverage.[188]

The program will likely benefit senior citizens in some respects, but other aspects of the program may reduce the impact of these benefits. The program does benefit senior citizens by allowing them to take coverage with them if they change jobs.[189] The portability of coverage is significant because 67.4% of senior citizens between the ages of fifty-five and sixty-four and 36.3% of senior citizens over sixty-five receive health coverage through their employer.[190] As costs have increased, however, fewer employers are offering benefits for retirees,[191] so senior citizens may not be able to rely on their employer for future health benefits. On the other hand, a senior citizen who purchases a plan through the Connector can maintain his or her plan regardless of employment.[192]

In addition, the Connector benefits senior citizens by ensuring that they receive a minimum quality of care.[193] For example, the Con-

184. Sidney D. Watson et al., *The Road from Massachusetts to Missouri: What Will It Take for Other States to Replicate Massachusetts Health Reform?*, 55 U. KAN. L. REV. 1331, 1351 (2007).

185. Joan H. Krause, *Fraud in Universal Coverage: The Usual Suspects (and Then Some)*, 55 U. KAN. L. REV. 1151, 1167–68 (2007).

186. *Id.*

187. HEALTH CARE ACCESS, *supra* note 147, at 1.

188. MASS. COMM. ON HEALTH CARE ACCESS & AFFORDABILITY, HEALTH CARE REFORM CONFERENCE COMMITTEE BILL 11 (2006), *available at* http://www.mass.gov/legis/presentation.pdf (multimedia presentation of the health care reform conference committee for the Joint Caucus for House Materials) [hereinafter HEALTH CARE REFORM].

189. *Id.*

190. *See* DENAVAS-WALT ET AL., *supra* note 3, at 66 tbl.C-3.

191. *See* Grudzien, *supra* note 2, at 785.

192. HEALTH CARE ACCESS, *supra* note 147, at 1.

193. *See* HEALTH CARE REFORM, *supra* note 188, at 11.

nector requires that no plan granted its seal of approval can charge a deductible until the plan allows at least three preventive care visits to a doctor.[194] These types of visits are important as they can reduce the impact of the chronic conditions from which many senior citizens suffer.[195] By requiring three visits prior to charging deductibles,[196] the program may also save senior citizens money because they tend to visit the doctor much more frequently than does the general population.[197] Massachusetts also helps senior citizens by preventing insurance companies from increasing premiums or denying coverage based on a preexisting condition or age.[198] Finally, the program increases senior access to necessary prescription drugs, as a drug plan is a requirement for all creditable coverage.[199]

Although the foregoing features will likely benefit senior citizens, the program may not have a significant impact on a large percentage of senior citizens. The statute exempts many senior citizens from all of its provisions because the state considers Medicare per se creditable coverage.[200] As a result, the program has little impact on senior citizens over the age of sixty-five. In addition, the care allowances designed to help low-income people purchase insurance are not available to people who qualify for other programs such as Medicare.[201]

The current regulations may also do little to reduce health care costs for senior citizens. The statute and its enforcing regulations allow for up to $5000 in out-of-pocket costs and do not limit out-of-pocket costs for out-of-network services,[202] which would be a significant burden on senior citizens with limited and fixed income. For example, a senior citizen with the median income for a person over sixty-five of $27,000[203] may have to commit over 20% of their income to health care costs.[204] The 3.4 million Americans over sixty-five that

194. *See* 956 MASS. CODE REGS. 5.03(2)(h)(1) (2007).
195. *See supra* Part II.D.
196. *See* 956 MASS. CODE REGS. 5.03(2)(h)(1).
197. *See* BHANDARI, *supra* note 63, at 5 fig.2.
198. MASS. ANN. LAWS ch. 176Q, § 5(c) (LexisNexis Supp. 2007).
199. *See* 956 MASS. CODE REGS. 5.03(2)(a).
200. Ch. 176Q, § 10.
201. Ch. 118H, § 3.
202. *See* 956 MASS. CODE REGS. 5.03(2)(d).
203. DENAVAS-WALT ET AL., *supra* note 3, at 5.
204. This is calculated by dividing the median income of $27,000 by the $5000 in total out-of-pocket expenses.

are below the poverty line[205] may have to commit over 50% of their annual income to health care costs.[206] Because of the limited scope and high price ceilings, the Massachusetts program benefits senior citizens less than does Holland's reform plan. For further comparison and evaluation of Holland's plan, this Note will now examine Vermont's recent health care initiative.

C. Vermont's Plan for Reform

Facing similar uninsured rates as Massachusetts, Vermont also attempted to address the problem through new legislation. In 2006, Vermont had 67,000 uninsured, which constituted nearly 11% of its population.[207] This number represents a significant growth in the percentage of uninsured, as the state had rates of 8.4% as recent as the year 2000.[208] Moreover, health care costs accounted for $3.5 billion and over 15% of the gross state product.[209] Treatment of chronic conditions such as diabetes or heart disease accounted for 70% of these costs.[210] Despite this significant outlay, the state's legislature still worried that people with chronic conditions were not getting the regular care that they needed.[211] Vermont expected the problem to worsen because its senior citizen population was growing at higher rates than its younger population.[212] With the state facing this burgeoning problem, a poll found that 84% of Vermont's citizens believed that the state government should take an active role to ensure that sick people have access to quality health care.[213]

In recognition of these problems and as part of a larger health care initiative,[214] Vermont created a program called Catamount

205. DENAVAS-WALT ET AL., *supra* note 3, at 11.
206. This is calculated by dividing the federal poverty line for people over sixty-five of $9669 by the $5000 in total out-of-pocket expenses.
207. DENAVAS-WALT ET AL., *supra* note 3, at 24.
208. Susan W. Besio, Dir. of Health Care Reform Implementation, Vt. Agency of Admin., Presentation: Vermont Health Care Reform 10 (July 2007), *available at* http://hcr.vermont.gov/presentations [hereinafter Vermont Reform Presentation].
209. *See id.* at 4.
210. *Id.*
211. *Id.*
212. *Id.* at 3.
213. *Id.*
214. The other aspects of the health care plan will not be discussed within this Note.

Health, making it available to the public in October 2007.[215] The State designed the program to increase access to insurance, improve the quality of care, and help contain growing health care costs.[216] Catamount Health makes plans administered by one of three private insurers available to any uninsured state resident.[217] Insurers providing these plans cannot deny coverage to a Vermont citizen based on age,[218] but can limit the coverage for preexisting conditions.[219] Plans offered through Catamount Health are not available to any person who maintained any type of insurance, including Medicare, during any of the last twelve months.[220] To increase participation for those eligible, Vermont provides premium assistance for people with incomes at or below 300% of the federal poverty level.[221]

To control costs for consumers, Catamount Health imposes cost restrictions and care requirements. First, insurers cannot use individual rating methods, such as age or health screening, but instead must rely on community ratings in determining monthly premiums.[222] Community ratings attempt to determine the risk of a broad population group rather than basing risk, and therefore premiums, on the individual characteristics of the insured.[223] As a result, those who would ordinarily face high rates, such as senior citizens or people with chronic conditions, receive the same rates as their comparatively healthy neighbors.[224]

Second, the statute provides explicit cost restrictions on all plans offered through Catamount Health.[225] For individuals, costs cannot exceed a deductible of $250 for in-network services, $500 for out-of-

215. Vermont Reform Presentation, *supra* note 208, at 26.

216. SUSAN W. BESIO, VT. AGENCY OF ADMIN., VERMONT HEALTH CARE REFORM: FIVE-YEAR IMPLEMENTATION PLAN 5 (2006), *available at* http://hcr.vermont.gov/five_year_implementation_plan [hereinafter VERMONT FIVE YEAR PLAN].

217. VT. STAT. ANN. tit. 8, § 4080f(b) (Supp. 2007); VERMONT FIVE YEAR PLAN, *supra* note 216, at 5 (noting that Blue Cross Blue Shield, MVP, and Capital District Physicians Health Plan will provide the plans available through Catamount Health).

218. Tit. 8, § 4080f(j)(1).

219. *Id.* § 4080f(e).

220. *Id.* § 4080f(d)(1).

221. Vermont Reform Presentation, *supra* note 208, at 25.

222. Tit. 8, § 4080f(j).

223. *See* Nancy Kass & Amy Medley, *Genetic Screening and Disability Insurance: What Can We Learn from the Health Insurance Experience?*, 35 J.L. MED. & ETHICS 66, 66–67 (2007).

224. *See id.* at 67.

225. Tit. 8, § 4080f(c)(1).

network services, 20% coinsurance, and $10 office copayments.[226] In addition, the statute caps out-of-pocket expenses at $800 for in-network expenses and at $1500 for out-of-network expenses.[227] In addition, all insurance plans must provide a prescription drug benefit with no deductibles and no copayments that exceed $10 for generic drugs, $40 for preferred drugs, and $50 for nonpreferred drugs.[228] Vermont also has sought to reduce cost growth by targeting chronic conditions; the statute requires the insurers to provide a "chronic care management program,"[229] defined by statute as a "system of coordinated health care . . . for individuals with chronic conditions . . . with the goal of improving overall health."[230] Through cost restriction and required care, Vermont is seeking to reduce costs both at their source and through top-down regulation.

In enacting Catamount Health, Vermont believed that giving coverage to the uninsured would reduce overall health care costs for the state's entire population.[231] Health care providers might not always receive compensation for procedures or other treatment provided to people that do not have insurance.[232] As a result, the providers must pass this risk and cost onto the insured in the form of higher premiums.[233] Because everyone has an opportunity to purchase insurance under the new system, the health care providers do not have to pass as much of these costs to the general population.[234] Moreover, according to the State, giving the uninsured preventative care, such as regular doctor or hospital visits through Catamount Health, reduces the need for expensive care later, further reducing costs for everyone.[235] In addition, to allow consumers to make informed decisions about the relative costs and merits of the offered plans, the govern-

226. *Id.* § 4080f(c)(1).
227. *Id.* § 4080f(c)(1).
228. *Id.* § 4080f(c)(1)(D).
229. *Id.* § 4080f(c)(2).
230. *Id.* § 4080f(a)(4). To improve patient health, chronic care management would include "significant patient self-care efforts, systemic supports for the physician and patient relationship, and a plan of care emphasizing prevention of complications, utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis." *Id.*
231. Vermont Reform Presentation, *supra* note 208, at 19.
232. *See id.*
233. *Id.*
234. *See id.*
235. *See id.*

ment performs the important function of disseminating information.[236] The State envisions this function as an aggressive and broad campaign, utilizing multiple media formats to increase consumer awareness as well as enrollment.[237]

As in Massachusetts, the Vermont legislation has both positive and negative components for senior citizens. The program would likely benefit some senior citizens by controlling costs to the consumer through multiple means. First, the statute provides mandatory price caps on most health care related costs.[238] These caps are significantly lower than those enacted in Massachusetts.[239] In addition, the mandatory chronic care programs[240] reduce the impact of chronic conditions on the uninsured and the overall costs faced by individuals as well as the population as a whole.[241] Because the program focuses on chronic conditions, it has a profound impact on senior citizens because they suffer from chronic conditions at disproportionately high rates.[242] Senior citizens also benefit from the forced use of community ratings,[243] which reduces the premiums paid by senior citizens because insurance companies can no longer use age as a basis for charging higher rates.[244] Finally, senior citizens benefit from the government's active information campaigning because it improves senior citizen awareness of the program.[245] Improved information helps senior citizens to make informed decisions, maximizing the quality of care and value of their health care dollars.[246]

Despite these benefits, certain limits placed on the program reduce the overall impact of Catamount Health on senior citizens. First, people who have qualified for Medicare payments are ineligible for coverage under the plan.[247] This condition prevents the plan from ap-

236. *See id.* at 31–36.
237. *See id.*
238. VT. STAT. ANN. tit. 8, § 4080f(c)(1) (Supp. 2007).
239. *Compare* tit. 8, § 4080f(c)(1), *with* 956 MASS. CODE REGS. 5.03(2)(h)(1) (2007) (capping out-of-pocket expenses at $800 in Vermont, as compared to $5000 in Massachusetts).
240. Tit. 8, § 4080f(c)(2).
241. Vermont Reform Presentation, *supra* note 208, at 19.
242. *See* WAN HE ET AL., *supra* note 25, at 54.
243. Tit. 8, § 4080f(j).
244. *Id.* § 4080f(j)(1).
245. *See* Vermont Reform Presentation, *supra* note 208, at 25.
246. *See* Jost, *supra* note 65, at 581–82 (noting that the effectiveness of managed care depends on improved information).
247. Tit. 8, § 4080f(d)(1).

plying to nearly all senior citizens over the age of sixty-five.[248] Second, the statute prevents people who have maintained coverage over the last twelve months from using the plan.[249] Because the uninsured often tend to obtain and lose coverage alternately,[250] this restriction significantly reduces the possible benefits of Catamount Health. Finally, the limits allowed on preexisting conditions could have the effect of denying coverage for the ailments that caused senior citizens to require and seek medical treatment.[251]

IV. Recommendation

Faced with the growing problem of the uninsured, Holland, Massachusetts, and Vermont recently sought to reform their health care systems by enacting new statutes. In evaluating these efforts, the effect of the new statutory schemes on the unique needs of senior citizens must be considered as part of the general goal of reducing the number and percentage of the uninsured. Senior citizens pose a significant hurdle for any system because their limited income seriously impedes access to health insurance and because of their rapidly rising health care costs and their greater health care requirements as compared to the general population.[252] As a result, a reform plan must control costs and ensure access to quality health care.

As noted previously, the plans enacted by all three jurisdictions do have components that would benefit senior citizens specifically and the population generally.[253] However, in considering the plans as a whole and contrasting their relative features, the statutory scheme enacted by Holland emerges as the plan that would have the most significant impact on senior citizens. The Massachusetts plan's impact on the uninsured, and senior citizens specifically, faces serious problems because the plan has set a very high out-of-pocket expense limit that may be too taxing for the limited income of senior citizens.[254] Moreover, the unavailability of subsidies for many senior citizens ex-

248. *See* DENAVAS-WALT ET AL., *supra* note 3, at 66 tbl.C-3 (indicating that 93.8% of Americans aged sixty-five and older were covered by Medicare in 2006).
249. Tit. 8, § 4080f(d)(1).
250. *See* Mayes, *supra* note 4, at 249.
251. Tit. 8, § 4080f(e).
252. *See* HIGH CONCENTRATION, *supra* note 1, at 3; Rasinski-Gregory & Cotler, *supra* note 67, at 66.
253. *See* tit. 8, § 4080f(c)(1); HEALTH CARE REFORM, *supra* note 188, at 11; MINISTRY OF HEALTH, WELFARE & SPORT, *supra* note 99, at 10.
254. *See* 956 MASS. CODE REGS. 5.03(2)(h)(1) (2007).

acerbates this shortcoming.[255] Vermont, on the other hand, has enacted very low cost limits on insurance,[256] which would have potentially significant benefits for senior citizens. Unfortunately, Vermont has structured its eligibility requirements in a way that prevents many senior citizens from taking advantage of the program, as people who qualify for Medicare or who had insurance in the last twelve months are ineligible.[257]

Conversely, Holland's plan incorporates all of the positive qualities of the Massachusetts and Vermont plans, but without the drawbacks. Holland's New Health Insurance Act limits costs to the insured through multiple methods. First, the plan spreads the burden across all of society, which allocates a portion of senior citizens' comparatively higher costs to others.[258] Second, the system reduces the amount of out-of-pocket expenses because the insured face only an annual premium rather than regular and expensive out-of-pocket payments.[259] Senior citizens' ability to receive subsidies based on their relatively low incomes further reduces the burden of obtaining health coverage.[260] Finally, the government in Holland has taken active steps to reduce an important cause of growing costs by negotiating directly with drug companies to reduce prescription drug costs.[261]

Holland's plan also ensures meaningful access to quality health care by preventing insurance companies from denying coverage based on age or other health conditions.[262] However, the statute protects insurance companies from absorbing the full brunt of the risk by implementing a risk-equalization pool, which compensates insurance companies that take on the disproportionately expensive senior citizens.[263] The government also improves access to quality health care by distributing information about the relative plans[264] and maintaining minimum standards for the plans.[265] Based on these features, Hol-

255. MASS. ANN. LAWS ch. 118H, § 3 (LexisNexis Supp. 2007).
256. Tit. 8, § 4080f(c)(1).
257. *Id.* § 4080f(d)(1).
258. *See* MINISTRY OF HEALTH, WELFARE & SPORT, *supra* note 99, at 16.
259. *See id.* at 10.
260. *See id.* at 15.
261. *See* Naik, *supra* note 95.
262. *See* MINISTRY OF HEALTH, WELFARE & SPORT, *supra* note 99, at 8.
263. *See* Naik, *supra* note 95.
264. *See id.*
265. *See* MINISTRY OF HEALTH, WELFARE & SPORT, *supra* note 99, at 12.

land's plan would have the most positive impact on the state of insurance generally, and on senior citizens specifically.

However, two considerations remain significant barriers to the adoption of Holland's plan. First, the political process and the different political agendas of the parties in power complicate any proposed health care reform. For example, passage of the plan enacted in Massachusetts took years of political negotiations to make the statute acceptable to all sides of the political process.[266] If the plan in Massachusetts had been more progressive, the state might not have enacted the plan.[267] Because the plan in Holland does represent a significant departure from the current form of U.S. health insurance, it is likely that there would be strong opposition.[268] Stakeholders such as the insurance companies, pharmaceutical manufacturers, and conservatives are likely to oppose such a change in policy and form.[269] Indeed, a similar national-level reform proposed by President Clinton failed during his recent presidential term.[270] The growing health care crisis as well as the current political view of health care, however, are evidence that it may now be possible to pass such an ambitious act.[271] In advocating the plan to political leaders, reformers should focus on the qualities of the plan that appeal to both Republicans and Democrats. The plan should appeal to Democrats because it is much closer to universal care than is our current system.[272] Similarly, the plan could appeal to Republicans because it relies on private delivery and managed competition.[273]

Apart from the political issues surrounding health care reform, the implementation of a system similar to Holland's will require significant modification to our current system. Though daunting, it is not impossible: Holland faced similar issues as the United States prior to enactment of its plan and has made the system work.[274] The states

266. Watson et al., *supra* note 184, at 1331–32.
267. Weeks, *supra* note 156, at 1285.
268. *See* Naik, *supra* note 95.
269. *See* Jost, *supra* note 65, at 615–16.
270. *See* Arthur Birmingham LaFrance, *Healthcare Reform in the United States: The Role of the States*, 6 SEATTLE J. FOR SOC. JUST. 199, 200 (2007).
271. *See* Jost, *supra* note 65, at 616–17.
272. *See* Michael Saul, *2008 Democratic Party Platform Calls for End of Iraq War, Ethics Reform*, N.Y. DAILY NEWS, Aug. 21, 2008, *available at* http://www.nydailynews.com/news/politics/2008/08/21/2008-08-21_2008deomcratic_party_platform_calls_for.html.
273. *See* President George W. Bush, *supra* note 9.
274. *See* Naik, *supra* note 95.

should focus on incremental steps to move towards such a program. States with progressive programs such as Vermont or Massachusetts will not have to make immediate changes, but instead should gradually phase in Holland's provisions. If reformers are able to overcome these political and logistical barriers, a plan modeled on Holland's reforms will have significant and lasting benefits for all Americans, especially senior citizens.

V. Conclusion

Health care reform, including a solution to the rising number of uninsured, is among the most serious issues facing the nation. The interrelated nature of its root causes further complicates this problem. Short-term fixes are unlikely to solve a problem this serious. In addition, the current divisive political situation adds yet another significant obstacle to true reform. The plans discussed in this Note have the lofty goals of reversing these negative trends and having a profound impact on people without insurance. Unfortunately, the evaluation of these plans is limited because the states and Holland have only recently enacted the plans. As a result, experts can only forecast the effects of the plans rather than providing concrete statistics. In addition, the adoption of any of these plans on a state-by-state basis would likely require some adaptation to account for the unique demographics of each state. Despite these issues, the evaluation and exploration of new reform plans must continue because the issues facing health care are unlikely to resolve themselves.