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Federal Mandates in the Health Care Context

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FEDERAL MANDATES IN THE HEALTH CARE CONTEXT

I. INTRODUCTION

> Every American must have the security of comprehensive health benefits that can never be taken away. That is what the Health Security Act is all about.[1]

> [The Health Security Act] is nothing more than a payroll tax that would discourage hiring, decrease wage growth, increase layoffs and reduce . . . profits for small businesses.[2]

An impassioned political battle over health care reform in the United States has followed the release of President Bill Clinton's Health Security Act.[3] If passed, the Act will represent the most sweeping change in the history of the American health care industry. While the concept of universal health care has been a widely publicized and strongly-supported ideal,[4] the means of providing adequate health care for all Americans has been an extremely controversial subject. The debate has centered around funding the comprehensive health care system, like other social welfare programs, through some combination of public and private financing.

The controversy over mandated participation and financing complicates the effort to achieve the restructured health care environment con-

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[1] WILLIAM JEFFERSON CLINTON. HEALTH SECURITY: THE PRESIDENT'S REPORT TO THE AMERICAN PEOPLE xiii (1993) [hereinafter PRESIDENT'S REPORT].

[2] Paul G. Merski. Hearing of the House Ways and Means Committee, February 3, 1994, 94 TAX NOTES TODAY 24-3.

[3] The President's Health Security Act, Title VII of H.R. 3600, S. 1757 and S. 1775, was officially unveiled at a Joint Session of Congress on October 22, 1993. The Bill was presented to Congress on October 27, 1993.

[4] A 1990 survey revealed that 60% of Americans surveyed supported the use of an additional Social Security tax to finance universal health insurance. Thomas Bodenheimer and Kevin Grumbach, *Financing Universal Health Insurance: Taxes, Premiums, and the Lessons of Social Insurance*, 17 J. Health Pol. Pol'y and L. 439 (1992) [hereinafter Bodenheimer].

templated by supporters of the Health Security Act. The issue is whether pervasive mandates like those embodied in the Act are merely taxes under the guise of being premium payments. Whether payments are eventually considered taxes or premiums has been argued to have less to do with budgetary consequences and more to do with perceptions about the role and size of the government.[5] Taxes are an extremely sensitive political issue and the tax label placed on the financing of any federal legislative effort becomes an obstacle tantamount to criticism of any substantive regulation the law seeks to impose.

An important preliminary step in classifying a financing provision is defining exactly what a mandate is, as distinguished from a "tax." Viewed in terms of other federal legislation, it is evident that the distinction is somewhat blurred and often arbitrary. Nonetheless, mandates are traditionally a method of accomplishing social objectives without imposing direct federal costs. Mandates have often been termed "hidden taxes" because of their economic effects.[6] As noted by Congressional Budget Committee member Judd Gregg (R-MT), "[w]hen the government mandates a cost and demands payment and then uses its power to collect and distribute funds, that cost is a tax and should therefore be on-budget."[7] This reasoning mirrors that of the Congressional Budget Office[8] [CBO] in its report on the mandate provisions of the Act.

The battle over financing universal health care in the United States is representative of the difficulty of financing government goods and services through mandates. The political challenge is to overcome hyper-technical labelling distinctions and utilize mandates as an effective and efficient means of implementing federal legislation. Whether a mandate is ultimately classified as a tax, cost control, user fee or phase out provision is largely irrelevant, as all similarly distort behavior and affect consumer incentives.[9] What will hopefully emerge from the health care financing debate is a framework for both Congress and the Executive branch to utilize in

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[5] Alexander Polinsky, *The Health Insurance Mandate: A Tax By Any Other Name?* TAX NOTES, October 25, 1993 at 935 [hereinafter Polinsky].

[6] EMPLOYEE BENEFIT RESEARCH INSTITUTE - ERF POLICY FORUM, GOVERNMENT MANDATING OF EMPLOYEE BENEFITS xxvi (1987).

[7] 94 TAX NOTES TODAY 27-2.

[8] *See* Congressional Budget Office, *An Analysis of the Administration's Health Proposal* 31 (1994) [hereinafter CBO].

[9] Gene Steuerle, *When is a Tax a Tax?*, TAX NOTES, Dec. 20, 1993 at 1512 [hereinafter Steuerle].

the future financing of government programs.

The Health Security Act, as formulated by President Clinton, relies heavily on two interacting concepts to fund universal health care in America — everybody plays and everybody pays.[10] From 1980-1992 American health care spending rose from 9% to 14% of the Gross Domestic Product (GDP). It is currently estimated that without reform, spending on health care would reach 19% of GDP by the year 2000.[11] These staggering figures leave no doubt reform is necessary. The precise classification of the participation requirement pursuant to the Act, particularly the 80% premium mandate placed upon employers,[12] is crucial to the fate of Clinton's health care proposal. Opponents of the Act, while not necessarily adverse to a system implementing health care for all American citizens, claim that the mandate provision in the Health Security Act are so pervasive as to amount to a tax.[13] So characterized, the cost of purchasing health insurance under the Health Security Act would be considered on-budget federal spending, thus increasing federal revenues by 25% and federal spending by more than 15%.[14] Those in support of the Health Security Act ardently deny that the mandate provisions are a new federal payroll tax. These supporters contend that the mandated payments are "merely premium payments for health insurance that should be treated as off-budget spending just like current employer/employee payments for health insurance.[15]

Under the Health Security Act, states will begin implementing reform in 1996, with all states participating by the end of 1997.[16] These target dates may be unrealistic for a plan designed to so profoundly alter the administration of health care in the United States. Employer financing is

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[10] Under the Health Security Act every employer would be required to remit, for each full-time employee, 80% of the weighted average premium for all plans in the alliance for the employee's class of enrollment. For further discussion of alliance, see *infra* note 21 and accompanying text.

[11] PRESIDENT'S REPORT, *supra* note 1, at 9.

[12] Although each employer is required to pay 80% of the premium for each employee, employer contributions are in most cases capped from 3.5% to 7.9% of the firms's payroll, based upon the size of the business and whether it is part of a corporate or regional alliance. WILLIAM JEFFERSON CLINTON, THE PRESIDENT'S HEALTH SECURITY PLAN 265 (1993)[hereinafter HEALTH SECURITY PLAN].

[13] Representative Robert H. Michel (R-IL) has asserted that the Republicans "are on the side of the public sector character that has made [the health care system]great while the Democrats favor taxes, fees, mandates . . . to embark on an uncharted course of government run medicine. 1993 DAILY TAX REPORT 207 d 15, 3.

[14] Polinsky, *supra* note 5, at 395.

[15] *Id.*

[16] THE PRESIDENT'S REPORT, *supra* note 1, at 34.

the cornerstone of the Act, and the classification of mandates as either taxes or premiums must be settled to the satisfaction of all — without hampering the Act's vitality — before further progress can be made. Ultimately, the issue is one of definition as the final impact on the economy is the same.[17]

This comment will focus on the mandate provisions of the Health Security Act, particularly whether they are properly characterized as taxes or as just premium payments to health insurers. Part I presents an overview of the proposed Health Security Act. This discussion provides a perspective on what the supporters of the Health Security Act are asking of America's business community, from the Fortune 500 to the self-employed. Part II examines federal mandates in the Health Security Act by viewing them in light of other federal legislation that provides for similarly required payments and activity. Part III discusses the implications of the mandate provision on the doctrine of federalism and how far the federal government is permitted to reach into state sovereignty to foster the success of a comprehensive health care system. Finally, Part IV addresses the public policy concerns that are a driving force of the Act and its financing.

I. OVERVIEW OF THE HEALTH SECURITY ACT

While an in-depth analysis of the Health Security Act is not the focus of this comment, an overview of relevant provisions is necessary to comprehend the significance of employer mandates to the success of the Act. The Clinton Administration formulated the Act with six basic underlying principles: security, simplicity, savings, quality, choice and responsibility.[18] Of primary concern to the drafters was the public perception of providing universal health care in the United States. Even in a society that has become largely dependent on government entitlements, the success of comprehensive health care hinges upon it not being considered yet another social welfare program. The President's report made it explicit that:

> The Health Security Act rejects the idea of a government-run

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[17] Steuerle, *supra* note 9, at 1511.

[18] THE PRESIDENT'S REPORT, *supra* note 1, at 21.

> health care system. Health care will remain rooted in the private sector . . . . The plan achieves universal coverage and recognizes that some direction from the government — including asking everyone to pay their fair share — will be necessary to achieve that goal. But it leaves the tasks of delivering care and controlling costs to the private market.[19]

While the Clinton Administration clearly emphasized that, under the Health Security Act, health care would remain "rooted in the private sector," it would be closely supervised by both federal and state governmental agencies. It is currently proposed that the entire scheme will be regulated by a newly created National Health Board, responsible for setting national standards and overseeing the establishment and administration of the new health system by the states.[20] While supervision would occur largely at the federal level, most of the Act's implementation would be left to the states and private industry through the alliance system.

Pursuant to the Health Security Act, individuals would obtain health insurance through a variety of regional alliances and corporate alliances run by certain large employers.[21] Regional alliances could be organized as non-profit organizations, independent state agencies or as agencies of the state. States would also have the option of becoming the "single-payer" for a region.[22] Only one alliance could serve any geographical area so as to enroll enough members and foster competition among the health plans that are offered through the alliance after being certified by the state.[23]

Under the Act, employers with greater than 5,000 employees[24] have the option of joining a regional health alliance, or forming an individual

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[19] *Id.* at 32-33.

[20] The National Health Board is proposed to be a seven member panel appointed by the President with advice and consent of the Senate. At least one of the members represents the interest of the states. The President shall designate one member as Chairman who serves a term concurrent with that of the President. The other members serve staggered four year terms. *Id.* at 46-47.

[21] In general if a family member is eligible to enroll in a corporate alliance, then the family would insure through the corporate alliance. Otherwise, the family will obtain insurance through the regional health alliance for the alliance area in which the family resides.

[22] Under a single-payer plan, the state or its agent makes all payments to health care providers with no intermediaries, plans or other entities assuming any risk. *Id.* at 58.

[23] *Id.* at 54.

[24] The threshold of 5,000 is applied by calculating the number of corporate workers on the national level.

corporate alliance. Corporate alliances, like their state counterparts, would have to provide coverage through a certified plan by way of a self-funded employee benefit plan or through contracts with state certified health plans.[25] One of the more controversial aspects of the corporate alliance system is that corporate alliances are further mandated to contribute one percent of payroll as additional funding to the health care system as a whole since they are not financing the regional alliances in which they are geographically located.[26] Corporate alliances would also not be eligible for federal subsidies, and would have to pay the difference for any premium shortfall by the employee.[27]

An essential element of the Clinton plan is that all Americans would be included in health care coverage, even those who do not maintain full-time employment status. For part time employees, all employers — corporate or regionally aligned — would contribute a pro-rated portion of the regular alliance appropriation per worker premium.[28] Non-workers would make contributions based on unearned income, and subsidies would be provided to families whose income is below 150% of poverty.[29] In this sense, the Health Security Act adheres to the "all play, all pay" concept as everyone must take some responsibility.[30]

The health plans would provide coverage for the national guaranteed comprehensive benefit package[31] through contracts with regional or cor-

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[25] Corporate alliances must submit plans to the Secretary of the Department of Labor to determine whether all statutory and regulatory requirements are met. *Id.* at 78.

[26] The concern over the one percent assessment is the effect the tax may have on corporate decisions to opt out of the alliance system, and the possibility the assessment could lead to a further erosion of the tax base by providing an incentive to provide compensation that is not subject to payroll taxation. *See* 1993 DAILY TAX REPORT 243 D 9, 3.

[27] Corporate alliances must subsidize premiums of full-time workers earning less than $15,000 per year, and also are not eligible for the 7.9% of payroll limit on premium costs. *See* CBO, *supra* note 8, at 31.

[28] Part-timers are viewed in terms of their "full time equivalence." Employees working less than 40 hours per month are disregarded for purposes of the plan. Part time employment is considered between 40 to 120 hours per month. *See* Joint Committee on Taxation, *Description and Analysis of the Employer Mandate and Related Provisions of H.R.* 3600 30 (1994)[hereinafter JCT].

[29] HEALTH SECURITY PLAN, *supra* note 12, at 272-73.

[30] Yet, it is the nature of this concept that endangers putting the tax label on the employer mandates as a whole, as in both the unemployment and small business areas, the employer/employee contribution will fall short of actual premium cost for the insurance policy and will require substantial commitments of federal tax revenues. *See* Polinsky, *supra* note 5, at 395. The important distinction for the HSA is that because some federal tax revenue is involved in the funding of the program, the employer mandates do not automatically become a federal tax.

[31] Covered health services include hospital and emergency care, physicians, clinical preventive

porate alliances. Health plans would not be allowed to terminate, restrict or limit coverage for any reason and would not be permitted to cancel a policy until the individual is enrolled in another health plan.[32] Health plans would negotiate premium rates with the alliances on an annual basis and would be required to maintain fiscal soundness, truth in marketing, confidentiality and consumer protection. In its current form the Health Security Act espouses three basic kinds of plans from which each individual would be able to choose: low cost-sharing HMO type plans, high cost-sharing plans on a fee for service basis but with additional requirements,[33] and a combination of these two.

The Health Security Act, on the whole, strives to take the best aspects of current American health care and develop a more equitable and efficient system. The plan attempts to increase coverage and control costs with the very minimum of government regulation that could sustain a program of this scope and complexity. The Act makes it evident that the Administration was cognizant of the role of health care in the United States and that, while the current atmosphere favors reform, American society is largely "unwilling to incur large public sector costs, eliminate the private health insurance industry and establish uniform cost containment policies."[34]

The United States represents one of the world's most technologically advanced societies. However, despite the scientific and social benefits reaped in America's research laboratories every year, the administration and allocation of health care benefits has fallen into chaos. The fair and equitable distribution of medical care to all those in need in the United States is not a new idea,[35] but a comprehensive plan satisfactory to all interested sectors has never had enough support to be implemented.[36]

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service, mental health and substance abuse services, family planning, pregnancy-related care, ambulances, vision and hearing care, and preventative dental care for children, among other benefits. HEALTH SECURITY PLAN, *supra* note 12, at 21-22.

[32] *Id.*

[33] High cost-sharing plans would require families to pay their first $400 in bills and 20% of all subsequent bills with maximum family spending of $3,000 per year. *Id.* at xi.

[34] JOHN HOLOHAN, ET. AL., BALANCING ACCESS, COSTS AND POLITICS 2 (1991)[hereinafter HOLOHAN].

[35] The first attempt at national health insurance in the United States, which never garnered enough support to pass, was a bill sponsored by Senators Robert Wagner and James Murray and Representative John Dingle in 1943 that advocated adding health insurance to the welfare programs under the Federal Security Agency. RICKEY HENDRICK, A MODEL FOR NATIONAL HEALTH CARE 83 (1993).

[36] The United States first utilized social insurance through industrial accident insurance in the

The United States has thus been among the slowest of industrialized economies to implement a comprehensive social insurance program.[37] Much of the reason for this lies in the very structure of American society and economy. A highly centralized system with strong government controls - like the single-payer system in Canada - could address inadequacies in the health care system directly, but "the United States' reliance on a market system for allocating most goods and services represents a strongly held philosophy favoring diversity and indirect incentives and controls."[38]

While isolated forms of social health care have existed, the peculiarities of American political, social and economic systems present barriers to universal health care implementation in this country. By 1974 twenty-two proposals for national health insurance had been brought before Congress.[39] The difficulty lies in the ability of any plan to strike a balance of interests acceptable to all, especially given the strong lobbying groups involved. For any reform to be feasible in the United States, it can not pose any sincere threat to well established interest groups and it must be perceived as being equitably borne throughout the public sector.[40]

The Health Security Act embraces many of the aspects of social insurance programs that have succeeded, while maintaining the privatized structure of the health insurance industry in the United States. While the possible characterization of employer mandates as a tax could hamper the national health insurance effort, this manner of implementation "reflects the historical role of the private sector in health coverage and [minimizes] the direct financing of health care through the public sector.[41]

The Act seems to strike a balance and formulate a workable model capable of satisfying the diverse interests involved. However, while the end may be the remedy to America's health care ills, the means which the Clinton plan has adopted is subject to much debate and a number of other

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early twentieth century and passage of the watershed Social Security Act of 1935. Yet, Social Security was limited to the aged and disabled, as universal coverage could never be agreed upon. Bodenheimer, *supra* note 4 at 16.

[37] The first national compulsory sickness insurance law to be passed was implemented in Germany in 1883. Much of Europe followed Germany's example, and similar forms of social insurance were pervasive in Europe by 1930. Bodenheimer, *supra* note 4, at 15.

[38] HOLOHAN, *supra* note 34, at 1.

[39] Part of the inability of the U.S. government to pass such legislation is attributed to the mid-1970s combination of inflation and recession which stalled consensus on any of the proposed bills. CHARLES J. DOUGHERTY, AMERICAN HEALTH CARE, REALITIES, RIGHTS AND REFORMS 167.

[40] HOLOHAN, *supra* note 34, at 32-33.

[41] *Id.* at 43.

proposals providing coverage without a strict employer mandate.[42] To carry the Health Security Act in substantially its current form will take some compromise by both the Clinton Administration and in Congress to reach a satisfactory balance of responsibility among individuals, employers and the government.

II. MANDATES

The mandate provisions of the Health Security Act raise a number of issues that warrant discussion in terms of their effect on individuals, employers and the economy as a whole. The most significant of these issues is whether or not the employer mandates are truly just a payroll tax in disguise. Politically, what is at stake is the net effect of health care reform on the federal budget deficit.

The CBO has concluded that the mandates are tantamount to a tax and thus the receipts from the program must be reported as part of the budget.[43] The CBO "concludes that the proposal would establish both a federal entitlement to health benefits and a system of mandatory payments to finance those benefits that represents an exercise of sovereign power . . . ." Therefore, the CBO believes that "the financial transactions of the health alliances should be included in the federal government's accounts and the premium payments should be shown as governmental receipts rather than as offsets to spending."[44]

There are a number of provisions and concepts inherent in the Act that lead the CBO to its conclusion.[45] First is the pervasiveness of the plan,

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[42] The Cooper-Breaux "Managed Competition Plan" introduced by Jim Cooper (D-TN) provides coverage through individual purchase without an employer mandate. Funding for the indigent would be acquired through employer tax incentives. Another proposal is that of the Senate Republicans, imposing an individual mandate. Both plans provide coverage for big employers as now and the formation of "cooperative" for smaller businesses. *See Comparison Shopping: The Major Health Plans and What They Would Mean to You*, BOSTON GLOBE, Feb. 6, 1994, at 22.

[43] Because of the size and complexity of the President's Health Security Act, the CBO has further determined that the transactions of the alliances should be distinguished from other federal operations and shown separately, similar to treatment of Social Security payments. CBO, *supra* note 8 at xv.

[44] *Id.* at 44.

[45] The CBO's view on the Health Security Act is intended to be advisory and not determinative in nature. The report cautions that the President and Congress should explicitly address the issue through legislation to ensure appropriate public control of and accountability for the transactions of the alliances. *Id.* at 41.

the manner in which the government specifies outcomes and the means by which those outcomes are achieved.[46] The CBO was also persuaded by budgetary precedents and the need to ensure fiscal accountability and control.[47]

The vast amount of federal regulation in the execution of the Act and the lack of choice that is being imposed on employers encourages a characterization of the employer mandate provisions as an on-budget exercise of taxing power.[48] Part of the reason for financing the Health Security Act through employer mandates is the fact that, under the present system, most working individuals receive their health insurance through their employer.[49] However, many employers choose not to provide health insurance to employees. Employers who do not provide insurance typically view it as a form of wage increase, feel employees can be adequately served at public hospitals and thus gain a competitive advantage over others in the industry who do provide coverage, or employ a particularly high risk group of employees.[50] By mandating coverage, the Health Security Act takes this discretion away from employers.

While budgetary precedents are illustrative of how federal programs similar to the Health Security Act have been classified, the uniqueness and complexity of the plan make it difficult to draw exact parallels. There is no scientific formula for characterizing a federal program as on or off budget; a determination is made based upon the provisions of the proposed legislation and where they seem to fall along the continuum of federal legislation. The President's Commission on Budget Concepts[51] found that for budget totals, receipts from activities which are expressly governmental

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[46] *Id.* at 95.

[47] The CBO's theory is that since the alliances would essentially be agents of the federal government, their financial flows should be subject to a level of oversight and control similar to that in other on-budget programs. *See id.* at 47.

[48] In many cases the employer/employee contribution will fall short of the actual premium cost and will require proceeds from federal tax revenues. Polinsky, *supra* note 5, at 395.

[49] The theory behind the Clinton plan is reliance on employers to pay the majority of insurance costs, which should have the advantage of being off the books politically. "Since employers are already a major source of health care financing in the U.S., maintaining the status quo is easier than shifting all financing to a new system." HOLOHAN, *supra* note 34, at 27.

[50] WARREN GREENBERG, COMPETITION, REGULATION AND RATIONING IN HEALTH CARE 55 (1991).

[51] This Commission was appointed in 1967 by President Lyndon B. Johnson to advise him on budgetary concepts and presentation. The report of the Commission has no legal status, but is the only authoritative statement on federal budgetary accounting. *See* CBO, *supra* note 8, at 42.

in character, involving regulation or compulsion, should be regarded as receipts. But revenues associated with activities which are operated as business-type enterprises, or which are market-oriented in character, should be included as offsets to the expenditures to which they relate.[52] The Health Security Act seemingly embodies all of these criteria, making its characterization all the more difficult. While no definitive line separates regulated activities that are outside the budget from governmental activities that are within it, when the federal government mandates a result, determines how the result is to be achieved, limits the ways in which the activity can be financed, and makes significant financial contributions, there is sufficient government regulation, at least in the CBO's view, to justify on budget treatment.[53]

In support of its position, the CBO points to the Coal Industry Retiree Health Benefits program, which is part of the federal budget although its funds do not pass through the Treasury.[54] Even though the benefit plans pursuant to the program are private and the government plays no role in selecting trustees, the plan is considered on-budget because federal law both requires payment and determines the use of the funds.[55] This, of course, is similar to the operation of the Health Security Act. The CBO also cites budgetary treatment of Medicaid and Aid to Families with Dependent Children (AFDC) plans, which are federal/state programs where only the federal contribution is on-budget.[56] The crucial distinction between these programs and the Health Security Act is that state adoption of both Medicaid and AFDC is optional, while states would not have this same discretion under the Administration's plan.

There are a multitude of federal programs that offer similar federal regulation yet are able to escape on-budget treatment. These mandated benefits nonetheless force fiscal transfers and thus permit exercise of the government's power to tax without assuming accountability for disposition of implied tax revenue.[57] The Americans with Disabilities Act provides one example of this type of a mandate.[58] An important goal of this Act is to prohibit employers from discriminating against qualified individuals

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52 *Id.*

53 *Id.* at 46.

54 *Id.* at 43.

55 *Id.*

56 *Id.*

57 Bodenheimer, *supra* note 4, at 441.

58 42 U.S.C. § 12101 (1993).

with disabilities with regard to any terms, conditions or privileges of employment.[59] To achieve this, employers, as well as public transportation systems and places of public accommodation, must make "reasonable accommodation"[60] for qualified disabled individuals.[61]

While there is no explicit assessment laid upon employers, the ADA expressly mandates employer expenditures to enable qualified disabled employees to function in the workplace. Much like HSA, employers do not have a choice whether or not to modify working conditions - it is a mandate. Yet the financial outlays mandated by the federal government under the ADA are not included on-budget.

Similar off-budget treatment is afforded under the Clean Water Act ("CWA").[62] Under the National Pollutant Discharge Elimination System within the Act, individuals must obtain permits and comply with their relevant terms and conditions before such an enterprise can discharge a pollutant.[63] The Environmental Protection Agency has the power to issue mandatory compliance orders and civil penalties,[64] as well as impose substantive reporting requirements on regulated entities.[65] Again, despite mandated organization compliance and expenditure, the CWA is accounted for off the federal budget.

Another obvious and accepted example of federal mandate of employer expenditure is via the minimum wage laws contained in the Fair Labor Standards Act ("FLSA") of 1938 as amended. The Act applies to all employers and federal, state and local governments even remotely engaged in interstate commerce.[66] Pursuant to the FLSA, employers must keep adequate record of hours employees work and are mandated to pay a specified minimum wage. Despite this federal mandate, which appears theoreti-

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[59] Bonnie P. Tucker, *The Americans with Disabilities Act: An Overview*, 1989 U. ILL. L. REV. 923, 926 (1989).

[60] "Reasonable accommodation" may include making existing facilities accessible to the disabled, developing modified schedules and acquiring or modifying equipment or other devices. *Id.*

[61] *Id.*

[62] The stated purpose of the CWA is to resolve and maintain the chemical, physical and biological integrity of the nation's waters. 33 U.S.C. §§ 1251-1387 (1988).

[63] William L. Andren, *Beyond Words of Exhortation: The Congressional Prescription for Vigorous Federal Enforcement of the Clean Water Act*, 55 GEO. WASH. L. REV. 202, 204 (1987).

[64] Interestingly, although the CWA is treated off-budget, civil penalties go exclusively to the U.S. treasury. *See generally* Elizabeth R. Thagard, *The Rule That CWA Penalties Must Go to the Treasury and How to Avoid It*, 16 HARV. ENVTL. L. REV. 507 (1992).

[65] Andreen, *supra* note 63, at 217.

[66] JOSEPH E. KALEZ, PRIMER ON WAGE AND HOUR LAWS 17 (1987).

cally equivalent to the mandates imposed under the HSA, activity under the FLSA is off-budget.

As the Americans with Disabilities Act, Clean Water Act and Fair Labor Standards Act illustrate, in contrast to the Coal Workers fund, whether federal mandates are placed on or off budget is largely an arbitrary decision. The "tax" label is able to be avoided in the name of "federal regulation." Thus employers are still required to offer employees particular services and benefits, but the mandate is not accounted for as a tax.[67] In the health care context, the employer expenditures could be classified as premiums of user fees[68] for which a service is returned, and thus avoid the tax label and on-budget recording altogether.

III. FEDERALISM

Article I, § 8 of the United States Constitution provides that "Congress shall have the power to lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and General Welfare of the United States." If the federal mandates in the HSA are finally determined to be derived from the taxing power, consideration must be taken of the Federalism implications inherent in the plan.[69] While the federal government is largely responsible for the organization of the proposed health care system, the states would oversee daily operation and would play a part in financing the new system.[70] Aside from substantial organizational responsibility,[71] states would pay the regional alliances for their share of premiums for individuals eligible for Medicaid and some "maintenance of effort" payments for individuals who lose Medicaid eligibility under the strictures of the new scheme but are able to have their

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[67] Steuerle, *supra* note 9, at 1511.

[68] User fees are prices a governmental agency charges for a service or product whose distribution it controls. Recently, state and federal governments have increasingly moved from tax-based financing of goods and services to user fee-based financing. *See generally* Clayton P. Gillette and Thomas D. Hopkins, *Federal User Fees: A Legal and Economic Analysis*, 67 B.U. L. REV. 795 (1987).

[69] Another potential technical concern is the requirement of Article I, § 7 of the Constitution providing that all bills for raising revenue shall originate in the House of Representatives.

[70] CBO, *supra* note 8, at 17.

[71] State responsibilities would include documentation to the NHB describing the health care system the state proposes to establish, establishment of one or more regional alliances, ensuring reporting standards and assisting regional alliances in establishing eligibility for subsidies and cost-sharing amounts. *Id.* at 17.

premiums state subsidized.[72] States could also be substantially penalized for failing to comply with the HSA by way of a fifteen percent surcharge on total premiums on the state if the federal government is forced to come in and run the program.[73]

It has long been elementary to the American concept of Federalism that the states remain sovereign entities and thus retain the power to finance public services and programs as they see fit within the limits of the law.[74] "Recognition of a retained spending power by the states, however, does not necessarily compel acceptance of the proposition that the states retain the power to control their treasuries in disregard of a directive by a branch of the national government acting within its delegated powers."[75] A brief look at the development of Federalism[76] in the United States assists in putting the proposed mandates in perspective in the whole intergovernmental scheme.

A seminal case in this area is Justice Marshall's opinion in *McCulloch v. Maryland*,[77] where Maryland had attempted to assess a state tax against the Bank of the United States and thus tax the federal government. The Supreme Court held that a reasonable construction of the Constitution was to allow the national legislature the discretion

> with respect to means by which the powers it confers are to be carried into execution, which will enable that body to perform the high duties assigned to it, in the manner most beneficial to the people. Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consistent with the letter and spirit of the constitution are constitutional . . . .[78]

This decision and its interpretation of the constitution seemingly ex-

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[72] *Id.*

[73] If the NHB determines a state is sufficiently far out of compliance that the state resident's access to health services is jeopardized, the Department of Health and Human Services is authorized to take over the state's health care system. *Id. at 16.*

[74] Joel H. Swift, *Fiscal Federalism*, 63 TEMP. L. REV. 251, 254 (1990).

[75] *Id.*

[76] Federalism in this sense being the interrelationship of federal and state government.

[77] 17 U.S. 316 (1819).

[78] *Id.* at 370.

tend plenary power to the federal government over the states. However, as the United States and its political system grew, this broad grant of power was curtailed. During the years immediately preceding and following the Great Depression, the Supreme Court took an extremely protective stance on state sovereignty as distinct from the Union. In *Metcalf* and *Eddy v. Mitchell*,[79] the Court held that "[a]gencies by which either state or federal government immediately and directly exercise its sovereign powers are immune from the taxing power of the other, which immunity extends, not only to the agency itself, but to income therefrom."[80] State immunity from federal taxation, while acknowledged, was not absolute; the Court would later decide that state immunity did not extend to a tax levied on individuals that affected the state only as the burden is passed on to it by the taxpayer.[81]

One of the most recent and significant cases interpreting the federalism issue is *Garcia v. San Antonio Metropolitan Transit Authority*,[82] where the Supreme Court held a city-run mass transit system subject to the 1974 amendments to the Fair Labor Standards Act that made the wage and overtime provisions of the FLSA applicable to most state and local employers. While *Garcia* explicitly dealt with the Commerce Clause, it may have significantly more far-reaching implications. For instance, it has been argued that the same approach may be taken by the Court to uphold federal taxation of the states unless it appears the political process has not functioned as intended.[83] The *Garcia* court found that "the principal means chosen by the Framers to ensure the role of the States in the federal system lies in the structure of the Federal Government itself."[84] Thus, the only limitation on the power of Congress to compel expenditure of state funds is that the law must be within the delegated power of Congress, not prohibited by the Constitution, nondiscriminatory and not destructive of the states.[85]

The manner in which all of this applies to the proposed health care legislation depends upon how the regional alliances are characterized and

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79 269 U.S. 544 (1926).

80 *Id.*

81 *See Helvering v. Gerhardt*, 304 U.S. 405 (1930).

82 469 U.S. 528 (1985).

83 Eduard A. Lopez, *The Constitutional Doctrines of State Immunity from Federal Regulation and Taxation after* Garcia v. San Antonio Metropolitan Transit Authority, 4 J.L. and Pol. 89 (1987).

84 *Garcia*, 469 U.S. at 553.

85 Swift, *supra* note 74, at 308.

how they actually operate. Pursuant to the HSA, the federal government would establish most of the criteria that the states would have to meet and would ensure that the states met those standards.[86] Requiring this administrative and financial outlay of the states clearly embodies many tax-like aspects. There is also the potential surcharge for noncompliance previously discussed that would significantly burden affected states with a federal assessment.

Despite the strong federal influence and control in regulating health care under the HSA, there does not seem to be any unlawful or undue burdens placed upon the states. The states undertake a great deal of responsibility under the plan and are directly answerable to the NHB. Yet, this is clearly reasonable regulation under *Garcia* and the states ultimately benefit by complying with the federal mandates.[87] The more pressing issue will be whether or not the benefits flowing to the states are substantial enough to enable the states to comply.

The dilemma of unfunded mandates has recently plagued both state and local governments. The states must implement federal legislation imposed upon them and localities must bear the burden of both state and federal regulation. As the United States becomes an increasingly regulated society, without accompanying funds to finance the mandated participation.[88] Once a federal or state law is handed down to a subordinate entity, even if the state or local government wishes to comply, often it is not fiscally possible given budgetary constraints. Unfunded federal mandates including the Clean Water Act and Americans with Disabilities Act, among others, currently account for more than eleven percent of city budgets.[89] While provision has been made for some federal grants to the states toward compliance with the HSA, the states still face a heavy burden.

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[86] CBO, *supra*, note 8, at 16.

[87] Complying states are eligible for federal funding of academic health centers and health service research, as well as federal planning grants to assist states in setting up their health care systems. *Id.*

[88] In a 1988 General Accounting Office [GAO] study, the GAO did not recommend federal reimbursement legislation in light of the large federal deficit and the perception that the federal government mandates certain directives to ensure uniformity among states. *See* GENERAL ACCOUNTING OFFICE, LEGISLATIVE MANDATES: STATE EXPERIENCES OFFER INSIGHTS FOR FEDERAL ACTION 3 (Sept. 1988).

[89] William Claiborne, *Nation's Mayors Press for Relief From Unfunded Mandates by Hill*, WASH. POST, Jan. 29, 1994 at A8(explaining that a relief bill was currently before Congress which would require that all future laws with regulations that state and local governments must follow make provision for the cost of compliance).

IV. POLICY

Legislation that threatens to change an aspect of society as important as health care inevitably becomes a particularly sensitive political issue. While some interest groups have a bigger financial stake than others, the Act will ultimately affect the manner and means of medical treatment of every member of society. Thus everyone has an interest in how the Act is structured and how services are facilitated. The question is whether American society is ready and willing to promote such an extensive social program.

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including . . . medical care . . . and the right to security in the event of sickness.[90]

This standard of basic human rights, announced by the United Nations nearly fifty years ago, today requires legislation as comprehensive and complex as President Clinton's HSA to form a workable model with the potential of passage into law. The skyrocketing costs of health care have made insurance coverage an impossibility for millions of American citizens.[91] The principal goal of the HSA is to remedy this problem and provide blanket coverage to meet the laudable United Nations standard of security in the event of sickness. To achieve universal health care, however, policymakers will have to overcome political factionalism and debate over who will expend and receive the billions of dollars in health care revenue.

An instinctive American resistance to anything resembling socialized resource distribution creates a threshold problem in the United States, despite the vast number of entitlement programs that currently exist. The battle over universal health care bears striking resemblance to the debate that raged over the inception of the Medicare program. "Debate over Medicare was cast in terms of class conflict, of socialized control against

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[90] UNITED NATIONS UNIVERSAL DECLARATION OF HUMAN RIGHTS, (1948), *cited in* MILTON I. ROEMER, NATIONAL STRATEGIES FOR HEALTH CARE ORGANIZATION 328 (1985).

[91] It is estimated that in 1994 the United States will have spent one trillion dollars on health care with 37 million Americans uninsured and 25 million with inadequate coverage. PRESIDENT'S REPORT, *supra* note 1, at xiii.

the octopus of the federal government."[92] There remains the perception that universal health care is no more than welfare health care — the wealthy subsidizing the impoverished while realizing no enhanced benefits themselves.

This demonstrates why participation of every member of society must be mandated if the system is to work. Social insurance is loosely based on the contributory principle that only contributors have the rights to benefits. However, in the health care context, many nations who have implemented social insurance programs have extended equal benefits to all citizens regardless of whether they have made adequate contribution.[93] This is, of course, the aim of the Clinton plan. The mandate becomes a necessary tool for universal coverage and uniform insurance pricing without regard to risk factors. "If insurance must be priced uniformly . . . then without a mandate on individuals to be insured, universal coverage will not occur because persons who pay more than the cost of the service they receive will choose not to buy it."[94]

The dilemma is that most individuals who are already covered provide some of the subsidy for those who are not covered. Mandated participation thus makes the covered sectors feel their freedom is being unduly restricted. There exists the idea that "claims regarding justice in health care or about rights to health care limit the property rights of those whose resources will be used to provide care. [A successful political effort to secure these rights to health care would] lead to others having duties to give aid and to relinquish claims over their own time, money and resources."[95]

Yet, if universal health care is an ideal that American society is willing to support, an unequal contribution scale is a necessary consequence. The benefit under the Clinton plan, in this respect, is that the goal is to get everyone on board as a participating member. Outright entitlement without contribution is, in theory, minimized and granted to only the most economically challenged sectors of society. The plan seeks to strike a workable balance between coverage and contribution. The model is imperfect, but seems to be a largely fair and reasonable means of attaining blanket medical coverage.

The Joint Committee on Taxation has enunciated five possible ratio-

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92 THOMAS J. BOLE, III, ED., RIGHTS TO HEALTH CARE 28 (1991).

93 Bodenheimer, *supra* note 4, at 29.

94 JCT, *supra* note 28, at 80.

95 BOLE, *supra* note 92, at vii.

nales for the employer mandate: (1) It is easier for the government to enforce an employer mandate, hopefully achieving similar compliance to tax withholding; (2) Many individuals already receive insurance through their employer; (3) Purchasing through a group is more effective and usually less expensive than individual policy purchase as risk is spread more effectively; (4) Employer responsibility to ensure employees have sufficient health insurance; (5) The government's desire to provide a subsidy for the purchase of health insurance.[96] The merits of all of these may be challenged, particularly the latter two. If employers wish to additionally compensate employees through insurance, ultimately employees are bearing the burden through a lower wage.[97] As far as the government subsidizing insurance cost, an employer mandate is certainly only one of many alternative ways of financing the purchase of insurance. However, the employer mandate seems to be the most effective way to meet all of these ideals simultaneously.

Financing universal coverage through an employer mandate seems to be a rational means of financing the American version of universal health care. Mandatory participation is necessary to ensure the program will be properly funded. However, as a policy matter in the health care context, compulsion does not necessarily have to equal taxation. A general distinction can be drawn between traits of premium-like insurance plans and tax-like plans. Premium plans are typically not earmarked with funds going into general government revenues and coverage does not depend on making payments.[98] Funds from the HSA do not flow through Treasury and are clearly earmarked for health care.[99] Earmarking payments in this manner allows the contributory principle to function by guaranteeing that funds paid in are utilized to pay out benefits. The earmarked nature is one of the strengths of the social insurance approach to universal health care, giving its programs an increased degree of stability.[100]

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[96] JCT, *supra* note 28, at 85-86.

[97] *Id.* at 86.

[98] Bodenheimer, *supra* note 4, at 1.

[99] However, there is some subsidy from general government revenues once the employer cap is implemented, to make up for the difference between the total premium cost and the employee/employer contribution which is subject to thee 7.9% of payroll cap.

[100] Bodenheimer, *supra* note 4, at 19.

V. CONCLUSION

It is unlikely that the Health Security Act is capable of sustaining Congressional approval in the form presented by President Clinton. A plethora of alternatives have been presented to Congress[101] with varied financing provisions that do not appear as facially tax-like as the Health Security Act, and it is the tax label that is currently among the Health Security Act's biggest obstacles. However, all of the plans that have been proposed share the common goal of improving the administration of health care in the United States, through some form of increased coverage and regulated insurance and medical services.

The health care debate will ultimately be resolved and a plan will be implemented that is satisfactory to all of the competing factions. What will be left behind as a matter of policy in the political system is the role that mandated financing will play in the future. The Health Security Act makes a reasonable attempt at utilizing mandates as mandates, that is, as distinct from a tax. Funds from the program are not funnelled into general federal revenues, but are specifically earmarked for health care. In this way the Act is substantially self-funding,[102] and its resources are kept separate from other federal funds to encourage the long-time health and independence of the program itself.

The benefit of the debate over mandates is that it should force both Congress and the Executive branch to look beyond mere classification, and into substance, when making policy choices. Whether the mandates in the Health Security Act are labelled as taxes, user fees or premiums, the impact on the economy will be the same. It is the underlying policy decisions that are important. If funding through mandates is a way of implementing a policy that the political system will support, as seems to be the indication with universal health care, then that must be the government's directive, regardless of how those mandates are classified.

Achieving the goal of universal health care coverage can, legitimately, only be accomplished by compulsory participation, which is what makes the employer mandates such an attractive means of financing the program:

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[101] Examples of other plans include the Cooper-Breaux Managed Competition Plan and the Chafee/Senate Republican Plan. For further discussion, see *supra* note 42.

[102] How much financial independence the Health Security Act is able to retain as separate from federal revenues is a subject of debate given the potential shortfall between employer-employee contribution and the total premium cost. For further discussion, see *supra* note 30 and accompanying text.

> The growth of voluntary health insurance leads inevitably to statutory insurance, because of both the strengths and weaknesses of a voluntary program. On the one hand, voluntary health insurance demonstrates the feasibility and value of the idea of health insurance; on the other hand its operation leaves various inadequacies and inequities that can be corrected only by governmental action.[103]

Universal health care is a program in which mandated participation and funding can facilitate an efficient and effective system. This is not to say that mandates are the best means of financing every government program, only that they represent a viable alternative. Ultimately this alternative is too valuable to be eradicated by mere political labels.

Kerry Hughes

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[103] Roemer, *supra* note 90, at 10.