Treating America's Ailing Healthcare System: Is the Illinois Covered Act a Panacea for America's Uninsured Poor?

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TREATING AMERICA'S AILING HEALTHCARE SYSTEM: IS THE ILLINOIS COVERED ACT A PANACEA FOR AMERICA'S UNINSURED POOR?

INTRODUCTION

Can governors and the states by themselves achieve the goal of universal coverage?
Not likely . . . .1

The political debate in America over the government's moral responsibility to facilitate universal healthcare predates even basic modern medicine.2 In 1912, sixteen years before Alexander Fleming discovered penicillin,3 Theodore Roosevelt endorsed universal healthcare while campaigning for President.4 In 1945, eight years before James Watson and Francis Crick discovered the structure of DNA,5 President Harry S. Truman proposed universal healthcare.6 Yet, in 2006, forty-seven million Americans, 8.7 million of whom were children, lacked health insurance for the entire year.7 Worse, upwards of ninety million Americans lacked health insurance at least sometime during the year.8 It is readily apparent that the opponents of universal healthcare have won the early rounds of the debate.

Nevertheless, proponents of universal healthcare have had some success: the debate has shifted from whether government should intervene to how government should intervene to remedy the problem.9 No longer is a laissez-faire approach to healthcare acceptable to most

2. See infra notes 3–6 and accompanying text.
4. Dukakis, supra note 1, at 71.
5. J.D. Watson & F.H.C. Crick, Molecular Structure of Nucleic Acids, 17 NATURE 737, 737 (1953).
6. Dukakis, supra note 1, at 82.
Americans. Bill and Hillary Clinton’s push for universal healthcare in 1993 serves as a prime example of this shift in public opinion. Opposition to their federal program was, for the most part, limited to its form only. Few opponents called for complete government non-intervention in the healthcare industry.

During the 2008 presidential campaign, candidates from both major parties reinforced the idea that government assistance in providing healthcare to all Americans is a mainstream, uncontroversial political position. On May 29, 2007, Barack Obama declared, “I . . . . believe that every American has the right to affordable healthcare . . . . We now face an opportunity—and an obligation—to turn the page on the failed politics of yesterday’s health care debates.” Fellow Democratic candidate John Edwards promised to “provide universal healthcare for every man, woman and child in America.” The eventual Republican presidential nominee, John McCain, echoed the sentiments of his Democratic counterparts: “we can and must provide access to healthcare for all our citizens.”


While the public supports action to extend health insurance coverage, there is little agreement on how to solve the problem. For example, Americans are divided over whether the government should make a major or a limited effort to provide health insurance to the uninsured. When presented with a variety of policy options that would extend health insurance coverage to more Americans, the public expresses a high level of support for each option, but when asked to select the best option, no single one attracts widespread support.

Id.

11. Id.

12. See id.


As usual, government intervention in the private market failed to deliver the promised benefits and caused unintended consequences, but Congress never blames itself for the problems created by bad laws. Instead, we are told more government—in the form of ‘universal coverage’—is the answer.
The current debate about government-assisted universal healthcare is best exemplified by the healthcare plans of two other 2008 presidential candidates, Hillary Clinton and Mitt Romney. The differences in their positions transcended the technicalities of how government should bring about universal healthcare, and instead focused on a more fundamental question: should the federal or state government bear the primary responsibility for establishing universal healthcare? Unsurprisingly, as foreshadowed by her involvement in the attempted healthcare overhaul of the 1990s, Hillary Clinton’s plan for universal healthcare called for the federal government to take control. On the other hand, Mitt Romney, who as Governor of Massachusetts successfully implemented a statewide universal healthcare program, proposed that states follow Massachusetts’s lead.

Illinois recently attempted to provide universal healthcare within its borders with Senate Bill 0005 (the Bill). That bill, if enacted, would have become the Margaret Smith Illinois Covered Act (the Illinois Covered Act or the Act). The Illinois Covered Act would have provided financial assistance to low income individuals so that they could afford health insurance. The Illinois Covered Act would have also established a roadmap for the adoption of future health insurance initiatives, like the universal, mandatory private coverage in Massachusetts.

We can hardly expect more government to cure our current health care woes.
The Illinois legislature provided the rationale for the Illinois Covered Act in the Bill’s opening lines: “for the economic and social benefit of all residents of the State, it is important to enable all Illinoisans to access affordable health insurance that provides comprehensive coverage and emphasizes preventive healthcare.” At its core, the Illinois Covered Act sounded in a proactive equality. It mirrored the foundational and founding principles of the United States: “We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life, liberty and the pursuit of happiness. That to secure these rights, Governments are instituted among men . . . .”

Massachusetts’s and, now, Illinois’s forays into universal healthcare demonstrate the federal government’s failure to fulfill its moral obligation to provide healthcare to all its citizens. Today, millions of Americans are without life-saving medical care, simply because they are too poor to afford it. Of the 46.1 million Americans who were uninsured in 2005, over eighty percent lived below 300% of the poverty line or were eligible for public health insurance assistance. An “unalienable” right to life, which, by definition, is a right that cannot be sold, is hollow indeed if it cannot be bought or sustained. The economic inequality inherent in this country’s healthcare system renders it both unjust and un-American.

Unfortunately, state-initiated healthcare reform cannot completely remedy the economic injustice of the current system. Even though many, like Mitt Romney, applaud the recent trend toward state responsibility for healthcare on federalism grounds, the federal government’s unwillingness to take responsibility for healthcare will continue to have real, far-reaching consequences for the nation’s poor, even with state intervention. If states are left to provide universal healthcare on their own, a two-tier system will develop in this country.

25. Id. § 1-5.
27. For purposes of this Comment, a “poor” American is one who earns less than 300% of the federal poverty level. See infra note 28 and accompanying text.
28. John Holahan et al., Kaiser Family Found., Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage 1 (2007). In 2004, seventy-five percent of the forty-six million uninsured in this country were ineligible for any governmental assistance in securing healthcare; however, twenty-five percent were eligible for assistance via Medicaid or State Children’s Health Insurance Program (SCHIP). Id. A broad-based effort to educate the public on the availability of aid would immediately reduce the number of uninsured. Even with increased awareness, a significant economic problem would remain.
in which a few rich states might be able to afford universal healthcare, but the vast majority of states will not be able to afford universal healthcare for their citizens.\textsuperscript{30} Such inequality is as unacceptable as the current economic inequality.

This Comment, therefore, is a call to action aimed at the federal government. The federal government is the only institution capable of fully remediying the nationwide healthcare crisis. Universal healthcare, implemented one state at a time, will not eliminate the underlying economic inequality present in the current system. Part II of this Comment examines the extent of the current economic inequality of this nation’s healthcare system.\textsuperscript{31} Part III explores Massachusetts’s present and past efforts to unilaterally move towards universal healthcare.\textsuperscript{32} Part IV comments on the limited scope of the proposed Illinois Covered Act, focusing particularly on what its limitations say about state-provided universal healthcare.\textsuperscript{33} Part V analyzes the problems with universal healthcare implemented one state at a time.\textsuperscript{34} Finally, Part VI concludes that the federal government is the only institution capable of achieving universal healthcare.

II. “THE UGLY WORLD OF AMERICAN HEALTH CARE ECONOMICS”\textsuperscript{35}

Economic inequalities are inherent in America’s current “free market” healthcare system.\textsuperscript{36} America’s market-based model not only systematically excludes the nation’s poor from access to healthcare, it does so without reducing costs or increasing effectiveness. Section A of this Part compares the accessibility, effectiveness, and cost of the American healthcare system with the Canadian system.\textsuperscript{37} Section B then examines the dangers posed to the nation’s poor by a healthcare system supported and sustained by employer-provided insurance and explores the paradoxes embedded in unregulated private insurance.\textsuperscript{38}

\textsuperscript{30} See infra notes 245–268 and accompanying text.
\textsuperscript{31} See infra notes 35–119 and accompanying text.
\textsuperscript{32} See infra notes 120–155 and accompanying text.
\textsuperscript{33} See infra notes 156–230 and accompanying text.
\textsuperscript{34} See infra notes 231–269 and accompanying text.
\textsuperscript{36} See supra note 28 and accompanying text.
\textsuperscript{37} See infra notes 39–85 and accompanying text.
\textsuperscript{38} See infra notes 86–119 and accompanying text.
A. Comparing the Accessibility, Effectiveness, and Cost of Healthcare in America and Canada

Linda Littlechild recently underwent quadruple bypass heart surgery in Alberta, Canada. She and her husband earn $29,000 per year, but that did not prevent her from receiving treatment because in Canada healthcare is a civil right. From her Edmonton hospital bed, Ms. Littlechild observed, "[i]n the States, I’d probably been dead. I couldn’t afford an operation like this." Another Canadian citizen, Sandra Reid, called the American healthcare system "shameful," adding that "[t]he common person is unimportant in the United States. . . . I’d never want to live there." Her husband Tom echoed her sentiment: "Hopefully in the future, things will improve . . . ."

In America, public sentiment toward the Canadian healthcare system is often as negative as the Canadian view of the American system. While Americans understand that economic inequality presently exists in our system, many Americans see such inequality as necessary. To them, Canada’s elimination of economic inequality comes at a cost. They believe that the Canadian healthcare system is inefficient and ineffective, an unhealthy form of socialized rationing. Many feel that universal healthcare “calls for change that . . . is too radical—socialized medicine! Loss of freedom to choose! Poor quality government health care! Lack of services and long waits for care!” In that same vein, 2008 Republican presidential nominee John McCain cautioned an audience during a forum on health issues, “I would urge you to go to Canada . . . before you make a decision

40. Id.
41. Id.
42. Id.
43. Id.
44. See id. Not all Americans view the Canadian healthcare system negatively. For example, consider Seattle resident Jeanne Sather. Cherie Black, SWF Seeks Canadian with Health Care, GLOBE & MAIL, Oct. 2, 2007, at L5. Ms. Sather has cancer. Id. As a political statement, she recently posted a personal ad on her blog seeking a “Canadian citizen living in Vancouver, B.C.” Id. Ms. Sather posted the ad to draw attention to the "absurdly expensive health-insurance premiums and medical costs" in America. Id. Surprisingly, she has had numerous replies to her ad. Id.
45. See Landers, supra note 39.
46. See id.
that you want that kind of health care in America.”

This Comment compares the accessibility, effectiveness, and cost of the Canadian healthcare system with that of the American system to determine whether the economic inequality pervasive in the American system is necessary.

1. Comparing Access

There is a significant correlation between individual access to healthcare and individual health. In fact, even the federal government, which has failed to provide universal healthcare, recognizes this correlation by listing healthcare access as one of the ten leading health indicators for its Healthy People 2010 project. As stated above, despite the recognized importance of access to healthcare, in 2006, forty-seven million Americans lacked health insurance for the entire year, and upwards of ninety million Americans lacked health insurance at least sometime during the year. Across the northern border, “[a]ll 33 million Canadians, regardless of income, get hospital and doctor care as a civil right.”

However, as any critic of federally funded universal healthcare is sure to quickly point out, healthcare access is a function of not only coverage, but also, and almost as importantly, a function of time. Even if every individual in a country has health coverage, if wait times for care are longer because of that fact, access is not necessarily greater than in a country without universal coverage. Indeed, a recent survey by the Commonwealth Fund, which compared wait times in seven industrialized nations, found that Canada has the longest wait times for medical care. However, the survey found that the United

50. Healthy People 2010 is a federal health awareness program dedicated to the identification and reduction of preventable health threats. Healthy People, About Healthy People, http://www.healthypeople.gov/About (last visited Apr. 28, 2009).
51. Casoy & Barry, supra note 7.
52. Yacht, supra note 8.
53. Landers, supra note 39.
54. See id.
55. See id. “[A]ccess to a waiting list is not access to health care.”
56. Cathy Schoen et al., Toward Higher-Performance Health Systems: Adults’ Health Care Experiences in Seven Countries, 2007, 26 HEALTH AFF. 717, 725 (2007). The seven countries were Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States.
States has the second longest wait times. Although fewer Canadians receive same-day access to medical care, and more Canadians have to wait more than five days for medical care than citizens in the other countries surveyed, the United States has the second longest wait times in both measurements, even though the remaining five countries in the survey all have government-funded universal healthcare. Regardless, in a country like the United States that does not have universal health insurance, the "wait" for healthcare is irrelevant to the uninsured poor, because they cannot afford healthcare in the first place. All things considered, even with its slightly longer wait times, the Commonwealth survey ranked Canada above the United States in overall performance of their respective healthcare systems.

2. Comparing Effectiveness

The infant mortality rate—the number of babies who die before one year of age per thousand live births—"is an important indicator of social well-being, which reflects multiple social determinants of health." In Canada, the infant mortality rate is 5.04; only 5.04 infants per thousand born die before their first birthday. On the other hand, in the United States, the infant mortality rate is 6.26. Put simply, a child born in Canada is more likely to live to the age of one than a child born in the United States.

Even Cuba has a lower infant mortality rate than the United States. Cuba has a gross domestic product per capita of $9,500, while the United States has a gross domestic product per capita of $47,000. America is over five times richer per citizen than Cuba, yet America lags behind Cuba in this one key indicator of health.

57. See id.
58. Id. Only twenty-two percent of Canadians interviewed for the survey received same day care, while thirty percent had to wait more than five days. Id.
59. Id. Only thirty percent of Americans interviewed for the survey received same day care, while twenty percent had to wait more than five days. Id.
63. Id.
64. See id.
The disparity in the infant mortality rates of the United States, Canada, and Cuba might be the result of a number of factors. First, a portion of the disparity might be illusionary; it could simply be the result of bias in reporting. Second, it is possible that the disparity can be explained by a difference in the quality of medical care available. Third, the disparity might be explained by a difference in "broader social forces" present in each country. Fourth, the disparity might be explained by a difference in the access to medical care available in the respective countries. Whatever the relative impact of the preceding factors, it is clear that "inadequate access to services, including prenatal care for pregnant mothers," has at least some role to play in the disparity, and that such inadequate access to services is largely the result of economic inequality.

66. When it comes to overall wealth, the differentiation between the United States and Cuba is even more dramatic. The gross domestic product for the United States eclipses fourteen trillion dollars, while Cuba’s gross domestic product is only $108.2 billion. Central Intelligence Agency, County Comparisons—GDP—(Purchasing Power Parity), THE WORLD FACTBOOK (2009), available at https://www.cia.gov/library/publications/the-world-factbook/rankorder/2001rank.html.

67. See Rodwin & Neuberg, supra note 61, at 86.

68. See id.

69. The general view is that the quality of healthcare is not the problem, but that the lack of access to healthcare is. Transcripts, supra note 48. "The most important point is that the problem with health care in America is not the quality of care. The quality of care is the best in the world . . . . The problem with healthcare in America is the cost . . . ." Id.

70. N. Gregory Mankiw, Beyond Those Health Care Numbers, N.Y. TIMES, Nov. 4, 2007, Sunday Business Section, at 4. Gregory Mankiw was an advisor to Mitt Romney’s presidential campaign. Id. In Mr. Mankiw’s view, comparisons of infant mortality rates and life expectancy rates in the United States and Canada “say little about our system of health care.” Id. In Mr. Mankiw’s estimation, “difference in health outcomes has more to do with broader social forces,” such as higher homicide rates, accident rates, obesity rates, and teen pregnancy rates in America than in Canada. Id. In other words, differences in health outcome are better explained by differences in individual lifestyle choices than by differences in healthcare access. Id. Mr. Mankiw’s theory that broader social forces affect America’s infant mortality rate and life expectancy rate is not without merit; however, his theory is incomplete. See Carol J. Rowland Hogue & Martha A. Hargraves, Class, Race and Infant Mortality in the United States, 83 AM. J. PUB. HEALTH 9, 9–10 (1993). Mr. Mankiw’s broader social forces argument merely hints at the underlying cause of the disparity: poverty. Id. at 9. “How societies reduce social disparities in infant mortality depends on how they identify and correct the causes of [social-class] differences. Poverty is generally identified as the primary cause of social-class differentials in infant mortality.” Id. Mr. Mankiw’s list of social forces merely illustrate the “relatively high level of poverty and the extent of income inequality in the United States.” Rodwin & Neuberg, supra note 61, at 86. The solution to health outcome disparity is not to write it off as the result of lifestyle choices, but to recognize and remedy the underlying cause of the disparity, economic inequality. Hogue & Hargraves, supra, at 9–10. Although the “elimination of high-risk behavior such as smoking and early childbearing among the poor” is important, so is providing access to healthcare. Id. at 10.

71. Rodwin & Neuberg, supra note 61, at 86.

72. Id.

73. See id.
Life expectancy at birth is another critical indicator of a nation’s overall health and, therefore, an indirect indicator of the effectiveness of a nation’s healthcare system. In Canada, an individual born today will, on average, live for 81.23 years. On the other hand, in the United States, an individual born today will, on average, live for 78.11 years. As with infant mortality, the disparity between life expectancy in the United States and Canada might be the result of a number of factors. However, lack of access to healthcare plays at least a strong part in the disparity. And again, inadequate access to health services is largely the result of underlying economic inequality.

3. Comparing Cost

When compared with healthcare in Canada, healthcare in the United States is less accessible and less effective; unfortunately, it is also more expensive. According to the World Health Organization, the United States spends 15.4% of its gross domestic product on healthcare, while Canada spends only 9.8% of its gross domestic product. Further, while healthcare represents 18.9% of the United States' total governmental expenditures, it represents only 17.1% of Canada’s total governmental expenditures.

Americans’ astronomical expenditures for healthcare also demonstrate the exorbitant cost of poor health in this country. In America, a family of four that is not offered employer-provided healthcare and is ineligible for government assistance in paying their premiums will spend an average of $1009 per month for health insurance. In Alberta, Canada, a family of four will pay eighty-eight dollars a month.
for health insurance. Therefore, while the United States justifies the economic inequality of its present healthcare model on efficiency and cost grounds, scripping has saved America nothing and has harmed the health of the nation.

B. The Problem with Employer-Provided and Unregulated Private Health Insurance

In America, individuals normally lack health insurance for one of the following reasons: (1) their employers do not offer health insurance; (2) their employers offer health insurance, but they cannot afford to pay their portion of the premiums; or (3) they are unemployed and cannot afford private coverage. This Section first examines the decline in availability of employer-provided healthcare and the increased portion of the premiums employers who still offer coverage are asking their employees to pay. It then outlines three distinct paradoxes inherent in the unregulated private health insurance available to those without employer-provided health insurance.

1. The Decline of Employer-Provided Healthcare

Most Americans' health insurance is employer-provided. However, in 2007, only sixty percent of employers offered health insurance packages to any of their employees. That sixty percent figure is down from sixty-nine percent in 2000. Moreover, employers who offer health insurance to their employees do not offer it to all of their employees. Only seventy-nine percent of those employed by employers who offer health insurance are eligible for coverage.

The decline in the percentage of businesses that offer health insurance packages is the result of small businesses dropping their em...
ployee coverage programs. From 2000 through 2007, the number of small businesses that offered health insurance dropped from fifty-seven to forty-five percent. During that same time period, the offer rate at large businesses remained relatively stable. This shows that small business owners are losing their financial ability to offer employer-provided health insurance. Because average employee wages are roughly correlated to business size, the decline in employer-provided health insurance has a disproportionate impact on this country's poor.

Even those workers with jobs that offer health insurance find it difficult to shoulder their share of the ever-increasing premiums and co-pays that now come standard with employer-provided healthcare plans. Eighteen percent of those who are offered employer-provided health insurance are either unable or unwilling to accept coverage. Because employers are asking employees to share in more of the costs of coverage, family coverage through an employer includes a $1729 average deductible, payable by the employee. For an individual, the average deductible for an employer-provided healthcare plan is around $400. Moreover, ninety-five percent of employer-provided plans require the employee to pay for a portion of hospital bills after the initial deductible is met. Additionally, seventy-five percent of employer-provided plans require a co-pay for routine doctor visits.

The extent of cost sharing required from an employee by an employer-provided healthcare plan increases as the employer's business size decreases. Small businesses require individuals to assume forty-four percent of the costs for plans they provide. In contradis-

94. See id.
95. Id.
96. See KAISER FAMILY FOUND., supra note 83, at 4.
97. See Pay Scale—United States Country Salary, Average Salaries by Company Size, http://www.payscale.com/research/US/Country=United_States/Salary/by_Company_Size (last visited Nov. 14, 2008). The median salary at a company with 50,000 workers or more is $73,344, while the median salary at a company with less than ten workers is $41,995. Id.; KAISER FAMILY FOUND., supra note 83, at 2, 6.
98. KAISER FAMILY FOUND., supra note 83, at 4.
99. See id.
100. See id. at 6 (explaining that a large percentage of firms are planning to increase employee cost sharing).
101. Id. at 3.
102. Id.
103. Id.
104. KAISER FAMILY FOUND., supra note 83, at 3.
105. Id.
106. Id.
tinction, large businesses require individuals to assume only nine percent of the cost of insurance. What the preceding makes clear is that employer-provided health insurance is declining, and it is declining most rapidly for America’s poor.


The problem is not just the decline of employer-provided healthcare. The alternative, unregulated private insurance, creates problems of its own. For example, consider the Shaeffer family. Steve Shaeffer is a self-employed construction worker, and his wife Leslie is a stay-at-home mother of two. In 2004, Steve and Leslie purchased private health insurance through Blue Cross, paying nearly $500 a month for coverage. In 2004, one of their daughters was diagnosed with fibromatosis. Once their medical bills reached $20,000, Blue Cross dropped the Shaeffer’s coverage. Blue Cross claimed that the Shaeffers breached their contract by failing to disclose in their application an undiagnosed bump removed from their daughter’s chin. Blue Cross, therefore, rescinded the contract. As of September 2006, the Shaeffers’ medical bills reached $60,000, and they remained uninsured.

Similar stories, regularly heard by anyone involved with the private health insurance industry, show that the current private health insurance model in this country is fatally flawed. In fact, the current for-profit health insurance model presents at least three distinct paradoxes for those seeking private coverage. First, insurers’ refusal to cover those with pre-existing conditions prevents those most in need of medical care from receiving it. Because it is cheaper for an insurance company to insure a healthy person than a sick one, the cost of health insurance for the sick—those most in need of coverage and care—becomes prohibitively high when not regulated. Second, an individual who fails to disclose a pre-existing condition, even if the nondisclosure is inadvertent or innocent, risks losing any private cov-
verage he might have. Sickness, therefore, becomes a weapon of the insurance companies to deny treatment to the insured sick. Third, an individual who is too sick to secure private insurance coverage is often too sick to utilize his only other option to secure health insurance, which is to find a job with employer-provided coverage.

III. Massachusetts's Attempt to Unilaterally Implement Universal Healthcare

The debate over government's proper role and moral responsibility to facilitate universal healthcare reemerged as a signature political issue during the 2008 presidential campaign due in large part to Massachusetts's recent effort to unilaterally implement universal healthcare for its residents. Not only are federal politicians debating national implementation of a plan similar to Massachusetts's plan, but twenty-four states are also considering universal healthcare plans significantly similar to the Massachusetts's model. Therefore, the particulars of Massachusetts's plan, as well as its financial vitality, are important considerations for the current political debate. Section A of this Part briefly explores the details of Massachusetts's current healthcare plan. Then, Section B examines an oft-forgotten piece of recent history: Massachusetts's failed attempt to implement universal healthcare in 1988.

A. Massachusetts's Recent Attempt at Implementing Universal Health Care

On April 12, 2006, Massachusetts Governor Mitt Romney signed into law Chapter 58 of the Acts of 2006: "an act providing access to affordable, quality, accountable health care" for Massachusetts residents. In effect, Chapter 58 makes "Massachusetts the first state to try to insure nearly all of its residents through an individual mandate to buy insurance." Though the sweeping scope of Chapter 58 represents a monumental achievement for universal healthcare propo-
ments, there is cause for concern regarding the act’s long term viability.\footnote{126}{Id.}

Chapter 58 extends health insurance to ninety-nine percent of Massachusetts residents using three major mechanisms. First, Chapter 58 expands the reach of Massachusetts’s State Children Health Insurance Program (SCHIP), MassHealth.\footnote{127}{COMMONWEALTH OF MASS. CONFERENCE COMMITTEE, HEALTH CARE ACCESS AND AFFORDABILITY CONFERENCE COMMITTEE REPORT (2006), \url{available at http://www.mass.gov/legis/summary.pdf} [hereinafter Access and Affordability Report].} Second, it creates the Commonwealth Care Health Insurance Program.\footnote{128}{Id.} Third, it mandates that all residents of Massachusetts obtain health insurance, receive a waiver, or pay a fine.\footnote{129}{Id.}

MassHealth is designed to provide health insurance for poor children.\footnote{130}{Id.} Chapter 58 increases the income cut-off for MassHealth so that children in families earning up to 300% of the federal poverty level are now eligible.\footnote{131}{Id.} Prior to Chapter 58, the income cut-off was 200% of the federal poverty level.\footnote{132}{Id.} Utilizing federal SCHIP funds, MassHealth provides comprehensive health insurance that includes medical, dental, vision, chiropractic, and prosthetic care to poor children in Massachusetts.\footnote{133}{Id.}

The Commonwealth Care Health Insurance Program provides state subsidies to Massachusetts residents who earn less than 300% of the federal poverty line to use toward the purchase of private health insurance.\footnote{134}{Id.} The Program establishes a sliding scale, based on an individual’s income, that caps the amount a resident must pay toward health insurance.\footnote{135}{Id.} Residents who earn less than 100% of the poverty line are not required to pay any premiums.\footnote{136}{Id.} A single resident earning about $40,000 per year is required to pay no more than nine percent of his income toward health insurance, while a single resident who earns about $25,000 per year is required to pay no more than 3.3% of his income toward health insurance.\footnote{137}{Id.}
Chapter 58 also includes an "Individual Mandate," requiring that everyone in Massachusetts must have health insurance, receive a waiver, or pay a fine.\textsuperscript{138} The reason for the "Individual Mandate" is simple: "No health care reform proposal without an individual mandate has ever been projected to enroll more than half of the uninsured."\textsuperscript{139} If a resident fails to secure health insurance, and does not receive a waiver because of an inability to pay, the resident loses his personal exemption for state income tax purposes and must pay an increased portion of what he would have had to pay to secure coverage in subsequent years.\textsuperscript{140}

For the fiscal year that started on July 1, 2008, it is estimated that Massachusetts's universal healthcare plan will cost the state $1.56 billion.\textsuperscript{141} For that same fiscal year, it is estimated that revenues dedicated to the plan will total only $1.40 billion.\textsuperscript{142} That leaves a $160 million shortfall.\textsuperscript{143} In other words, "[t]here are a lot of things that have to happen right for there to be enough money" for the plan to remain financially viable.\textsuperscript{144} The potential financial downfall of universal healthcare in Massachusetts is not surprising; the state has recognized the threat of financial collapse before.\textsuperscript{145}

\textbf{B. Massachusetts's Past Attempt at Implementing Universal Health Care}

The February 21, 1989 edition of the \textit{Boston Globe} ran a story entitled "Now—Universal Health."\textsuperscript{146} The first sentence read, "Implementation of Massachusetts's ambitious—and possibly quixotic—universal health insurance law begins, in a concrete sense, today."\textsuperscript{147} The \textit{Boston Globe}'s proclamation of universal healthcare in Massachusetts was fifteen years premature.

Massachusetts's 1988 universal health insurance law, known as Chapter 23, proved to be quixotic. Chapter 23 died an ignominious death on January 1, 1992, when the employer mandate portion of the law failed to garner the political support necessary to take effect.\textsuperscript{148}

\begin{itemize}
  \item \textsuperscript{138} Access and Affordability Report, supra note 127.
  \item \textsuperscript{139} Id.
  \item \textsuperscript{140} Id.
  \item \textsuperscript{141} Helman \& Kowalczyk, supra note 124.
  \item \textsuperscript{142} Id.
  \item \textsuperscript{143} Id.
  \item \textsuperscript{144} Id.
  \item \textsuperscript{145} See infra notes 146–155 and accompanying text.
  \item \textsuperscript{147} Id.
  \item \textsuperscript{148} Dukakis, supra note 1, at 83.
\end{itemize}
Chapter 23's failure was not a surprise. Critics recognized from its initial implementation that "[t]he venture can hardly claim a solid political foundation." Along with ideological opposition, financial realities rendered the success of Chapter 23 doubtful. Not only was Massachusetts facing "a monster budget crisis" that "threw every state initiative on the defensive," but "the program [was] sailing against a powerful tide of rising health-care costs." It was estimated at the time that it would cost about one billion dollars to insure the then 400,000 uninsured residents of Massachusetts. The costs proved too much for Massachusetts to bear.

Chapter 23 should serve as a cautionary tale and a prime example of what can go wrong when a state unilaterally attempts to implement universal healthcare. As Part V argues, states lack the financial capabilities of the federal government. These financial limitations continuously threaten any state-initiated universal healthcare program. This reality must be considered when debating the merits of state versus federal intervention in the current healthcare crisis.

IV. THE LIMITED SCOPE OF THE ILLINOIS COVERED ACT

Illinois is among the states endeavoring to follow Massachusetts's lead in achieving universal healthcare within its borders. As stated above, the Illinois Senate recently considered Senate Bill 0005, which would have become the Illinois Covered Act. That Act

149. Knox, supra note 146, at 39.
150. Id.
151. Id.
152. Id.
154. Dukakis, supra note 1, at 83.
155. See infra notes 231–269 and accompanying text.
156. Reference to the "limited scope" of the Act should be taken in context. The Act filled nearly 200 pages and expounded on a number of topics, many of which are beyond the limited scope of this Comment. For example, this Comment does not discuss in detail Article 15 (Expanding Access to Health Insurance For Young Illinoisans), Article 16 (Expanding Access to Affordable Health Insurance For Employees), Article 18 (Ensuring Accountability of Health Insurers), Article 20 (Building Healthcare Capacity Through Comprehensive Healthcare Workforce Planning), Article 30 (Building Healthcare Capacity Through Community Health Provider Targeted Expansion), and Article 50 (Illinois Covered Assessment Act) of the Act. Additionally, this Comment is not intended to minimize the ambitious nature of the Act. But even in a politically favorable state—a state that explicitly recognizes universal health insurance as the goal—half measures rule the day. See S. 0005, 95th Gen. Assem., Reg. Sess. (Ill. 2007).
158. See supra note 21 and accompanying text.
159. Ill. S. 0005 § 1-1. Senator Carol Ronen filed the most current version of the Bill (Amendment 009) on July 25, 2007.
would have provided financial assistance to low income individuals so that many of them could have afforded health insurance.\(^{160}\) It also would have established a roadmap for the adoption of future health insurance initiatives, like the universal, mandatory private coverage found in Massachusetts.\(^{161}\)

This Part examines the Act in detail. First, section A considers the stated legislative intent of the Act.\(^{162}\) Then, Section B explores the Illinois Covered Rebate Program provided for by the Act.\(^{163}\) Section C examines the Illinois Covered Assist Program.\(^{164}\) Section D explores another major component of the legislation, the Illinois Covered Choice Program.\(^{165}\) Finally, Section E considers provisions within the Act dealing with future implementation of an individual mandate for private health insurance, like that recently adopted in Massachusetts, and comments on what the lack of an individual mandate meant for the Act's immediate goal of providing universal healthcare.\(^{166}\)

\section*{A. The Legislative Intent}

As noted in the Introduction of this Comment, the Illinois Senate laid out the intent of the Illinois Covered Act as follows: "for the economic and social benefit of all residents of the State, it is important to enable all Illinoisans to access affordable health insurance that provides comprehensive coverage and emphasizes preventive health care."\(^{167}\) The Bill then explicitly recognized that many individuals across the country lack health insurance.\(^{168}\) Many of the facts listed in support of the Bill mirror those presented in this Comment. For example, the Bill specifically stated that the cost of private health insurance for a family of four—$11,480—exceeds the annual wages of a full-time minimum wage worker—$10,712.\(^{169}\)

After establishing the prohibitive cost of health insurance for many Illinoisans, the Bill then claimed that an uninsured underclass affects the state at large, even those who are insured. The Bill stated that

\begin{footnotesize}
\begin{enumerate}
\item[160.] \textit{Id.} § 5-15(a)(4).
\item[161.] \textit{Id.} § 50-501(b).
\item[162.] \textit{See infra} notes 167–171 and accompanying text.
\item[163.] \textit{See infra} notes 172–183 and accompanying text.
\item[164.] \textit{See infra} notes 184–196 and accompanying text.
\item[165.] \textit{See infra} notes 197–218 and accompanying text.
\item[166.] \textit{See infra} notes 219–230 and accompanying text.
\item[168.] \textit{Id.} "Many working families are uninsured and numerous others struggle with the high cost of health care." \textit{Id.}
\item[169.] \textit{Id.} It also cited a Families USA study as evidence that private health insurance for a family of four increased by $1059 in 2006. \textit{Id.}
\end{enumerate}
\end{footnotesize}
skyrocketing inflation in the healthcare market is at least partially due to "cost shifting from the uninsured." The Bill further contended that lack of health insurance adversely affects the health of uninsured citizens and that sick workers decrease statewide worker productivity, thus slowing the State's economy.

B. Illinois Covered Rebate Program

The Illinois Covered Rebate Program would have been substantially similar to Massachusetts's Commonwealth Care Health Insurance Program. The Program would have provided financial assistance to most Illinois residents who earn less than 300% of the federal poverty level. Specifically, to qualify for premium assistance under the Illinois Covered Rebate Program, an individual would have had to fully satisfy the following four criteria: the individual must (1) have been between nineteen and sixty-four years of age; (2) have been a resident of Illinois; (3) have been residing legally within the United States; and (4) have had an income below 300% of the federal poverty line. An individual eligible for premium assistance who had access to employer-provided health insurance may have received annual assistance of up to twenty percent of the amount the individual contributed to the employer plan or $1000, whichever was greater. Alternatively, individuals eligible for premium assistance who had access to employer-provided health insurance may have opted out of the employer's plan and into Illinois Covered Choice. An individual

170. Id.
171. Id.
172. Id. § 5-15(a)(4).
174. Id. § 5-15(a)(1); see also id. § 5-30(a), (b) ("[S]ubsequent to the implementation of the Illinois Covered Rebate Program, the Department shall conduct a study to determine whether the program should be made available to persons older than 64. The result of the study shall be submitted to the Governor and the General Assembly no later than October 1, 2011."). The reluctance of the Illinois legislature to take prompt action for those over sixty-four years of age strongly reinforces the argument that, where the federal government has entered the healthcare arena, states are more than willing to defer responsibility; only where the federal government has shown an absolute unwillingness to intervene do states find it prudent to intercede. On the other hand, in 2006, Illinois initiated the All Kids program, which guarantees healthcare coverage for any child in Illinois who has been uninsured for over a year because of a loss of parental coverage via job loss or change in the family composition. FAMILIES USA, ILLINOIS COVERED PROPOSAL (May 2007), available at http://www.familiesusa.org/assets/pdfs/state-expansion-il.pdf. Article 7 of the Illinois Covered amends the All Kids Program. Ill. S. 0005 § 7.
175. Ill. S. 0005 § 5-15(a)(2).
176. Id. § 5-15(a)(3).
177. Id. § 5-15(a)(4).
178. Id. § 5-20(b).
179. Id. § 5-20(c)(3), (c)(4).
with an income at or above 250% of the federal poverty line who opted out of an employer plan may have received up to $210 annually in premium assistance; someone with an income below 250% of the federal poverty line may have received up to $350 in annual premium assistance.\textsuperscript{180}

Those who did not have access to employer-provided health insurance would have been entitled to a dramatically increased premium assistance for enrolling in Illinois Covered Choice.\textsuperscript{181} The maximum assistance for someone with an income at or above 250% of the federal poverty line was $1500, while the maximum state contribution for someone with an income below 250% of the federal poverty line was $2500.\textsuperscript{182} Nevertheless, despite the significant aid for poor individuals without access to employer-provided health insurance coverage, it is important to note that the dollar figures presented were ceilings, not floors. The Illinois Department of Healthcare and Family Services may have lowered the amount of financial assistance provided through the Program in response to budgetary considerations.\textsuperscript{183}

\section*{C. \textit{The Illinois Covered Assist Program}\textsuperscript{184}}

The Illinois Covered Assist Program was substantially similar to a component of Massachusetts's Commonwealth Care Health Insurance Program. Broadly speaking, the Program would have provided full health insurance coverage to currently uninsured Illinoisans who earned no more than 100% of the federal poverty line. To qualify for the Illinois Covered Assist Program, an individual would have had to satisfy the following six criteria\textsuperscript{185}: the individual must (1) have been between nineteen and sixty-four years of age;\textsuperscript{186} (2) have been an Illinois resident;\textsuperscript{187} (3) have been residing legally within the United States (as defined by S. 0005 § 5-15);\textsuperscript{188} (4) have been ineligible for other medical assistance;\textsuperscript{189} (5) have had no access to employer-pro-

\begin{footnotesize}
\begin{enumerate}
\item[180.] \textit{Id.} § 5-20(c)(3), (c)(4).
\item[181.] \textit{Ill. S. 0005} § 5-20(c)(1), (c)(2).
\item[182.] \textit{Id.}
\item[183.] \textit{Id.} § 5-20(c) (stating that "[t]he Department shall set the amount of premium assistance that will be provided, but those amounts shall not exceed the following").
\item[184.] The Illinois legislature explained the purpose of the Illinois Covered Assist Program: "[T]he General Assembly, in order to improve the health of low-income individuals, reduce emergency room visits, and reduce overall costs in the Illinois health system, seeks to provide regular primary care to low-income Illinoisans." \textit{Id.} § 9-5.
\item[185.] \textit{Id.} § 9-20.
\item[186.] \textit{Id.} § 9-20(1).
\item[187.] \textit{Ill. S. 0005} § 9-20(2).
\item[188.] \textit{Id.} § 9-20(3).
\item[189.] \textit{Id.} § 9-20(4).
\end{enumerate}
\end{footnotesize}
vided healthcare;\textsuperscript{190} and (6) have had an income at or below the federal poverty line.\textsuperscript{191} An individual who qualified for the Illinois Covered Assist Program would have received comprehensive health insurance.\textsuperscript{192} Illinois Covered Assist would have provided coverage for "primary health care services,"\textsuperscript{193} "disease management and wellness programs,"\textsuperscript{194} "non-elective inpatient care,"\textsuperscript{195} and "pharmacy benefits."\textsuperscript{196}

\textbf{D. The Illinois Covered Choice Program}

The Illinois Covered Choice Program would have mandated\textsuperscript{197} that all managed care entities\textsuperscript{198} operating within the state establish an insurance plan that provided major medical benefits\textsuperscript{199} to all qualifying small employers and all eligible individuals.\textsuperscript{200} A qualifying small employer would have included any business that (1) employed twenty-five or fewer employees;\textsuperscript{201} (2) contributed eighty percent or more to an individual employee's insurance premium or sixty-five percent or more to an employee's family insurance premium;\textsuperscript{202} and (3) utilized Illinois as its primary place of business.\textsuperscript{203} To be eligible, the individual would have had to (1) have been unemployed, self-employed, or employed by an employer who had not offered health coverage for eighteen months;\textsuperscript{204} (2) not have had an annual income that exceeds

\begin{footnotesize}
\begin{enumerate}
\item Id. § 9-20(5).
\item Id. § 9-20(6).
\item Id. § 9-30(a).
\item Ill. S. 0005 § 9-30(a)(1).
\item Id. § 9-30(a)(2).
\item Id. § 9-30(a)(3).
\item Id. § 9-30(a)(4).
\item Id. § 10-15(b).
\item Id. § 10-10. The Act defined a "managed care entity" as "any health maintenance organization or insurer . . . whose gross Illinois premium equals or exceeds 1% of the applicable market share." Id.
\item Ill. S. 0005 § 10-15(r)(1).
\item Id. § 10-15(a).
\item Id. § 10-15(c)(1).
\item Id. § 10-15(c)(2).
\item Id. § 10-15(c)(3).
\item Id. § 10-15(l)(1). This requirement would not have applied to veterans, or to individuals who had had their insurance terminated due to a death in the family, a change of residence, or legal separation. Id. § 10-15(m), (n).
\end{enumerate}
\end{footnotesize}
400% of the federal poverty line;205 (3) have been ineligible for Medicare;206 and (4) reside in Illinois.207

The Illinois Covered Choice Program would have been significant in at least two respects. First, a managed care entity may have adjusted the base rate coverage charge for a specific individual but only for a limited number of specific factors.208 Those factors included geographic area, age, smoking status, and participation in a wellness-management activity.209 Additionally, adjustment based on the aforementioned factors would have been limited to no more than thirty percent based on geographic area,210 twenty-five percent based on age,211 and ten percent based on participation in a wellness-management activity.212 Second, the Department of Healthcare and Family Services would have had the power, pursuant to the Act, to determine "appropriate co-pay amounts, deductible levels, and benefit levels."213 Although the Act would not have explicitly constrained the Department in making its determinations, the Governor of Illinois had outlined what he believed to be reasonable co-pay amounts and deductible levels.214 The Governor suggested that Illinois fully subsidize Illinois Covered Choice costs for individuals with incomes under the federal poverty line.215 The Governor recommended that Illinois cap individual costs at 1.5% of an individual's income if that income was under 250% of the federal poverty line.216 The Governor also suggested that Illinois cap individual costs at 2.5% of income for individuals with incomes under 400% of the federal poverty line.217 Finally, according to the Governor, individuals with incomes over 400%
of the federal poverty line should have had to pay the full cost of coverage.\textsuperscript{218}

\textbf{E. Merely a Roadmap to Universal Healthcare}

The text of the Illinois Covered Act reveals the Illinois legislature’s belief that the Act’s programs would not lead to universal healthcare within the State.\textsuperscript{219} Unless the number of uninsured Illinoisans between the ages of nineteen and sixty-four remained above 500,000, the Department of Healthcare and Family Services would not have needed to even consider mandating individual coverage.\textsuperscript{220} Such a large threshold number indicated the Illinois Senate’s lack of faith in the ability of the Act to obtain its lofty goal of health insurance for all Illinois’s citizens. This lack of faith seems reasonable since “[n]o health care reform proposal without an individual mandate has ever been projected to enroll more than half of the uninsured.”\textsuperscript{221} The Act did provide for the creation of a task force to “analyze the effects of establishing an individual mandate to purchase health insurance,”\textsuperscript{222} but the Department of Healthcare and Family Services was under no legal obligation to act on any task force recommendation until December 31, 2010.\textsuperscript{223}

Despite the Illinois Senate’s explicit recognition of the problems caused by allowing Illinoisans to remain uninsured, the Act would not have facilitated universal healthcare within the State. While the Senate intended to provide “comprehensive coverage” to “all Illinoisans,” the Bill was an imperfect vessel for implementing that type of change.\textsuperscript{224} The bill described the problems caused by a lack of universal health insurance\textsuperscript{225} and stated that a lack of universal health affects the individual health of citizens,\textsuperscript{226} shifts costs to others,\textsuperscript{227} threatens their long-time ability to access healthcare,\textsuperscript{228} and impairs the whole State’s economy.\textsuperscript{229} Despite acknowledging these problems, the Illi-

\begin{itemize}
\item \textsuperscript{218} Id.
\item \textsuperscript{219} S. 0005, 95th Gen. Assem., Reg. Sess. § 50-501(d) (Ill. 2007).
\item \textsuperscript{220} Id.
\item \textsuperscript{221} Id.
\item \textsuperscript{222} Id. § 50-501(b). The task force was to be appointed by the Governor and would have included customer advocates, business representatives, healthcare professionals, health policy experts, a hospital representative, and an economic expert. \textit{Id.} § 50-501(a).
\item \textsuperscript{223} Id. § 50-501(d).
\item \textsuperscript{224} Id. § 1-5.
\item \textsuperscript{225} See supra notes 167–171 and accompanying text.
\item \textsuperscript{226} See supra notes 170–171 and accompanying text.
\item \textsuperscript{227} See supra note 170 and accompanying text.
\item \textsuperscript{228} See supra note 170 and accompanying text.
\item \textsuperscript{229} See supra note 171 and accompanying text.
\end{itemize}
Illinois legislature offered an inadequate instrument for change because Illinois, like most states, is financially unable to implement universal healthcare.230

V. THE PROBLEMS WITH UNIVERSAL HEALTHCARE IMPLEMENTED ONE STATE AT A TIME

Former U.S. Supreme Court Justice Sandra Day O'Connor referred to state governments as "laboratories for the development of new social, economic, and political ideas."231 As Justice O'Connor explained, state government first implemented unemployment insurance and, state government first experimented with no-fault automobile insurance.232 The idea of state governments as laboratories of experimentation predates Justice O'Connor's discussion. In 1932, Justice Louis Brandeis wrote: "It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."233

In addition to being laboratories for experimentation with new ideas, states are also, at least in theory, more responsive to the needs of the electorate.234 State governments are "closer to the people, more sensitive to local conditions, and more attuned to social problems than are national officials."235 Further, the close proximity between state governments and the people allows for substantial local participation in politics.236 Such participation serves as an educational tool for representative government.237 Finally, state governments de-

230. See infra notes 231–269 and accompanying text.
232. Id. at 788–89.
233. New State Ice Co. v. Leibmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting). It must be noted that the "risk" involved with comprehensive federal reform of healthcare is minimal. Universal healthcare is not a "novel" idea; it has been successfully implemented in numerous countries around the world. See supra notes 49–84 and accompanying text.
235. Id.
236. F.E.R.C., 456 U.S. at 789.
237. Id. at 790. Justice O'Connor elaborated on the civic benefits of active participation in state governments: "[i]f we want to preserve the ability of citizens to learn democratic processes through participation in local government, citizens must retain the power to govern, not merely administer, their local problems." Id. The healthcare crisis in this country is not a local problem, though. It is a nationwide epidemic and therefore does not fit neatly within this rationale for state government.
centralize power, thereby serving as a safeguard against possible excesses by the federal government.\textsuperscript{238}

However, state governments also have disadvantages. In the 1830s, Alexis de Tocqueville, author of the historic critique of American government, \textit{Democracy in America}, wrote that America's federal government was "infinitely better conducted" than its state government counterparts.\textsuperscript{239} He believed that the federal government was wiser, fairer, more skillful, more moderate, and more consistent than the governments of the various states.\textsuperscript{240} Since the 1960s, however, state governments have moved away from the time when "good old boys ran the states with winks and backslaps."\textsuperscript{241} Despite improvement, however, certain financial limitations of state government remain as unalterable byproducts of American federalism.\textsuperscript{242}

This Part analyzes how financial limitations render state governments unable to remedy the healthcare crisis in this country. First, Section A argues that while the federal government is financially capable of implementing universal healthcare for all Americans, most states are not.\textsuperscript{243} Then, Section B predicts that reliance on state governments to provide universal healthcare will harm the health of America's poor.\textsuperscript{244}

\textbf{A. Most States Are Financially Unable to Implement Universal Healthcare}

In the United States, healthcare is a $2.2 trillion industry.\textsuperscript{245} In 2006, the gross national product of the United States was thirteen trillion dollars.\textsuperscript{246} Obviously, providing universal healthcare for all citizens is within the financial capacity of this country. Consider Hillary Clinton's plan for universal healthcare. It is estimated that her plan would have cost the federal government an additional $110 billion per year to achieve its lofty goal of healthcare for all Americans.\textsuperscript{247} Hillary Clinton, though, proposed alternative mechanisms for paying for
her universal healthcare plan. Senator Clinton suggested that phasing out unnecessary or excessive Medicaid and Medicare spending, constraining prescription drug costs through increased competition, and modernizing the healthcare system would save fifty-six billion dollars. Moreover, discontinuing the Bush tax cuts for individuals earning over $250,000 would provide fifty-four billion dollars of additional revenue. Therefore, according to her plan, administrative savings coupled with a slight increase in taxes for Americans who earn more than a quarter of a million dollars per year pays for universal healthcare.

However, providing universal healthcare is not possible in most states. While the United States raised $2.4 trillion in tax revenue in 2006, all states combined raised just over $500 billion. The fed-

249. Id. at 11.
250. Id.
252. Id. Below is a chart showing the amount of revenue each state in America collected in 2006. Three states—California, Massachusetts, and Illinois—have recently indicated a strong desire to move independently toward statewide universal healthcare.

<table>
<thead>
<tr>
<th>State</th>
<th>Revenue (Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>7,155</td>
</tr>
<tr>
<td>Alaska</td>
<td>4,470</td>
</tr>
<tr>
<td>Arizona</td>
<td>9,303</td>
</tr>
<tr>
<td>Arkansas</td>
<td>3,825</td>
</tr>
<tr>
<td>California</td>
<td>93,427</td>
</tr>
<tr>
<td>Colorado</td>
<td>7,322</td>
</tr>
<tr>
<td>Connecticut</td>
<td>14,999</td>
</tr>
<tr>
<td>Delaware</td>
<td>3,170</td>
</tr>
<tr>
<td>Florida</td>
<td>27,434</td>
</tr>
<tr>
<td>Georgia</td>
<td>18,462</td>
</tr>
<tr>
<td>Hawaii</td>
<td>4,925</td>
</tr>
<tr>
<td>Idaho</td>
<td>2,432</td>
</tr>
<tr>
<td>Illinois</td>
<td>25,258</td>
</tr>
<tr>
<td>Indiana</td>
<td>12,205</td>
</tr>
<tr>
<td>Iowa</td>
<td>5,382</td>
</tr>
<tr>
<td>Kansas</td>
<td>5,394</td>
</tr>
<tr>
<td>Kentucky</td>
<td>8,479</td>
</tr>
<tr>
<td>Louisiana</td>
<td>8,305</td>
</tr>
<tr>
<td>Maine</td>
<td>2,858</td>
</tr>
<tr>
<td>Maryland</td>
<td>12,390</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>26,306</td>
</tr>
<tr>
<td>Michigan</td>
<td>8,186</td>
</tr>
</tbody>
</table>
eral government currently spends upwards of $500 billion on governmental healthcare programs such as Medicaid and Medicare, and states currently spend an additional $300 billion on healthcare.\footnote{253} If the federal government discontinued healthcare expenditures, and left states to pick up the difference, states would be left with a bill approaching one trillion dollars.\footnote{254} In other words, states could provide universal healthcare under current conditions only if they doubled their tax revenues and completely cut all other spending. Such a proposal is impracticable, imprudent, and ultimately impossible. Simply put, states cannot pay for universal healthcare; only the federal government can.

This conclusion is reinforced by the historical record. The United States is the only industrialized nation in the world without universal healthcare; every other industrial nation has been able to pay for

<table>
<thead>
<tr>
<th>State</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota</td>
<td>15,962</td>
</tr>
<tr>
<td>Mississippi</td>
<td>4,265</td>
</tr>
<tr>
<td>Missouri</td>
<td>7,520</td>
</tr>
<tr>
<td>Montana</td>
<td>1,708</td>
</tr>
<tr>
<td>Nebraska</td>
<td>3,349</td>
</tr>
<tr>
<td>Nevada</td>
<td>3,402</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>1,329</td>
</tr>
<tr>
<td>New Jersey</td>
<td>28,705</td>
</tr>
<tr>
<td>New Mexico</td>
<td>5,541</td>
</tr>
<tr>
<td>New York</td>
<td>47,206</td>
</tr>
<tr>
<td>North Carolina</td>
<td>17,874</td>
</tr>
<tr>
<td>North Dakota</td>
<td>1,094</td>
</tr>
<tr>
<td>Ohio</td>
<td>25,846</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>6,213</td>
</tr>
<tr>
<td>Oregon</td>
<td>6,312</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>24,819</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>3,141</td>
</tr>
<tr>
<td>South Carolina</td>
<td>6,226</td>
</tr>
<tr>
<td>South Dakota</td>
<td>1,018</td>
</tr>
<tr>
<td>Tennessee</td>
<td>9,954</td>
</tr>
<tr>
<td>Texas</td>
<td>36,675</td>
</tr>
<tr>
<td>Utah</td>
<td>4,864</td>
</tr>
<tr>
<td>Vermont</td>
<td>1,112</td>
</tr>
<tr>
<td>Virginia</td>
<td>16,052</td>
</tr>
<tr>
<td>Washington</td>
<td>13,329</td>
</tr>
<tr>
<td>West Virginia</td>
<td>3,661</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>12,030</td>
</tr>
<tr>
<td>Wyoming</td>
<td>1,247</td>
</tr>
<tr>
<td>Total</td>
<td>585,468</td>
</tr>
</tbody>
</table>


\footnote{254. The $500 billion that the federal government spends plus the $300 billion that states spend plus the $110 billion for Senator Clinton’s universal plan totals nearly one trillion dollars.}
healthcare for all.\textsuperscript{255} Even some non-industrialized nations, such as Cuba, have been able to provide universal healthcare for their citizens.\textsuperscript{256} Importantly, universal healthcare funded at the national level has not reduced accessibility or effectiveness or increased cost.\textsuperscript{257} As shown by the comparison of the United States' and Canada's healthcare systems in Part II, the opposite is true: Federally funded universal healthcare increases accessibility, improves overall effectiveness, and reduces costs.\textsuperscript{258}

Moreover, the historical unwillingness and inability of state governments to unilaterally implement universal healthcare further reinforces the thesis that states cannot pay for universal healthcare on their own. The only state presently succeeding in providing universal healthcare is Massachusetts.\textsuperscript{259} However, Massachusetts's momentary success with universal healthcare must be viewed in the proper context. Massachusetts's current foray into universal healthcare is the state's second; the first ended prematurely, due in part to concerns about the cost of the program.\textsuperscript{260} Moreover, Massachusetts's present program is already facing major financial trouble after less than three years of existence.\textsuperscript{261} As explained in Part III, Massachusetts universal healthcare plan faces a $160 million shortfall for the fiscal year that started on July 1, 2008.\textsuperscript{262}

Further, the limited scope of the Illinois Covered Act validates the conclusion that states are incapable of implementing universal healthcare.\textsuperscript{263} As Part IV demonstrated, the Act, perhaps the second most ambitious healthcare proposal at the state level, would not have achieved universal healthcare.\textsuperscript{264} As the Act provides, unless the number of uninsured Illinoisans between the ages of nineteen and sixty-four remains above 500,000, the Illinois Department of Healthcare and Family Services is under no legal obligation to consider mandating individual coverage.\textsuperscript{265}

Finally, a plethora of other financial constraints, whether inherent byproducts of federalism or self-imposed restrictions, limit the finan-

\textsuperscript{255} Greg Mathis, Universal Health Care Can Save the Uninsured, CHI. DEFENDER, Sept. 29, 2006, at 10.
\textsuperscript{256} Ronald Brownstein, The Plague or the Cure, L.A. TIMES, July 1, 2007, at M4.
\textsuperscript{257} See supra notes 39–84 and accompanying text.
\textsuperscript{258} See supra notes 39–84 and accompanying text.
\textsuperscript{259} See supra notes 124–145 and accompanying text.
\textsuperscript{260} See supra notes 146–155 and accompanying text.
\textsuperscript{261} See supra notes 141–145 and accompanying text.
\textsuperscript{262} Helman & Kowalczyk, supra note 124.
\textsuperscript{263} See supra notes 156–218 and accompanying text.
\textsuperscript{264} See supra notes 219–230 and accompanying text.
cial capacity of state governments. For example, unlike the federal
government, state governments cannot print money.\textsuperscript{266} Also, many
states are legally obligated to balance their budget each year and over
half have tax or expenditure limitations codified in their statutes or
mandated by their constitutions.\textsuperscript{267} Such limitations either prevent
states from initially implementing universal healthcare or inhibit their
ability to continue such a policy during an economic downturn.\textsuperscript{268} The
federal government, on the other hand, does not suffer from such
limitations.

B. The Impact of State-Initiated Universal Healthcare on
America's Poor

Predicting the impact of relying on states to implement universal
healthcare is not difficult. Since the debate over universal healthcare
began in 1912, there has been \textit{de facto} reliance on the states to provide
universal healthcare. The result of such reliance is clear: forty-seven
million Americans have no health insurance, and of those forty-seven
million Americans, eighty percent are poor.\textsuperscript{269}

Most of the forty-seven million Americans who have no health in-
surance will remain uncovered if the federal government continues to
accept the status quo. However, across the northern border, all
Canadians will continue to receive healthcare, and ninety miles off the
coast of Florida all Cubans will continue to receive healthcare. Be-
cause the American government views healthcare as a private, for-
profit venture rather than a civil right, millions of Americans will con-
tinue to have their lives jeopardized because of federal inaction in the
healthcare crisis and the resulting economic inequality in access to
healthcare.

VI. CONCLUSION

The time for debate is over. States are financially unable to imple-
ment universal healthcare, so the federal government must act. It is
no longer acceptable to ignore the forty-seven million Americans who
lack health insurance, most of whom are too poor to buy insurance. It
is no longer acceptable to rely on the failing employer-based health-
care model. It is no longer acceptable to trust unregulated private
insurance companies. It is no longer acceptable to view healthcare as

\begin{itemize}
\item \textsuperscript{266} U.S. Const. art. 1, § 10, cl. 1.
\item \textsuperscript{267} Frank J. Thompson, \textit{Federalism and Health Care Policy: Toward Redefinition?}, in \textit{The New Politics of State Health Policy}, supra note 1, at 41, 47.
\item \textsuperscript{268} \textit{Id.} at 48.
\item \textsuperscript{269} See supra notes 27–28 and accompanying text.
\end{itemize}
a matter of dollars and cents rather than as a matter of life and death. Most of all, it is no longer acceptable to wait on the states to do what they financially cannot. In short, the economic inequality in healthcare access is unacceptable.

Those who cite Massachusetts's recent success in implementing universal healthcare in support of continued federal inaction must remember four facts: (1) Massachusetts is the only state that has ever successfully implemented universal healthcare; (2) Massachusetts's plan became fiscally insolvent in July 2008; (3) Massachusetts failed to sustain a similar healthcare plan in 1988 because of financial obstacles; and (4) the Illinois Covered Act's limited scope reinforces the notion that financial limitations prevent states from completely remedying the healthcare crisis.

On the other hand, nationally funded universal healthcare works. In country after country, from Canada to Cuba, national governments that have implemented universal healthcare have succeeded. It is time for the United States, the last industrialized country on Earth without universal healthcare, to finally live up to its fundamental obligation to secure the right to life for all its citizens.

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