2004

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Journal of Health Law

Spring 2004 Volume 37, No. 2

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ABSTRACT: Several recent films have villainized the health-insurance industry as a central element of their plots. This Article examines three of those films: *Critical Care*, *The Rainmaker*, and *John Q.* It analyzes these films through the context of the consumer backlash against managed care that began in the 1990s and shows how these films reflect the consumer sentiment regarding health-insurance companies and the cost controlling strategies they employ. In addition, the Article identifies three key premises about health insurance in the films that, although exaggerated and incomplete, have significant factual support. Ultimately, the author argues that, despite their passionately critical and liberal tone, these films actually put forward solutions that are highly individualist and conservative, rather than inclusive and systemic.

> *There's nothing more thrilling than nailing an insurance company!*
>
> –Deck Shifflet, *The Rainmaker*[1]

Hollywood has a new villain—the private health-insurance system. Viewers of the 1997 film *As Good As it Gets* probably remember the profane outburst of Helen Hunt's character describing her private insurance coverage—a health maintenance organization (HMO)[2]—and its failure to provide

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appropriate medical treatment for her sick child.[3] One probably also remembers that the audience cheered.[4] The scene, viewed by millions,[5] attracted an extraordinary amount of attention. Even President Clinton referred to the scene in a speech presenting the Patient's Bill of Rights in 1998, joking that the film is "going to be disqualified for an Academy Award because it's too close to real life."[6]

Three additional films show that the tremendous audience response to this scene was not a fluke. They signal a new and unexplored focus on private health insurance,[7] now dominated by managed care and its relationship to healthcare, in contemporary mainstream films. Sidney Lumet's *Critical Care*,[8] Francis Ford Coppola's *The Rainmaker*,[9] and Nick Cassavetes's *John Q*[10] each center on negative and disturbing images of modern insurance companies from the perspective of a doctor, a lawyer, and a parent. Each portrays the inner workings of these companies and the victimization of patients and their families as a result of insurer policies and practices. The narratives also reflect common public perceptions about private health insurance, such as: the link between lack of coverage and lack of access to care, including life-saving care; the perverse and distorting effect of certain managed care reimbursement arrangements on treatment decisions; and the loss of adequate health coverage for workers and their families.

As Good As it Gets, *Critical Care*, and *The Rainmaker* were released in 1997.[11] *John Q*, the most sensational of the films, appeared five years later in 2002.[12] Prior to these films, no mainstream film villainized the health-insurance industry as a central element of the plot. Why did private health insurers emerge as villains in popular films in the late 1990s? Each of these films offers a sharp critique of the current state of health insurance and its relationship to healthcare; but is the system really failing in the ways these films suggest? If so, what can we learn from the solutions these films offer?

To answer those questions, Part I of this Article identifies the vivid and overwhelmingly negative images of modern health-insurance companies within each film. Part II examines the films within the context of the powerful consumer backlash against managed care in the 1990s. It shows that the intensity and emotional power of the images accurately reflect the public's dismal opinion of health-insurance companies and the various strategies they employ. Part III identifies three key premises about health insurance in the films and demonstrates that, although exaggerated and incomplete, the premises have significant factual support. Finally, Part IV contends that, despite their passionately critical and liberal tone, these films actually put forward solutions that are highly individualist

and conservative, rather than inclusive and systemic. Indeed, the resolution of each of the narratives comes about through the actions of one individual—one good doctor, one good attorney taking one good case, and, most disturbingly, one good father with a gun—and resolves the situation of one patient. This "dissolving critique" effect is significant because it resonates with similar shifts in current healthcare policy, evidenced by the turn toward consumer-driven health plans.

I. Images of Health Insurance in Recent Popular Films

The emergence of private health-insurance companies as villains in these three films[13] fits within the familiar popular theme of consumer mistrust of powerful, private corporate entities and their lawyers. Professor Anthony Chase has described this trend as the "characteristic, populist skepticism of law, courts, and people in pin-stripe suits."[14] The new, vivid, and overwhelmingly negative portrayal of health insurers and their strategies of managed care in these three recent films—each featuring well-known directors, actors, and movie studios and marketed at the masses—warrants attention.[15]

A. Critical Care

Critical Care, based on Richard Dooling's novel,[16] is a darkly comic portrayal of doctors, death, and money in the modern, high-technology practice of medicine. The film centers on Dr. Werner Ernst, an exhausted resident watching over a futuristic and impersonal intensive care unit filled with seemingly lifeless patients. The unit looks more like the inside of a spaceship than a hospital, a stark white space in which the patients seem to float, restrained atop translucent blue inflatable beds. The patients are silent and anonymous—usually referred to only by bed number—and kept alive at great expense by the machines surrounding them. Indeed, dehumanization is established as a goal, rather than a by-product, of high-tech medicine. Dr. Ernst aspires, at least initially, to join Dr. Hofstader's prestigious lab, where "seeing patients is a waste of a doctor's time" because actual patients have been replaced with continuously monitored patient data. The benefits, as one of Dr. Hofstader's protégées proudly explains, are obvious, as "there is no longer any condition that is truly terminal. Just patients that we chose not to maintain."[17]

Initially, Dr. Ernst appears more interested in the privileges of his profession than his patients. Nonetheless, he is drawn into an ethical quandary over the care of one of his nonresponsive patients, Mr.

Potter, and specifically the propriety of a gastronomy procedure to keep him alive. Mr. Potter's daughters, Felicia and Constance, disagree on the surgery and continuation of his life support. Each daughter appears to be concerned with the best interests of her father, but Dr. Ernst learns that Constance controls her father's $10 million estate while he lives, and Felicia stands to inherit it when he dies. He is drawn into their legal battle when he is seduced by Felicia and blackmailed with a videotape of their encounter, during which he made professionally damaging statements about her father's condition.

Along the way, Dr. Ernst is counseled by the cynical Dr. Butz, the putative Chairman of Intensive Care Medicine, and the wise and compassionate Nurse Stella.[18] Dr. Butz is portrayed—to comedic effect—as a washed-up and unfit physician, so impaired by alcoholism that he is barely competent to operate his own phone, let alone on an actual patient. Dr. Butz repeatedly tries to teach Dr. Ernst about the economics of managed care, such as when Dr. Ernst questions the futility of further invasive treatment for Mr. Potter:

> *Butz:* What's wrong with Bed 5? He's all paid up. Got three insurance companies paying off his bills . . . .
>
> *Ernst:* If there is no reasonable prospect of cure, why should we proceed?
>
> *Butz:* Where have you been all of your life? It's called revenue. He's got catastrophic health insurance, long-term health care, the works! . . . If the patient were part of an HMO then I could understand your dilemma. With those babies, we get paid *not* to perform medical procedures. It's a little like when the government pays the farmers not to grow crops. However, with insurance we get paid to perform medical procedures. Do you understand the difference? . . . Well, do it. My God! I get a cut of every procedure we do on the guy. He's got catastrophic health insurance.[19]

Dr. Ernst's attempt to bring empathy into the decisionmaking calculus is met with incredulity:

> *Ernst:* My question is, if you were comatose, would you want to be kept alive for months by machine?

> *Butz:* Hell no! . . . That's why I don't have health insurance. . . . Just make sure you don't have money for health care and you'll die a happy fellow with a big smile on your face in your own king-sized bed![20]

During another meeting with Dr. Butz regarding the Potter lawsuit, Dr. Ernst is paged to the emergency room to treat a nineteen-year-old patient with a potentially severe head injury. After confirming that the patient has no insurance, Dr. Butz insists that Dr. Ernst disregard the page, explaining:

> *Butz:* He's 19. He's got no medical coverage and he's some rowdy kid. What do you think would happen if I got in my car one Sunday and drove over to this kid's house and said "hey kid, come next door and cut my grass and if I ever get any money I'll pay you. Just send me the bill, kid." What do you think would happen?
>
> *Ernst:* Cutting grass is a little different from emergency medical care.
>
> *Butz:* I know that, but it's still a service economy and if you want service in a service economy you pay for it. And if you don't pay for service in a service economy you ruin the whole country.[21]

Throughout, Mr. Potter shows no signs of awareness except for the constant tapping of his finger against the steel bar of his inflatable bed. When a member of the intensive care unit (ICU) staff learns that Potter was a Navy signalman, he discovers that the tapping is a message in Morse Code—"if you love me . . . if you love me . . . if you love me."[22] Dr. Ernst does not know what to make of this ambiguous communication—if you love me, do what? Echoing his prior attempts to approach the dilemma from the standpoint of Mr. Potter, a nun appears at Potter's beside and advises Dr. Ernst to "Listen to your heart. Think of this man as your father. Love him, comfort him."[23]

At the guardianship hearing in the Potter lawsuit, Dr. Ernst finally emerges as an advocate for his patient. He impugns the motivations of each of the parties represented at the large table—the grasping daughters, the greedy doctors and hospital, and the indistinguishable representatives of the insurance companies:

> I almost forgot about the insurance companies. But I don't really need to say anything about them because no one ever believes that an insurance company cares about anything except getting paid the premiums and honoring as few claims as possible. I see you don't object.[24]

He then turns on himself:

> [I cared] about making money and getting a new car and meeting pretty women, becoming a big shot doctor, when I should have been concerned and should have cared about this patient. My patient. . . . The only one missing is the patient. The one without a voice is the patient. And, all of us together are the health care system. A system as collapsed and comatose and near death as Mr. Potter in Bed 5 in the ICU, and we should care. We should care.[25]

Ultimately, Dr. Ernst is permitted to work out a settlement where the daughters will split the money, release all claims, and give power of attorney to Dr. Ernst to make treatment decisions for their father.[26] He returns to the hospital and turns off Mr. Potter's ventilator. His ethical awakening is underscored by the last scene, in which "some rowdy kid" crashes on roller blades in the hospital parking lot. Dr. Butz speeds off, admonishing Dr. Ernst to "ask him for proof of insurance!" Dr. Ernst rushes to aid the injured kid who asks "are you a doctor?" Dr. Ernst answers, "Yeah, I'm a doctor."[27]

B. The Rainmaker

The Rainmaker, based on John Grisham's novel,[28] was released shortly after *Critical Care* in 1997. It has generated significant attention in legal scholarship, particularly with respect to its depiction of lawyers, the legal system, and legal ethics.[29] Considerably less attention, however, has been paid to the portrayal of the health-insurance industry.[30]

Rudy Baylor, an idealistic and inexperienced lawyer who wants to "shine the blazing light of justice into every corner," stumbles into a major case against a powerful and corrupt health-insurance company, Great Benefit. Baylor's client, Donny Ray Black, needs a life-saving bone marrow transplant for treatment of his leukemia, but his claim has been denied eight times and for several different reasons, including exclusion of the bone marrow transplant as experimental. Great Benefit's final letter to Mrs. Black states,

"[o]n seven prior occasions this company has denied your claim in writing. We now deny it for the eighth and final time. You must be stupid, stupid, stupid. Sincerely, Everett Lufkin. Vice President, Claims Department."[31]

As Baylor meets with the family to prepare the case, he reflects on the deterioration of Donny Ray's health:

> So this is how the uninsured die. In a society filled with brilliant doctors and state of the art technology, it's obscene to let this boy just wither away and die. He was covered by an insurance policy that his mother paid good money for. It wasn't big money, but it was good money. I'm alone in this trial. I'm seriously outgunned and I'm scared, but I'm right. I sit here with this poor suffering kid and I swear revenge.[32]

As Donny Ray dies, Baylor struggles to expose Great Benefit's actions. Great Benefit's team of arrogant, high-powered lawyers hides crucial information from Baylor, including the whereabouts of the claims manager who handled Donny Ray's claim, Jackie Lemanczyk. Meanwhile, Baylor arranges to have the deposition of Donny Ray take place out in the open, in the yard of the Black's home. At trial, Baylor projects Great Benefit's denial letter on an overhead projector for all to see, exposes the denial as experimental to be fraudulent using one of Great Benefit's own internal documents, and uncovers the key witness and supporting documents in the nick of time.

In closing arguments, Great Benefit's attorney warns that finding for the Blacks in this case will cause premiums to spin out of control and will pave the way for "government controlled health coverage."[33] Baylor counters by projecting the deposition of Donny Ray, who died prior to trial, his face floating above the courtroom like a ghost. Donny Ray tells the jury that he "had a 90% chance of living."[34] Baylor reminds the jury, "if you don't punish Great Benefit, you could be their next victim."[35]

Although Baylor is rewarded with a stunning victory at the end of trial—$150,000 in compensatory and $50 million in punitive damages—Donny Ray has died and Great Benefit's executives loot and bankrupt the company. In the words of Great Benefit's attorney, "[e]verybody loses on this one."[36]

C. John Q

Like *The Rainmaker*, *John Q* features a working-class parent up against a powerful corporate entity. The parent in *John Q,* however, a working-class everyman figure played by Denzel Washington, foregoes lawyers and the courtroom and seeks justice on his own. John Q. Archibald is a long-time Illinois factory worker, recently reduced to twenty hours a week and struggling to find a second job to make ends meet. One of the first scenes juxtaposes the sound of President George W. Bush on television discussing the failing economy with the repossession of the Archibald family station wagon, immediately and obviously introducing the theme of economic disparities, the haves versus the have-nots.

John's son, Mikey, collapses at a Little League game and is rushed to the hospital. After Mikey is admitted to the hospital, the Archibalds are ushered from the dingy limbo of the emergency room into a well-appointed conference room to meet with the Chief of Cardiology, Dr. Turner, and the hospital administrator, Ms. Payne. Dr. Turner explains that Mikey needs an immediate heart transplant, and given his medical condition and blood type, he would be at the top of the organ transplant waiting list. Unfortunately, Ms. Payne explains that the Archibald's insurance is insufficient to cover the minimum cost of $250,000, and the hospital will not place Mikey on the organ transplant waiting list without a down payment of $75,000. When confronted with the seeming heartlessness of her decision, she responds, "[i]t costs money to provide health care. It's expensive for you, it's expensive for us."[37]

Speaking with a nurse after the meeting, the uncomprehending Archibalds ask why Mikey's condition was not caught sooner. She replies, "HMOs pay the doctors not to test. That's how they keep costs down."[38] She also warns them that the results will be the same, if not worse, at the nearby public hospital and urges them to explore all options to secure payment.

John first tries to work with his insurer. The human resource representative at his work explains that he now has a $20,000 lifetime limit on his health insurance benefits as a result of two factors: the factory switched from a preferred provider organization (PPO)[39] to a more restrictive HMO plan, a less expensive option for the factory; and John recently went from full-time to part-time employment, making him eligible for a less comprehensive level of coverage. His request for authorization for the transplant is denied and his appeal abandoned as futile.[40]

A succession of scenes shows John trying to secure coverage or funds elsewhere by the following methods: applying for Illinois's Medicaid program; inquiring at the public hospital; accepting donations from sympathetic but equally strapped workers, friends, and parishioners; selling the family's belongings, including the refrigerator, the remaining family car, and his wife's engagement ring; and trying to interest the local media. John's applications for Medicaid and private charitable coverage are denied, and his fundraising efforts fall far short of the required $75,000 down payment. Ms. Payne notifies the Archibalds that she must release Mikey from the hospital to die at home.

A desperate John approaches Dr. Turner to plead with him to do the operation, agreeing to do whatever it takes to pay the full price:

> This hospital does over three hundred heart surgeries a year. Three hundred surgeries, two hundred fifty thousand a pop. . . . That's seventy five million dollars worth of heart surgeries and you're telling me you can't do one for me in good faith? . . . I'm not asking you to waive your fee . . . I can pay. I swear to God I'll pay you the money back. I don't know how I'm going to do it, but I promise you I will. You just gotta trust me. I give you my word as a man.[41]

When his appeal fails, he pulls a gun, and takes Dr. Turner and the emergency room hostage in a bid to get Mikey's name on the organ transplant waiting list.

Despite his violent actions, the film goes to great lengths to portray John Q as an honorable, caring everyman, one whom even the hostages describe as "a good man." He arranges for the emergency room patients to get care, declaring "[t]he hospital is under new management. From now on, free health care for everybody." He also oversees life-saving surgery for a gunshot victim (without verifying insurance coverage),[42] releases vulnerable hostages, and exposes one of the hostages as a perpetrator of domestic violence. It is later revealed that his gun was never loaded. Aided by live media coverage, he becomes a folk hero to the gathering crowds outside the hospital.

Inside, John also engages the surprisingly talkative group of hostages in a discussion of Mikey's experience with managed care:

> *John:* How could the doctor's not have picked [Mikey's condition] up?

Turner: He may not have been tested thoroughly enough.

John: Why not?

Intern: You got an HMO, right? Well, that's your answer. HMOs pay their doctors not to test. That's their way of keeping costs down. Let's say Mike did need additional testing and insurance says they won't cover them. The doctor keeps his mouth shut and, come Christmas, the HMO sends the doctor a fat-ass bonus check.

John: Is that true?

Turner: Possible. Not likely, but possible.[43]

Emboldened by the frank discussion, an intern describes the even worse situation for the uninsured in the emergency room, despite the law: "if you don't have any money, you get a band aid, a foot in the ass, and you're out the door."[44]

As time runs out for an existing heart to be transplanted, John convinces the now repentant Dr. Turner to take John's own heart for his son. Meanwhile, Ms. Payne also has a change of heart and puts Mikey on the organ transplant waiting list, and a matching heart becomes available for Mikey. Mikey and John are saved, and the hostage crisis ends without serious injury to anyone.

Following John's arrest, we see a montage of media response to the crisis and its end interwoven with actual clips of people such as Hillary Clinton, Jesse Jackson, Arianna Huffington, Gloria Allred, Jay Leno, Larry King, and Bill Maher offering a variety of viewpoints on the healthcare crisis. These fade into a courtroom scene in which John is convicted of kidnapping and false imprisonment, while the gallery, including several of the hostages, cheers his acquittal on the more serious charges of attempted murder and armed criminal action. John will likely serve two or three years in prison, but his son will live.

II. Why Did Health Insurers Emerge as Villains in the Late 1990s?

The overwhelmingly negative portrayal of the state of health insurance today—a system "as collapsed and comatose and near death"[45] as Dr. Ernst's unconscious patients—arises in the context

of a powerful consumer backlash against managed care in the 1990s. Indeed, the intensity and emotional power of the images accurately reflect the public's dismal opinion of the health-insurance companies and the managed care strategies they employ.

A. The Historical Context: A Brief History of Managed Care

As many have documented, until the 1990s, most private health coverage was indemnity insurance following a fee-for-service model.[46] The insured or his employer purchased a policy from a health insurer that assumed the risk of the potentially high cost of medical care in the event of the insured's disease or injury.[47] When the insured received care, the insurer reimbursed the healthcare provider for the cost of each service, such as an office visit, procedure, or medical supply. This is the type of health insurance policy extolled by Dr. Butz in *Critical Care*: "with [traditional] insurance we get paid to perform medical procedures. . . . I get a cut of every procedure we do on the guy."[48]

As Dr. Butz's comment suggests, one problem with this arrangement is that individual patients were free to use more healthcare services without additional payment, and healthcare providers were free to provide more healthcare services for additional reimbursement. This led to increased use of healthcare services, which, along with other factors, resulted in ballooning healthcare expenditures in the 1980s.[49] Private health insurers sought to control expenditures fostered by the traditional fee-for-service structure through a variety of strategies designed to change the incentives of healthcare providers and consumers to provide and use care.[50] They employed a variety of organizational, managerial, and reimbursement strategies, including: preauthorization requirements; consumer co-payments; capitation payments, where one payment is made to the provider for each enrolled patient's care for a specified period, regardless of the amount of treatment provided; restriction of patient choice to the healthcare providers within a defined network, often comprised of providers who agree to accept a discounted rate of reimbursement; and healthcare provider incentive arrangements.[51] The term "managed care," coined in the 1990s, describes such strategies designed to control the cost and use of healthcare.[52] A widely used but inexact term, managed care has been aptly described as "a fusion of two functions that once were regarded as largely separate: the financing of medical care and the delivery of medical services."[53]

Managed care's initial success at cost-containment was a welcome message to insurance purchasers, particularly purchasers of group policies, such as private employers.[54] Indeed, many employers

moved their employees into lower-cost managed care plans and away from the more expensive fee-for-service plans in the 1990s.[55] By the late 1990s, however, managed care's initial success at controlling costs had waned, and consumers and providers of healthcare began to object to many of its cost-containment strategies.[56] The vehement and powerful consumer protests became known as the managed care backlash.[57] While some of the techniques employed by managed care, and HMOs in particular, may have been objectionable in and of themselves, the historical shift from a relatively generous fee-for-service arrangement to widespread use of more controlled and cost-conscious managed care arrangements appears to have played a major role in fueling consumer resentment. As suggested by Alain V. Enthoven, a healthcare economist often described as one of the "fathers of managed care," the root of the consumer backlash is the lack of information given to consumers regarding the reasons for and consequences of the large-scale switch to cost-controlling measures employed by organizations such as HMOs and the subsequent perception of HMOs as a "takeway" of benefits.[58]

Today, the historical distinction between private health insurance and managed care has blurred. Outside of the federal Medicare program,[59] unrestricted fee-for-service insurance is increasingly rare,[60] and virtually all private health-insurance incorporates some aspect of managed care.[61]

B. The Dismal Public Opinion of Health Insurance Companies and Managed Care

At the same time private health insurance was increasingly turning away from the traditionally generous fee-for-service model and toward the diverse cost-controlling strategies of managed care, the public's perception of private health-insurance companies fell dramatically.[62] In recent years, the number of consumers reporting that managed care plans do a "bad job" serving consumers has almost doubled.[63] As of 2002, surveyed consumers reported that the managed care industry served its customers poorly, ranking it at the bottom of the list of industries, along with tobacco and oil companies.[64] They also reported that dealing with health insurance is stressful—nearly as stressful as doing their taxes.[65]

Though a few recent studies suggest that the plummeting opinion of managed care strategies may be bottoming out,[66] the level of public distrust of health insurers and of managed care companies is shockingly high. Surveys suggest that very few people believe statements made by managed care or health insurance companies. Only seven percent of consumers believed that health insur-

ance companies are generally honest and trustworthy and only four percent believe the same about managed care companies.[67] When asked how much they would trust various industries to "do the right thing if faced with a serious problem with one of their products," consumers ranked the health-insurance and managed care companies very low, only slightly above the tobacco and oil industries.[68] The majority of consumers worry that if they become ill, "their health plan [would] be more concerned about saving money than providing the best treatment."[69] Those with plans that are more restrictive expressed even greater concern.[70] Moreover, surveys suggest that nearly three-quarters of Americans believe that managed care plans keep the savings achieved using cost-containment strategies.[71]

Although these studies demonstrate an overwhelmingly negative public opinion of private health insurance and its reliance on managed care strategies, it is difficult to draw a conclusion as to the basis for such an opinion. It seems unlikely that consumers base their opinions on full knowledge of the studies and statistics associated with the strategies of managed care. Some studies suggest that the high level of consumer dissatisfaction and distrust arises in significant part from personal experiences with managed care and health insurance companies.[72] A study in 2001 by the Kaiser Family Foundation found that over half of private healthcare consumers under sixty-five experienced a problem with their healthcare plan, such as a delay or denial of coverage or care, difficulty seeing a physician, a billing or payment problem, or a customer service problem in the past year.[73] Moreover, women, those in more restrictive managed care plans, those in fair or poor health, and those with a health condition were more likely to report problems.[74] Although most consumers reported relatively minor consequences, a "substantial minority of people with problems experienced financial losses, lost time from life activities, or declines in health" as a result of the problems.[75] Interestingly, a few recent studies report consumer opinions of their own health insurance plans to be less harsh than of health insurance plans in general and suggest that the discrepancy is due to negative media coverage of private health insurance and managed care.[76]

In any event, public support for consumer protection in healthcare is high.[77] Even after the events of September 11, 2001, Americans surveyed identified healthcare as a critical issue for the nation, just behind terrorism and national security.[78] Americans also identified healthcare as a critical personal issue, as they are more worried about healthcare costs than losing their job, paying their rent or mortgage, losing money in the stock market, or being a victim of a terrorist attack.[79] Notwithstanding the growing consensus for

reform,[80] support declines when consequences such as cost or employers dropping coverage are raised.[81]

III. Is the Health Insurance System Failing in the Ways These Films Suggest?

Scholars of law and popular culture have long argued that "popular culture mirrors, often in an exaggerated and caricatured form, actual popular attitudes and beliefs about the institutions and characters that it describes."[82] The harsh tone of these films certainly reflects the critical and concerned attitude of the public. The impact of these films[83] and their resonance with consumers' concerns has not gone unnoticed by politicians[84] or by the private health insurance industry itself.[85] These films also articulate certain common beliefs about private health insurance and its reliance on the strategies of managed care. At least in the case of *John Q*, there is evidence that the public believes that the film accurately reflects the reality of modern private health insurance for workers and their families.[86] Is the system really failing in the ways these films suggest?

A. The Uninsured and Access to Care

All three films suggest that people without insurance are routinely denied care—even life-saving care. In *The Rainmaker*, Baylor laments the "obscene" fate of Donny Ray, denied a life-saving operation and left to die for lack of a legitimate insurance policy. Although *John Q* focuses on the impact of underinsurance, the treatment of Mikey as a "cash account" requiring a sizeable down payment prior to receiving care, coupled with the intern's commentary on what the uninsured can expect in the emergency room, make clear that the uninsured who cannot afford to pay cannot expect to receive necessary care. In *Critical Care*, Dr. Butz argues that the uninsured "rowdy kid[s]" should not get any service, including healthcare, for which they cannot pay.[87]

It is well-documented that people without insurance receive less care, delayed care, and suffer worse outcomes than people with insurance.[88] Although health insurance is neither necessary nor sufficient to receive healthcare, "[h]ealth insurance makes a difference in when and if people get necessary medical care, where they get their care, and ultimately, how healthy people are."[89] People without insurance coverage or the ability to pay are three times as likely to forgo a necessary doctor visit, prescription, or medical test or treatment,[90] three to four times more likely to "experience problems getting needed medical care, even for serious condi-

tions,"[91] and three times as likely to have a medical need that goes unmet.[92] Unfortunately, this is true even for children like Donny Ray and Mikey, as children without insurance are six times as likely to have gone without necessary healthcare, four times more likely to experience a delay in care, and up to forty percent less likely to receive medical attention even for a serious injury.[93] Indeed, a third of uninsured children did not see a doctor in the past year.[94]

As suggested by the discussion of Mikey's condition in *John Q*, the delay and denial of treatment can lead to more serious illness and worse health outcomes for the uninsured.[95] Indeed, people without insurance are more likely to experience avoidable hospitalizations and die during hospitalizations,[96] and uninsured cancer patients die sooner than those with insurance, largely because of delayed diagnosis.[97]

Nor are these disparities limited to preventative or non-urgent care, as the emergency room intern in *John Q* suggests. Nonetheless, the intern's characterization of the treatment of the uninsured in the emergency room, notwithstanding the hospitals' legal duty—"if you don't have any money, you get a Band-Aid, a foot in the ass, and you're out the door"[98]—appears unnecessarily bleak. Indeed, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA)[99] in 1986 to avoid such a result.[100] EMTALA requires that a patient who arrives at the emergency room of a hospital that participates in the Medicaid program be provided with a medical screening and stabilization of any emergency medical condition, regardless of ability to pay.[101] Thus, if the intern's hypothetical patient arrived at the emergency room with an emergency medical condition, the hospital would have a duty to screen the patient and to stabilize any known emergency medical condition prior to kicking him "out the door" through discharge or transfer.[102]

The depiction of Mikey's treatment in *John Q* appears to be a more realistic example of the impact of nonexistent or insufficient insurance. Consistent with the mandates of EMTALA, Mikey was diagnosed upon arrival at the emergency room, and his condition was stabilized to the extent possible. As Mikey's treatment suggests, however, EMTALA does not require the hospital to provide complete or continuous care beyond stabilization of the immediate emergency condition.[103] Nor does it eliminate disparities in the level or amount of services that patients receive in emergency rooms for urgent conditions. For example, the Institute of Medicine's recent review of the literature revealed that people without insurance who experience traumatic injuries are "less likely to be admitted to the hospital, receive fewer services when admitted, and are more likely to die than insured trauma victims."[104]

As also dramatized in these films, people without insurance do not regularly receive healthcare on a no- or low-cost basis.[105] Most people without insurance pay for healthcare out-of-pocket, with a credit card, or on a payment schedule.[106] Medical care devastates the financial health of many families without insurance.[107] This is particularly disturbing in light of the evidence that people without insurance may be charged a higher price for the same services and medicines than people with private insurance.[108]

Although *John Q* suggests an unnecessarily stark outcome for the uninsured in the emergency room, the overall portrayal of the plight of the uninsured in each of these films does have significant factual support in light of the strong and well-documented link between lack of coverage and lack of access to care.

B. The Effect of Reimbursement Arrangements on Treatment Decisions

For patients who have insurance, *Critical Care* and *John Q* suggest that managed care reimbursement arrangements distort their doctors' professional and medical judgment. *Critical Care* makes the case most overtly, starting with its tag line: "At Memorial Hospital, no one ever dies . . . Until their insurance runs out."[109] Traditionally-insured patients, such as Mr. Potter, are subject to unnecessary and futile care for the sake of the insurance reimbursement. In contrast, those with managed care receive only the care that will be reimbursed, and not the type of care that doctors are financially rewarded for withholding. These are the patients that Dr. Hofsteader's protégées seems to have in mind as "[those] we chose not to maintain."[110]

John Q also plays upon the theme of the perverse and distorting effect of reimbursement; focusing on the financial incentives for healthcare providers in a managed care setting to provide less, rather than more, care for their managed care patients.[111] Early on, a nurse tells the Archibalds that Mikey's condition wasn't caught sooner because "HMOs pay the doctors not to test. That's how they keep costs down,"[112] a theme echoed in the discussion about managed care among the hostages. Although the narrative stops short of actually asserting that any tests were denied on this basis, or even that earlier testing would have made a difference in Mikey's case, the corrupting effect of financial incentives for physicians to provide less care is invoked by sympathetic characters throughout the film.

The problem of inappropriate or excessive care dramatized in *Critical Care* was identified as a problem under private fee-for-service

indemnity plans.[113] As discussed, unrestricted fee-for-service insurance is increasingly rare outside of the federal Medicare program, and virtually all private health insurance incorporates some aspect of managed care.[114] Thus, in the context of these films, the problem of "too much care" under fee-for-service plans functions mainly as a foil to the presumed problem of "too little care" under modern private health insurance plans.[115]

There is considerable information about the types of financial incentives used by managed care to reduce the use of healthcare services, as well as the conflicts of interest they create for physicians.[116] As noted by Professor Marc Rodwin in his 1993 book, *Medicine, Money and Morals: Physician's Conflicts of Interest*, there is significantly less information about whether these incentives actually affect the clinical decisions of physicians.[117] Some data indicate, however, that financial incentives may affect physicians' decisions to provide certain types of care and perhaps even information about certain types of care. As noted by Professor Rodwin, a 1989 study published in the *New England Journal of Medicine* found that some, but not all, types of financial incentives influenced the behavior of physicians toward patients. Specifically, it found "no relationship between distribution of risk-sharing bonuses and physicians' referral decisions, . . . [b]ut paying physicians by capitation led to lower rates of hospitalization, and placing physicians at financial risk was associated with lower rates of outpatient visits."[118]

Since Professor Rodwin's work was published, at least one additional study has found that financial incentives may affect physicians' decisions to provide certain types of care, to the detriment of patients.[119] In addition, a recent national survey of physicians found that almost a third reported that they did not tell their patients about a useful treatment because they believed the patient's insurance would not cover it.[120] Physicians who had a financial stake in the profits of the managed care plan were more likely to withhold treatment option information.[121]

The evidence, however, is far from conclusive. There is a dearth of more recent studies focusing on specific and recent managed care organizations, management strategies, reimbursement arrangements, and their influence, if any on the clinical judgments of physicians. Nor is it clear that physicians actually withhold medically necessary or appropriate care in response to such arrangements. Indeed, there is significant evidence that physicians have employed deception, both currently and in the past, to resist the influence of reimbursement arrangements on their clinical decisions.[122]

Despite the paucity of direct and timely evidence, many consumers, physicians, and managed care executives believe that financial incentives affect physicians' decisions to provide certain types of care.[123] Consumers have claimed that reimbursement arrangements distort physician's clinical judgment to the detriment of patients for over a decade, although with little success.[124] Physicians also remain concerned, as noted in a recent article in the *New England Journal of Medicine*: "[e]ven within the medical profession, prominent voices have warned that physicians cannot be trusted if they are paid more to do less."[125]

Thus, *Critical Care* and *John Q* draw attention to the widely-held fear that reimbursement arrangements distort treatment decisions to the detriment of patients, a belief that is suggested, although not clearly supported, by the available evidence.

C. The Erosion of Employment-Based Coverage

John Q focuses on the nature and consequences of the erosion of employment-based health insurance coverage.[126] John, with fifteen years of experience as a heavy machine operator, no longer has insurance that will cover his son's life-saving transplant because of his employer's switch to a cheaper HMO and his drop to part-time status. *John Q's* depiction of the erosion of employment-based health insurance is troublingly accurate, as "[w]orkers and their dependents are increasingly at risk of being uninsured, inadequately insured, or lacking in choices among health plans."[127] Like John, most Americans get their health insurance through their employment. In 2001, 62.6% of workers and their families were covered by employer-sponsored health plans.[128] As John's experience dramatizes, however, employment does not guarantee coverage, adequate or otherwise. Employment-based coverage is strongly associated with employer size and level of wage, with low-wage, part-time, or small-employer workers most likely to lack coverage.[129] Today, nearly one in five workers is uninsured,[130] and eighty percent of the uninsured come from working families.[131] Further, the number of workers without insurance is growing.[132]

As suggested in *John Q*, one of the reasons for the erosion of employment-based insurance is the increasing cost of coverage for employers and to employees. In response to the powerful backlash against the cost-controlling strategies of managed care, many employers moved away from the more restrictive managed care plan features and toward features that offered employees more choice.[133] As a result of this move and other factors, group health insurance premiums began to rise again in the late 1990s and have risen sharply since 2000.[134] This trend is also likely to continue, as premiums are expected to rise to even higher rates in 2004.[135]

Faced with spiraling costs, employers are increasingly likely to pass on more of the costs to their employees. Indeed, the amount the employees pay for employer-sponsored health benefits has risen significantly since 2001 and is expected to rise up to 24.2% over 2003.[136] Available data suggest that an increasing number of workers will forgo coverage as the costs continue to rise.[137]

As the actions of John's fictionalized employer suggest, employers are also offering fewer benefits, often to fewer employees, trying to control costs by raising annual deductibles and specific co-payments, limiting benefits, as well as limiting or eliminating coverage for part-time or low-wage workers.[138] Recently, there have been reports in the press that employers are cutting health insurance benefits for employee spouses and children, or offering incentives to get families out of their health plans.[139] Although not raised by these films, an employer's ability to reduce or eliminate health insurance benefits based on protected characteristics such as race, sex,[140] age,[141] and disability[142] are limited by federal civil rights law. The Employee Retirement Income Security Act of 1974[143] (ERISA) also prohibits an employer from terminating an employee for the purpose of interfering with the worker's protected rights to benefits under the terms of its health insurance plan.[144]

Notwithstanding these legal limitations, the trend toward shrinking benefits is likely to continue.[145] According to a 2002 study by the Kaiser Family Foundation, employees experienced less, rather than more, benefits in 2002 for the first time in four years.[146] As a result, workers like John who manage to retain coverage may find themselves underinsured.[147] Indeed, many workers have even more limited benefits than John. Consider, for example the emergence of so-called "limited benefit" plans offered for under $10 per week but with a benefit *cap*—not deductible—of $1,000. According to a recent article in *The Wall Street Journal*, about 750,000 workers and their family members at companies such as McDonald's and Wal-Mart are already covered under such plans.[148]

Asking workers to pay more while many are receiving less creates conflict, particularly as employees do not feel responsible for higher healthcare costs.[149] A recent poll revealed that fewer than half of the respondent employees believe that employers are unable to absorb the increases or that it is fair for employers to ask employees to pay more for health insurance.[150] Increases in employee contributions to health benefits sparked the strike at General Electric (GE) in January of 2003, the first national strike against GE in thirty years.[151] Thousands of unionized GE workers protested GE's increases in health insurance co-payments for emergency room

visits, prescription drugs, specialists, and hospital stays—reported to cost the average employee as much as $400 per year.[152] As one reporter noted:

> This is the first time in more than three decades that GE workers have felt passionate enough about any issue to stage a national strike, one that spread to 48 locations in 23 states, affecting plants that make everything from consumer products to jet engines. The catalyzing issue, in this case, had nothing to do with wages, job cuts, or factory safety. It had to do with fast rising health costs—and who was going to pay for them.[153]

While the narrative of *John Q* effectively calls attention to the erosion of employment-based insurance coverage, it obscures the availability of important but limited protections for workers and their families without adequate health insurance. For example, if John had lost his health insurance benefits as a result of the reduction in hours or lost his job entirely, he probably would be eligible to continue his health insurance coverage for eighteen months at the group rate under the federal Consolidated Omnibus Reconciliation Act of 1985 (COBRA).[154] Continuation coverage could not be denied on the basis of Mikey's health,[155] but John would have to pay the entire premium plus a small administrative fee.[156] Once John exhausted his COBRA extension period, and assuming that other conditions were met,[157] he could be eligible to purchase an individual policy pursuant to the Health Insurance Portability and Accessibility Act (HIPAA).[158] The individual coverage could not exclude pre-existing conditions such as Mikey's heart condition, and the policy would be guaranteed renewable.[159] Unfortunately, the cost could be prohibitive under this option, in that HIPAA does not limit the premium that the offering insurer may charge.[160]

In addition, the treatment of John's application for and denial of coverage for Mikey under public programs, specifically Medicaid,[161] appears misleading. Medicaid is a public program funded jointly by the federal and state governments to provide coverage to the poorest and most vulnerable Americans, including 24 million children.[162] Based on the limited facts provided by the film,[163] it is unclear if Mikey would be eligible for Medicaid coverage in Illinois, which currently provides coverage for children between the ages of six and nineteen at an income level of $19,258.[164]

More likely, Mikey would be eligible for his state's Children's Health Insurance Program (CHIP), a program that expands coverage to millions of additional children whose parents earn too much

to quality for Medicaid yet too little to buy private coverage.[165] Illinois's CHIP program, KidCare, covers children in families at 200% of the federal poverty level, or $30,516 for a family of three in 2003.[166] KidCare would also be available to reimburse John for the premiums he pays for Mikey's coverage, and to cover services that his employer-sponsored plan does not cover.[167]

Thus, *John Q* effectively calls attention to the erosion of employment-based insurance coverage, a disturbing reality for an increasing number of workers and their families. It obscures, however, several significant but limited restrictions on an employer's ability to limit benefits, as well as the existence of private and public coverage options.

IV. The Dissolving Critique: Retreating Into Private, Individualistic Solutions

Beyond their value as entertainment, why should we care about the images presented in these films? To paraphrase Professor Michael Asimow, these films can teach us what the insurance company does and what is wrong with health insurance and managed care institutions.[168] They can also teach us how health insurance and managed care arrangements affect consumers and their families. Indeed, we would expect that images of health insurance and managed care companies would "reflec[t] the already existing perception of [these arrangements] even as it helps to model and reinforce [them]."[169] Despite inaccuracies and omissions, which tend to capitalize on public mistrust and misperceptions,[170] the premises raised by the films have significant factual support. There is a link between lack of coverage and lack of access to care; reimbursement arrangements may distort treatment decisions, and certainly are believed to do so; and workers and their families are losing adequate health coverage. Moreover, they tell an important symbolic or emotional truth about the gross disparities between the treatment of the uninsured and the insured, even though the specifics of each of the stories may not be complete or factually true. As noted by one commentator on the factual accuracy of *John Q*:

> The heart transplant is just the narrative tool that has been used to tell a deeper story. . . I think this is a film about disparities in care, and I suspect that the vast majority of people who see the film are, subconsciously, going to be reacting to it on the level of disparities in care, and not on the level of, is this literally, technically correct about heart transplantation.[171]

In addition to their ability to educate and move audiences, these films provide a window into the public perception of the current crisis in health coverage and healthcare and what we plan to do about it. If these films present a strong critique of the current system, what can we learn from the solutions, if any, that they offer?

A. The Dissolving Critique: Three Private, Individualistic Solutions

These films capture the intensity of the managed care backlash at its height, and dramatize certain truths—symbolic or emotional, if not always literal—about the consumer experience of managed care. A close reading reveals that despite their passionately critical tone, these films actually put forward solutions that are highly individualist and conservative, rather than inclusive and systemic. Although each film appears to be a daring and defiant attack on the healthcare system and its institutions, in reality the films do not threaten the status quo in any meaningful way. Instead, the resolution of each of the narratives comes about through the actions of one individual—one good doctor, one good attorney taking one good case, and, most disturbingly, one good father with a gun—and resolves the situation of one patient.

The climax of *Critical Care* is the guardianship hearing in which Dr. Ernst decides to protect his patient instead of his professional prestige. Watching each of the self-serving participants in the "care" of Mr. Potter denounced in turn is satisfying, and we are relieved when Dr. Ernst is able to resolve the legal dispute and take charge of Mr. Potter's care. Despite the lingering presence of Dr. Butz and his avaricious philosophy, the last scene makes clear that Dr. Ernst will go on to care for and love his patients.

What will be the fate, however, of patients without a Dr. Ernst? Instead of challenging a system that encourages too much care for the overinsured, too little for the underinsured, and none for the uninsured, the answer is for a good doctor to resist the powerful financial and professional incentives to provide a level of care other than that medically appropriate for the patient. Although we can be gratified by Dr. Ernst's transformation, we should still be deeply afraid of being admitted to Hope Memorial, at least when he is not on call.

Unlike the ray of hope offered in the form of caring individuals such as Nurse Stella and Dr. Ernst, everybody loses in *The Rainmaker*. Baylor wins the Black's case, but Donny Ray is dead and Great Benefit's executives escape with the "pot of gold." The legal system, or more

specifically private, individual litigation against Great Benefit, is not able to bring justice to the Blacks. In fact, the legal system is seen by Baylor as so corrupting that he retires from the practice of law rather than risk losing his soul for another legal victory. The idea of meaningful reform beyond the tragedy of Donny Ray is floated briefly by Great Benefit at the end of the trial, but only as a scare tactic.[172] In the end, the poor of Memphis are no longer the prey of Great Benefit, but they are no more able to afford health insurance than they were before the lawsuit.

Five years after *The Rainmaker*, *John Q* shows us an even bleaker world, in which the underinsured are denied life-saving care, and left without any legal remedy. As the tag line suggests, violence, or the threat of violence, is the only alternative: "Give a father no options and you leave him no choice."[173] Despite John's proclamation of "Free health care for everyone!," he makes clear that he is not asking for "charity"—only a single exception to the down payment requirement to allow him more time to pay the entire cost. There is no meaningful inquiry into the dramatically increasing costs of healthcare, or critique of a system of private insurance that links adequate coverage to employer's economic choices and employees' full-time employment. Certain scenes, such as the speech of one of John's co-workers to the media, do suggest such questions:

> This whole thing . . . it all could have been avoided so incredibly easy. I mean, none of this had to happen. If John had just been a friggin' millionaire, right? Or if his last name was Rockefeller. But y'know John don't get it. He don't understand that what we hold dear in the country isn't values, it's value that's important. . . . There's a lot of people out there—a lot of people here—who don't have $250,000 in their billfold, but to shame a man like that and back him into a corner. Seems to me that something is out of whack, not someone. . . . But what do I know . . . I'm a factory worker.

Although this scene can be read as a critique of a system in which only great disparities in wealth lead to great disparities in care, its potential force is blunted by the individualistic and melodramatic tone of the end of the film. Despite suggestive scenes such as this one and the jumbled montage of commentators toward the end of the film, we are left with the sense that rather than working for meaningful reform, we are all, like John, "waiting for an act of God."[174]

The first of the three films released, *Critical Care*, comes closest to suggesting the possibility of real change. Perhaps this is due in part because it effectively and powerfully plays upon the author's perspective both as a respiratory therapist in intensive care units and as a lawyer to fashion its critique and its solution.[175] Dr. Ernst's transformation occurs in time to rescue Mr. Potter from further futile and invasive treatment, and is portrayed as a permanent change in the way Dr. Ernst views himself as a doctor. Near the end of the film, Dr. Ernst is able to withstand Nurse Stella's test of his newfound resolve with both his compassion and sense of humor intact:

> *Nurse Stella:* Doesn't really change anything, you know. This patient will be gone when you come back tomorrow but there'll be a new patient in his place and everything else will be the same. Disease, injury, old age, all the same old problems will be here. Hosftader, Butz, it'll all be the same.
>
> *Dr. Ernst:* No it won't.
>
> *Nurse Stella:* No?
>
> *Dr. Ernst:* How could it? Tomorrow is the start of National Pickle Week.

This scene also shows that Dr. Ernst is not alone—he joins the ranks of providers such as Nurse Stella, who work secretly and perhaps outside the "system" in terms of the rules of the profession and even the law, to ease the suffering of patients.[176] Thus, although Dr. Ernst's transformation is private and individual, it does underscore the idea that one individual can make a difference in the lives of others, and that change can happen one person at a time.

Notwithstanding this interpretation of *Critical Care*, these films raise serious questions about our health insurance and healthcare arrangements on a systemic level, but ultimately retreat into individualistic and deeply conservative solutions. Even *As Good As It Gets* neatly resolves its single anti-HMO scene[177] with a private, individualist solution—all medical expenses, including house calls by a kindly, expert physician, will be paid by a wealthy friend. Moreover, *The Rainmaker* and *John Q* can be read as suggesting that the problem is a flaw in the system, rather than a flawed system. In *The Rainmaker*, Great Benefit is portrayed as so thoroughly and irredeemably corrupt that the narrative never engages more difficult questions, such as why must so many poor families go without af-

fordable health insurance and how can a society provide adequate healthcare for all?[178]

Similarly, a heartless hospital administrator appears to create, and ultimately resolve, the problem in *John Q;* no blame is laid on the erosion of employment-based health insurance or the potentially bankrupting cost of life-saving care.[179] This does not resolve the larger questions raised by the narrative, such as: Who should pay for the healthcare? How should we prioritize limited resources? What alternatives exist to an employment-linked, market-based system?[180] The narrative also implicitly raises questions about the sufficiency of our public healthcare programs, as well as the efficacy of existing federal legislative initiatives, which are left unexplored. Instead of following through on the large, systemic issues they raise, the resolution of each of the narratives comes about through the actions of one individual—one good doctor, one good attorney taking one good case, and, most disturbingly, one good father with a gun—and resolves the situation of one patient.

B. A Similar Shift in Health Insurance: The New Consumer-Directed Health Plans

The "dissolving critique" of these films is significant because it resonates with similar shifts in current healthcare policy, evidenced by the turn toward consumer-driven health plans. Since the first of these films was released in 1997, healthcare costs have again risen dramatically, and "we are back to health care inflation with a vengeance."[181] According to the federal government, healthcare spending will more than double in the next ten years—to approximately $3.1 trillion in 2012—outpacing the rate of economic expansion.[182] At the same time, we are facing a growing crisis of uninsurance: 41.2 million Americans were uninsured for an entire year in 2001,[183] and 75 million Americans were uninsured for at least three months during 2001–2002.[184] Despite public programs, such as Medicare, Medicaid, and CHIP, the ranks of the uninsured are increasing by a million a year—faster than the rate of overall population growth.[185]

As suggested by *John Q,* the employers' role as major purchasers of group health benefits places them in a unique position to influence developments in health coverage and care for the majority of covered Americans.[186] In the early 1990s, employers turned to managed care to control costs, but retreated from its most restrictive practices in the face of a powerful consumer backlash.[187] Today, it appears that employers are turning toward consumer-driven health plans.[188]

The term "consumer-driven health plan" describes a variety of different approaches to providing employee health benefits that share two common themes: the employer makes a fixed, rather than variable, dollar contribution toward the employee's health benefits; and the consumer assumes a greater degree of choice and risk in choosing and paying for healthcare.[189] For example, under a "defined contribution" approach, instead of offering a specific health insurance plan or a choice of plans for a set annual premium, an employer provides a specific contribution that the employee can use to purchase the plan of his choice, either from a menu of options provided by the employer, or, in its most pure form, from the Yellow Pages.[190] Any shortfall between the amount of the employer's defined contribution and the cost of the chosen health plan is borne by the employee.

Another emerging approach is the combination of a high-deductible catastrophic health insurance policy—typically $1,500 or more for an individual—with some form of tax-exempt employee spending account that the consumer can use to satisfy all or part of the deductible.[191] It is unknown whether consumer-driven plans can control costs for employers and empower consumers to make better and more efficient choices as claimed, and initial consumer response to such plans is mixed.[192] Notwithstanding some skepticism, many employers report that they will use more consumer-oriented strategies in healthcare benefits in the coming years.[193]

Consumer-driven health plans tout individual choice and freedom as the solution to a variety of problems with the current system of health coverage and care. In this context, "choice" also includes individual responsibility to make the right choices in terms of price and quality and the individual obligation to bear the consequences of such choices. It remains to be seen whether consumer-driven plans will enable individual consumers to make better or more appropriate choices and whether "choice" as conceived will lead to better financial or health outcomes for consumers.[194] Moreover, concern that consumer-driven plans will not address systemic issues such as the increasingly high cost of healthcare[195] and the growing crisis of uninsurance and underinsurance,[196] or whether the plans will disproportionately disadvantage the chronically ill, remain to be addressed.[197]

Much like how the films raise the critical issues but allow the dramatic tension to dissipate into private and individualistic resolutions, the current healthcare crisis raises fundamental and systemic issues that are simply not addressed by private, nonsystemic options, such as emerging consumer-driven health plans. How do you

protect yourself as a consumer in the current healthcare system? The films suggest you should have a doctor like Werner Ernst, a lawyer like Rudy Baylor, or a parent like John Archibald. Similarly, the shift toward consumer-directed health plans suggests you should simply make better choices.

C. An Opportunity for Hollywood, Policymakers, and Consumers

Faced once again with a healthcare crisis, the retreat into private, individual solutions in film and in real life is a missed opportunity for Hollywood, policymakers, and healthcare consumers.

Films can play an important role in the development of healthcare policy because of their potential to inform and educate the public.[198] At the same time, films are designed to profitably entertain. The "dissolving critique" can be seen as an expression of the commercial function of these films because the personal and individualistic endings are consistent with our culturally-preferred storytelling mode of entertainment. The types of simplistic, unlikely, or even impossible solutions portrayed also speak to the fantasy needs of the audience: We want to imagine that, like the protagonists, we can effect a direct and effective solution to the healthcare crisis with common sense or ordinary courage, if only for our loved ones. Like John, we want to believe we can "do something." Indeed, *John Q* can be seen as a dark fantasy of director Nick Cassavetes himself, as he dedicated *John Q* to his daughter Sasha, who suffered from congestive heart disease and was a candidate for a heart transplant at the time of the film.[199]

Given that mainstream films are commercial products, is it fair to ask them to propose and defend a systemic, inclusive solution to the healthcare crisis?[200] As *Critical Care*, *The Rainmaker*, *John Q*, and even *As Good As It Gets* illustrate, it is easier to criticize health insurers or managed care organizations than to propose real solutions to the problems raised, particularly while telling an entertaining story.[201] Films offer a unique opportunity, however, to imagine and explore fantasies, including different and more fundamental changes to our healthcare system. There is also a rich and powerful history of collective concern from which to draw. Despite the powerful influence of conservative ideals, such as rugged individualism and self-help in American social welfare policy,[202] health insurance in the United States began as a social enterprise, and the concept of health insurance as a collective concern continues to resonate with the public.[203] As Deborah Stone has written:

> Insurance is one of the main mechanisms by which modern societies define problems as amenable to human agency and collective action. Insurance is not only an institution of repair, but also of social progress. Insurance is a major way that communities can make life better for their individual members. As a mechanism for providing security and fostering collaboration, insurance offers polities the moral opportunity to strengthen the sense of community and collective well-being.[204]

Despite erosion of the social enterprise model in healthcare policy,[205] many continue to believe that, as John states in *John Q*, "[w]hen people are sick they deserve a little help." The social, collective roots of health insurance can be seen in the campaign for universal health coverage in the United States. The campaign has been waged for nearly a century[206] and was exemplified recently in a proposal published by the *Journal of the American Medical Association* and endorsed by nearly 8,000 doctors, urging universal health insurance coverage though a single-payor, government-financed system.[207]

As discussed, there is a growing consensus for change, even radical change, to our healthcare system that echoes these social and collective roots.[208] Most Americans believe in the principle of equal access to healthcare for the rich and the poor, with the healthier and wealthier subsidizing the cost of care for the sicker and poorer.[209] Many support a systemic solution. Consider a recent poll in which sixty-nine percent of respondents agreed that "the government should do whatever is necessary, whatever it costs in taxes, to see that *everyone* gets the medical they need."[210] Of course, significant areas of disagreement remain, particularly on issues of how to pay for expanded coverage,[211] but taken as a whole, *Critical Care*, *The Rainmaker*, and *John Q* are not on the leading edge of public opinion. Instead, they appear to lag behind and become less daring in their solutions over time.

Overall, the "dissolving critique" of these films is a missed opportunity to reflect and reinforce public opinion regarding the healthcare crisis and to imagine inclusive solutions. Even though personal transformations like that of Dr. Ernst hold promise for systemic change, and incremental changes like John's rampage or the Blacks' lawsuit bring relief to a few, they do not address the larger, systemic problems. Incremental, private, and individualistic solutions, such as consumer-directed health plans, appear similarly inadequate. Hopefully, these three films signal a new critical focus on health

insurance and healthcare in contemporary mainstream film that will reflect and reinforce public opinion rather than retreating from it and, therefore, spark and support discussion of more inclusive and systemic solutions to the worsening healthcare crisis.

V. Conclusion

It is not surprising that images of health insurance and managed care emerged in popular film in the late 1990s, given the intensity of the managed care backlash and the inherently dramatic nature of narratives that force us "to contemplate our physical and economic vulnerability, even our death."[212] Despite their factual limitations, these images have significant factual support: There is a link between lack of coverage and lack of access to care; reimbursement arrangements may distort treatment decisions, and certainly are believed to do so; and workers and their families are losing adequate health coverage. Although these films raise serious questions about our private health insurance and healthcare arrangements on a systemic level, they ultimately retreat into individualistic and deeply conservative solutions. How do you protect yourself as a consumer in the current healthcare system? Have a doctor like Werner Ernst, a lawyer like Rudy Baylor, or a parent like John Archibald. Or, in light of the predicted shift toward consumer-directed health plans, simply make better choices.

This is a missed opportunity for Hollywood, popular culture, and public debate. Most Americans believe in the principle of equal access to healthcare for the rich and the poor, with the healthier and wealthier subsidizing the cost of care for the sicker and poorer.[213] We do not agree, however, on how to make that principle a reality. Instead of exploring the difficult issues involved in making our principles a reality, we appear to be retreating into private and individualist solutions in our films and our healthcare policy. Of course, *Critical Care*, *The Rainmaker*, and *John Q* are the first three mainstream films to focus on health insurance and healthcare arrangements. They mirror our frustrations and fears about our healthcare system and reflect its failings, but show us how one person can survive the system rather than how we can try to reform it. Perhaps they are the beginning of a new critical focus on health insurance and healthcare in contemporary mainstream film that could use the power of the personal narrative to push beyond a dissolving critique and toward real solutions, in both our movies and our lives.

Endnotes

[1] The Rainmaker (Paramount Pictures 1997). Deck Shifflet, Rudy Baylor's "paralawyer," makes this gleeful exclamation upon learning that Baylor has stumbled into a case against the health insurer Great Benefit.

[2] A health maintenance organization (HMO) is a common type of managed care organization designed to provide healthcare, including preventative care, to its enrolled consumers. Peter R. Kongstvedt, MD, Managed Care: What It Is and How It Works 43-49 (2d ed. 2002) (describing traditional HMOs).

[3] As Good As It Gets (Columbia TriStar Pictures 1997).

[4] *See, e.g.,* Clark C. Havighurst, *The Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 Ind. L. Rev. 395, 395 (2001) (noting audience response).

[5] According to The Numbers, an internet website dedicated to gathering and reporting box office data, *As Good As it Gets* grossed $147,666,088.00. *See* The Numbers, *at* www.the-numbers.com/movies/1997/ASGOD.html (last visited Feb. 18, 2004).

[6] President Bill Clinton, Address at the Holiday Senior Park Center (Feb. 20, 1998), 1998 WL 68683 (discussing the subject of Patient's Bill of Rights).

[7] Unless otherwise stated, "health insurance" refers to private health insurance coverage, rather than public programs such as Medicare or Medicaid.

[8] Critical Care (Live Film & Mediaworks, Inc. 1997).

[9] The Rainmaker (Paramount Pictures 1997).

[10] John Q (New Line Cinema 2002).

[11] *Critical Care* was generally released to the U.S. market on October 31, 1997. The Internet Movie Database, *Release dates for Critical Care*, *at* www.imdb.com/title/tt0118901/releaseinfo (last visited Mar. 29, 2004). *The Rainmaker* was generally released to the U.S. market on November 21, 1997. The Internet Movie Datebase, *Release date for The Rainmaker*, *at* www.imdb.com/title/tt0119978/releaseinfo (last visited Mar. 29, 2004). *As Good As it Gets* was generally released to the U.S. market on December 25, 1997. The Internet Movie Datebase, *Release date for As Good As It Gets*, *at* www.imdb.com/title/tt0119822/releaseinfo (last visited Mar. 29, 2004).

[12] *John Q* was generally released to the U.S. market on February 15, 2002. The Internet Movie Datebase, *Release date for John Q, at* www.imdb.com/title/tt0251160/releaseinfo (last visited Mar. 25, 2004).

[13] There have, of course, been many films prominently featuring life insurance as a plot device, metaphor or both, although rarely is the life insurance industry itself cast as the villain. Such films generally involve a scheme by the beneficiary(ies) to misrepresent, cause, or fake a death in order to obtain life insurance proceeds or to assume a new identity. *See, e.g.*, Double Indemnity (Paramount Pictures 1944); *see also* Thomas Morawetz, *Insurance: How It Matters As Psychological Fact and Political Metaphor,* 6 Conn. Ins. L.J. 1, 3-5 (1999-2000) (discussing rare use of insurance as a plot device or metaphor in film and fiction).

[14] Anthony Chase, *Toward a Legal Theory of Popular Culture*, 1986 Wis. L. Rev. 527, 543 (1986). *See also* Michael Asimow & Shannon Mader, Law and Popular Culture: A Course book (forthcoming 2004); Michael Asimow, *Embodiment of Evil: Law Firms in the Movies*, 48 UCLA L. Rev. 1339 (2001) (the structure and content of this article was a major source of inspiration); Michael Asimow, *Bad Lawyers in the Movies*, 24 Nova L. Rev. 533 (2000) (hereinafter Asimow, *Bad Lawyers*); Stacy Caplow, *Still in the Dark:Disappointing Images of Women Lawyers in the Movies*, 20 Women's Rts. L. Rep. 55 (1999).

[15] *Critical Care* was directed by Sidney Lumet for Live Film & Mediaworks, and featured James Spader, Kyra Sedgwick, Helen Mirren, Anne Bancroft, Albert Brooks and Jeffrey Wright. *See* Internet Movie Database, *Critical Care*,

www.imdb.com/title/tt0118901/combined (last visited Mar. 29, 2004). *The Rainmaker* was directed by Francis Ford Coppola for Paramount Pictures, and featured Matt Damon, Claire Danes, Danny DeVito, Jon Voight and Dean Stockwell. *See* The Internet Movie Database, *The Rainmaker*, *at* www.imdb.com/title/tt0119978/combined (last visited Mar. 29, 2004). *John Q* was directed by Nick Cassavetes for New Line Cinema, and featured Denzel Washington, Anne Heche, Robert Duvall, and James Woods. *See* The Internet Movie Databased, *John Q*, *at* www.imdb.com/title/tt0251160/combined (last visited Mar. 29, 2004). According to The Numbers, an Internet Web site dedicated to gathering and reporting box office data, *Critical Care* grossed $220,175; *The Rainmaker*, over $45 million; and *John Q*, over $71 million. *See* The Numbers, *at* www.the-numbers.com/ (last visited Mar. 29, 2004).

[16] Richard Dooling, Critical Care (William Morrow and Company, Inc. 1992).

[17] Critical Care, *supra* note 8. Considering this vision of the future, Nurse Stella imagines a robotic doctor floating in cyberspace. Borrowing a classic line from Walt Kelly's *Pogo*, she remarks, "I have seen the enemy and he is us." *See id.*

[18] *Id.* Nurse Stella consistently acts to ease the suffering of her patients. When one of her patients says that he wants to die rather than go through another round of aggressive treatment or painful maintenance of his severe renal failure as urged by his family, Dr. Hofstader brushes off the patient's clearly expressed wishes as "confusion." Once alone with the patient and sure that he understands the nature and consequences of his decision, she honors his request to discontinue treatment and allows him to die peacefully. *See id.* Although beyond the scope of the Article, this scene reflects another theme of *Critical Care*: Patient choice and dignity at the end of life. *See Id.*

[19] Critical Care, *supra* note 8.

[20] *Id.*

[21] *Id.*

[22] *Id.*

[23] *Id.*

[24] *Id.*

[25] *Id.*

[26] This ending is a departure from the novel, which does not include a guardianship hearing scene and closes with Mr. Potter's heart stopping on its own. Dooling, *supra* note 16, at 248. Also, a state may prohibit appointment of an involved healthcare provider as decisionmaker. *See, e.g.,* 755 Ill. Comp. Stat. Ann. 45/4-10 (West 2003); *see also* Unif. Guardianship & Prot. Proc. Act § 310 (1997) ("[a]n owner, operator, or employee of [a long-term care institution] at which the respondent is receiving care may not be appointed as guardian unless related to the respondent by blood, marriage, or adoption").

[27] Critical Care, *supra* note 8.

[28] John Grisham, The Rainmaker (1995). Several other of John Grisham's books have been made into movies, including *The Firm* (1991), *The Pelican Brief* (1992), *The Client* (1993), *The Chamber* (1994), *A Time To Kill* (1989), *The Gingerbread Man* (1998), *Mickey* (2003), *A Painted House* (2003) (for television), and *Runaway Jury* (2003).

[29] *See, e.g.,* Asimow, *Bad Lawyers, supra* note 14 (ethics); Christopher W. Deering, *Candor Toward the Tribunal: Should An Attorney Sacrifice Truth and Integrity for the Sake of the Client,* 31 Suffolk U. L. Rev. 59, 91 at n. 40 & 41 (1997) (ethics); James R. Elkins, *Troubled Beginnings: Reflections on Becoming a Lawyer,* 26 U. Mem. L. Rev. 1303, 1304 (1996) (professionalism, ethics); Amanda K. Esquibel, *Be Led Not Into Temptation: Ethics Lessons from The Rainmaker,* 26 U. Mem. L. Rev. 1325 (1996) (ethics); Marc Galanter, *The Faces of Mistrust: The Images of Lawyers in Public Opinion, Jokes, and Political Discourse,* 66 U. Cin. L. Rev. 805, 839 (1998) (attorney's roles); Tonja Haddad, *Silver Tongues on the Silver Screen: Legal Ethics in the Movies,* 24 Nova L. Rev. 673 (2000) (ethics); Jeffrey L. Harrison & Sarah E.

Wilson, *Advocacy in Literature: Storytelling, Judicial Opinions, and The Rainmaker,* 26 U. Mem. L. Rev. 1285 (1996) (approaches to literary characterizations); Amy R. Mashburn & Dabney D. Ware, *The Burden of Truth: Reconciling Literary Reality with Professional Mythology,* 26 U. Mem. L. Rev. 1257 (1996) (ethics); Carrie Menkel-Meadow, *Can They Do That? Legal Ethics in Popular Culture: Of Character and Acts,* 48 UCLA L. Rev. 1305 (2001) (ethics); John B. Owens, *Grisham's Legal Tales: A Moral Compass for the Young Lawyer,* 48 UCLA L. Rev. 1431 (2001) (ethics); Nancy B. Rapoport, *Dressed for Excess: How Hollywood Affects the Professional Behavior of Lawyers,* 14 Notre Dame J.L. Ethics & Pub. Pol'y 49 (2000) (ethics); William H. Simon, *Moral Pluck: Legal Ethics in Popular Culture,* 101 Colum. L. Rev. 421 (2001) (ethics); Jeffrey W. Stempel, *Embracing Descent: The Bankruptcy of A Business Paradigm for Conceptualizing and Regulating the Legal Profession,* 27 Fla. St. U.L. Rev. 25, 29 (1999) (ethics).

[30] There have been a few articles, mostly in the insurance literature, discussing the insurance aspects of the novel. *See, e.g.,* Alan I. Widiss, *"Bad Faith" in Fact and Fiction: Ruminations on John Grisham's Tale About Insurance Coverages, Punitive Damages, and the Great Benefit Life Insurance Company,* 26 U. Mem. L. Rev. 1377 (1996); Robert H. Jerry, II, *Health Insurance Coverage for High-Cost Health Care: Reflections on The Rainmaker,* 26 U. Mem. L. Rev. 1347 (1996).

[31] The Rainmaker, *supra* note 9.

[32] *Id.*

[33] *Id.*

[34] *Id.*

[35] *Id.*

[36] *Id.*

[37] John Q, *supra* note 10.

[38] *Id.*

[39] *See* Kongstvedt, *supra* note 2, at 41-43. A PPO is a healthcare provider network comprised of independent healthcare providers who have agreed to provide services at a discounted rate. PPOs are considered less-restrictive than closed networks because they often allow consumers to see a healthcare provider outside of the network at an increased out-of-pocket cost, and/or a specialist without receiving prior approval. *Id.*

[40] John Q, *supra* note 10. He files an appeal with the insurance company, but Ms. Payne informs him that he needed to file an immediate "grievance" to contest the denial of coverage, not a drawn-out "appeal" which relates to an existing claim. *See id.* The needlessly bleak portrayal of the internal grievance process may reflect the public's fear or distrust of the health insurance bureaucracy. Although real, this fear may be misplaced, as a recent study by the Harvard School of Public Health and the RAND Corporation found that the majority of such appeals did not involve life-threatening situations, and in cases involving claims of medical necessity, consumers prevailed more that half of the time. David M. Studdert & Carole Roan Gresenz, *Enrollee Appeals of Preservice Coverage Denials at 2 Health Maintenance Organizations*, 289 J.A.M.A. 864, 866-67 (2003).

[41] John Q, *supra* note 10.

[42] *Id.* When Dr. Turner initially hesitates to treat the gunshot victim in the emergency room, John asks scornfully, "[w]hat the matter, doctor? You want to see an insurance card first?" *See id.*

[43] *Id.*

[44] *Id.*

[45] Critical Care, *supra* note 8.

[46] *See* Kongstvedt, *supra* note 2, at 39-40 (defining traditional indemnity insurance). The history of health insurance, including managed care, has been well-documented. For an overview, see *id;* Paul Starr, The Social Transformation of American Medicine (1982).

[47] *See* KONGSTVEDT, *supra* note 2, at 32-35 (comparing group health benefits with individual health insurance).
[48] CRITICAL CARE, *supra* note 8.
[49] *See, e.g.,* ELEANOR DEARMAN KINNEY, PROTECTING AMERICAN HEALTH CARE CONSUMERS 27-30 (2002).
[50] GARY CLAXTON, THE HENRY J. KAISER FAMILY FOUND., HOW PRIVATE INSURANCE WORKS: A PRIMER 3 (2002), *available at* www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14053 (last visited Mar. 29, 2004).
[51] *See* KINNEY, *supra* note 49, at 27-30.
[52] *See, e.g., id*. at 28.
[53] Jacob S. Hacker & Theodore R. Marmor, *How Not to Think About "Managed Care,"* 32 U. MICH. J.L. REFORM 661, 669 (1999).
[54] Alain C. Enthoven et al., *Consumer Choice and the Managed Care Backlash*, 27 AM. J.L. & MED. 1, 2 (2001); Havighurst, *supra* note 4, at 398.
[55] THE HENRY J. KAISER FAMILY FOUND., TRENDS AND INDICATORS IN THE CHANGING HEALTH CARE MARKETPLACE CHARTBOOK (2002), *available at* www.kff.org/insurance/3161-index.cfm (last visited Mar. 29, 2004) (indicating by 2001, 93% of Americans with health coverage were in managed care plans); THE HENRY J. KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 2001 ANNUAL SURVEY 34 (2001), *available at* www.kff.org/insurance/20010906a-index.cfm (last visited Mar. 29, 2004) [hereinafter THE HENRY J. KAISER FAMILY FOUND., 2001 EMPLOYER HEALTH BENEFITS] (percentage of workers enrolled in conventional health plans decreased from 73% in 1988 to 7% in 2001); KEN MCDONNEL ET AL., EMPLOYEE BENEFIT RESEARCH INSTITUTE, EMPLOYEE BENEFIT RESEARCH INSTITUTE HEALTH BENEFITS DATABOOK (1999) [hereinafter EMPLOYEE BENEFIT RESEARCH INSTITUTE HEALTH BENEFITS DATABOOK] (noting the percentage of insured Americans enrolled in a fee-for-service plan declined from 58.9% in 1992 to 23.6% in 1997 and the percentage of full-time workers with coverage through medium or large employers declined from 98% in 1980 to 27% in 1997).
[56] *See, e.g.,* John K. Iglehart, *Changing Health Insurance Trends*, 347 NEW ENG. J. MED. 956, 957 (2000); Enthoven, *supra* note 54, at 3; AON CONSULTING CORP., AON SPRING 2003 HEALTH CARE TREND SURVEY 1 (2003) (basing the findings on 2003 data, the gap between managed care and indemnity medical trend rate is closing), *at* www.aon.com/about/publications/pdf/issues/healthcaresurvey_29may03.pdf (last visited Mar. 29, 2004).
[57] For a recent and comprehensive analysis of the managed care backlash, see the articles published at 24 J. HEALTH POL., POL'Y & L. 873-1244 (1999) (Health Law Symposium issue).
[58] Enthoven, *supra* note 54, at 3.
[59] Although none of the three films involve coverage under the Medicare program, it provides an interesting contrast. Medicare is a federal program that provides health insurance benefits to 41 million people over the age of 65 who have paid at least forty quarters of payroll taxes, people with disabilities who have received Social Security Disability Income Benefits, and people with end-stage renal disease. *See generally* 42 U.S.C. § 1395c (2004); Ctrs. for Medicaid and Medicare Services, *Medicare Information Resource*, *at* www.cms.hhs.gov/medicare/ (last visited Mar. 28, 2004). Although Medicare beneficiaries can choose to receive their benefits through an HMO as part of the Medicare+Choice program, 89% still receive care under a traditional fee-for-service arrangement. THE HENRY J. KAISER FAMILY FOUND., MEDICARE AT A GLANCE, FACT SHEET (2003), *available at* www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14184 (last visited Mar. 29, 2004).
[60] According to The Kaiser Family Foundation and Health Research Education Trust, only 5% of workers with employer-sponsored coverage were enrolled in conventional, fee-for-service type plans in 2002. THE HENRY J. KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS 2002 ANNUAL SURVEY 4 (2002), *available at* www.kff.org/insurance/3251.pdf (last visited Mar. 29, 2004) [hereinafter THE HENRY J.

KAISER FAMILY FOUND., 2002 EMPLOYER HEALTH BENEFITS]. *See* EMPLOYEE BENEFIT RESEARCH INSTITUTE HEALTH BENEFITS DATABOOK, *supra* note 55 (indicating the percentage of insured Americans enrolled in a fee-for-service plan declined from 58.9% in 1992 to 23.6% in 1997, and the percentage of full-time workers with coverage through medium or large employers declined from 98% in 1980 to 27% in 1997).

[61] *See, e.g.,* CLAXTON, *supra* note 50, at 3, *at* www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14053 (last visited Mar. 29, 2004) ("Although it remains true that HMOs generally are the most tightly managed arrangements and most tightly integrate insurance and the delivery of care, virtually all private health coverage now involves some aspect of managed care.").

[62] *See* Harris Interactive, *Consumer Backlash Against Managed Care and Pharmaceutical Industries—Bottomed Out or in Remission?* HEALTH CARE NEWS, May 29, 2001, at 1, *at* www.harrisinteractive.com/news/newsletters/healthnews/HI_HealthCareNews2001Vol1_iss17.pdf (last visited Mar. 29, 2004) (finding that public perception of the healthcare industry fell dramatically from 1997 to 2001); Harris Interactive, *The Managed Care Paradox*: *Many Dislike Managed Care, Yet They Like Their Own Health Plans*, HEALTH CARE NEWS, Feb. 12, 2001, at 1, *at* www.harrisinteractive.com/news/newsletters/healthnews/HI_HealthCareNews2001Vol1_iss6.pdf (last visited Mar. 29, 2004) [hereinafter Harris Interactive, *The Managed Care Paradox*] ("The last few years have seen a sharp increase in public hostility toward the health insurance and managed care industries."); Havighurst, *supra* note 4, at 398.

[63] Harris Interactive, *Some Good News for the Industry*? HEALTH CARE NEWS, July 12, 2002, at 3, *at* www.harrisinteractive.com/news/newsletters/healthnews/HI_HealthCareNews2002Vol2_Iss15.pdf (last visited Mar. 29, 2004) [hereinafter Harris Interactive, *Some Good News*]; *see* THE HENRY J. KAISER FAMILY FOUND., KAISER PUBLIC OPINION UPDATE: THE PUBLIC MANAGED CARE, AND CONSUMER PROTECTIONS (2001), *available at* www.kff.org/insurance/3177-index.cfm (last visited Mar. 29, 2004) [hereinafter THE HENRY J. KAISER FAMILY FOUND., KAISER PUBLIC OPINION UPDATE].

[64] Harris Interactive, *Some Good News*, *supra* note 63, at 1.

[65] THE HENRY J. KAISER FAMILY FOUND., NATIONAL SURVEY ON CONSUMER EXPERIENCES WITH HEALTH PLANS: SUMMARY OF FINDINGS AND CHART PACK (2000) (people report similar levels of stress for dealing with their health insurance company as for doing their taxes), *available at* www.kff.org/insurance/3025-index.cfm (last visited Mar. 29, 2004) [hereinafter THE HENRY J. KAISER FAMILY FOUND., NATIONAL SURVEY ON CONSUMER EXPERIENCES].

[66] *See* Harris Interactive, *While Managed Care Is Still Unpopular, Hostility has Declined*, HEALTH CARE NEWS, Oct. 21, 2002, at 1, *at* www.harrisinteractive.com/news/newsletters/healthnews/HI_HealthCareNews2002Vol2_Iss20.pdf (last visited Mar. 29, 2004); Harris Interactive, *Some Good News, supra* note 63, at 1; Harris Interactive, *More Evidence that Backlash Against Managed Care has Bottomed Out; Image May Be Improving Slightly*, HEALTH CARE NEWS, July 30, 2001, at 1, *at* www.harrisinteractive.com/news/newsletters/healthnews/HI_HealthCareNews2001Vol1_iss23.pdf (last visited Mar. 29, 2004).

[67] HUMPHREY TAYLOR, THE HARRIS POLL #19: ATTITUDES TO GOVERNMENT REGULATION VARY GREATLY FOR DIFFERENT INDUSTRIES (2003), *at* www.harrisinteractive.com/harris_poll/index.asp?PID=367 (last visited Mar. 29, 2004).

[68] *See* Harris Interactive, *Survey on Trust in Different Industries Finds Reasonably High Trust in Pharmaceuticals, Less Trust in Biotech and High Distrust of Health Insurance and Managed Care*, HEALTH CARE NEWS, Sept. 18, 2001, at 1, *at* www.harrisinteractive.com/news/newsletters/healthnews/HI_HealthCareNews2001Vol1_iss26.pdf (last visited Mar. 29, 2004).

[69] THE HENRY J. KAISER FAMILY FOUND., KAISER PUBLIC OPINION UPDATE, *supra* note 63.

[70] *Id*.

[71] Kenneth E. Thorpe, *Managed Care As Victim or Villain?* 24 J. Health Pol., Pol'y & L. 949, 953-54 (1999) ("nearly three-quarters of Americans believe that the savings generated by managed care, using tools that the public often objects to, are retained by the health plans").

[72] The Henry J. Kaiser Family Found., National Survey on Consumer Experiences, *supra* note 65 (poll results "sugges[t] that the types of issues discussed in the patients' rights debate are grounded in actual patient experiences, not just in anecdotes"). *See* Harris Interactive, *Why Public Opinion on Health Care Issues Changes*, Health Care News, Dec. 12, 2001 at 1-3, *at* www.harrisinteractive.com/news/newsletters/healthnews/HI_HealthCareNews2001Vol1_iss33.pdf (last visited Mar. 29, 2004) (important factors effecting consumer opinion of healthcare issues include: personal experiences, media coverage, advertising and advocacy campaigns, events, physicians, election campaigns, costs, the aging of the population, and the gap between expectations and reality); Employee Benefit Research Institute Health Benefits Databook, *supra* note 55, at 29 ("Thirty percent of Americans form their opinions about managed care based on their own personal experiences, 23% percent rely on what they learn from family and friends, and 20% rely on what they hear or see in the media."). *But see* Harris Interactive, *Most People Continue to Think Well of Their Health Plans*, Health Care News, Feb. 5, 2002, at 2, *at* www.harrisinteractive.com/news/newsletters/healthnews/HI_HealthCareNews2002Vol2_Iss03.pdf (last visited Mar. 29, 2004) [hereinafter Harris Interactive, *Most People Continue to Think*] ("The personal experiences of the public with their own health plans are not nearly as bad as their beliefs about health insurance and managed care, which in many cases come from what they see on TV, in movies, or in magazines and newspapers."); Harris Interactive, *The Managed Care Paradox, supra* note 62, at 1-2 ("We believe that these deteriorating public perceptions of managed care are due to fears that are media-driven or physician-driven, and not experience-driven. Managed care 'horror stories' and word-of-mouth reports may also play a role in creating misperceptions among consumers.").

[73] The Henry J. Kaiser Family Found., National Survey on Consumer Experiences, *supra* note 65. *See* The Henry J. Kaiser Family Found., Kaiser Public Opinion Update, *supra* note 63.

[74] The Henry J. Kaiser Family Found., National Survey on Consumer Experiences, *supra* note 65. *See* J. Bridget Sheehan-Watanabe, Health Rights Hotline When What's Ailing You Isn't Only Your Health, ii-iv (2000) (report on consumer experiences in four California counties from 1997-99 showed that consumers with conditions such as cancer, diabetes, injuries, mental health conditions, musculoskeletal conditions, neurological conditions, and respiratory conditions disproportionately experience problems accessing care), *available at* www.hrh.org/reports/hrh2000.pdf (last visited Mar. 29, 2004).

[75] The Henry J. Kaiser Family Found., National Survey on Consumer Experiences, *supra* note 65.

[76] Harris Interactive, *Most People Continue to Think*, *supra* note 72, at 2; Harris Interactive, *The Managed Care Paradox*, *supra* note 62, at 1-2.

[77] *See* The Henry J. Kaiser Family Found., Kaiser Public Opinion Update, *supra* note 63 ("at least three out of four Americans supporting such laws over time"); Harris Interactive, *Attitudes Toward the United States' Health Care System: Long-Term Trends*, Health Care News, Aug. 21, 2002, at 1, *at* www.harrisinteractive.com/news/newsletters/healthnews/HI_HealthCareNews2002Vol2_Iss17.pdf (last visited Mar. 29, 2004) [hereinafter *Attitudes Toward the United States' Health Care System*] (describing a 2002 poll showing that the prior-documented gaps between the views of the public, physicians, employers, hospital managers, and health plan managers have narrowed, with the level of support for "radical change" similar across these groups). *See also* Taylor, *supra* note 67 (reporting that in a 2002 poll, the two industries most often characterized as needing more

regulation were the managed care industry and the health insurance industry, again ranking just below oil and tobacco industries).

[78] Employee Benefit Research Institute, 2002 Health Confidence Survey (2002), *available at* www.ebri.org/hcs/2002 (last visited Mar. 29, 2004).

[79] The Henry J. Kaiser Family Found, *Health Security Watch, in* Kaiser Health Poll Report (Jan./Feb. 2004 ed.) *available at* www.kff.org/healthpollreport/currentedition/security/index.cfm (last visited Mar. 29, 2004). *See* Press Release, Harris Interactive, Latest National Poll Says Health Care Issues May Influence 40% of Votes in Tuesday's Congressional Election (Nov. 4, 2002), *at* www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=540 (last visited Mar. 29, 2004) (prior to the November 2002 elections, 40% of voters reported that healthcare issues could influence the their votes, with the two most important issues being the expansion of health insurance to lower the number of uninsured, and the total cost of healthcare).

[80] *Attitudes Toward the United States' Health Care System*, *supra* note 77 (a stronger consensus for reform among the various players in the debate appears to be building, as a 2002 poll showed that the prior-documented gaps between the views of the public, physicians, employers, hospital managers, and health plan managers have narrowed, with the level of support for "radical change" similar across these groups).

[81] The Henry J. Kaiser Family Found., Kaiser Public Opinion Update, *supra* note 63 ("Concern about managed care and support for consumer protection proposals remain strong, yet arguments about potential costs and consequences of reforms also continued to resonate with the public.").

[82] Michael Asimow, *Introduction to Papers from UCLA's Law and Popular Culture Seminar*, 9 UCLA Ent. L. Rev. 87, 87 (2001). *See* Paul Joseph, *Law and Popular Culture*, 24 Nova L. Rev. 527, 527 (2000).

[83] For example, notwithstanding critical reviews, *John Q* was ranked number one over the weekend of its release and took in $23.6 million, a record for a President's Day release. Amy Snow Landa, *John Q Desperate: Hollywood Takes on Health Insurance*, Am. Med. News, Mar. 4, 2002, at 1, *available at* www.ama-assn.org/amednews/2002/03/04gvl20304.htm (last visited Mar. 29, 2004). More than 15 million people saw *John Q,* and it had a "ripple effect" throughout the public: while only 6% actually saw it, more than 44% said they had heard of it. Press Release, The Henry J. Kaiser Family Found., *John Q* Goes to Washington: Health Policy Issues in Popular Culture (July 16, 2002), *available at* www.kff.org/entmedia/20020716a-index.cfm (last visited Mar. 29, 2004). *See* Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 Conn. Ins. L.J. 11, 32 (1999-2000) ("The publicity about coverage denials, deaths, suits and plaintiffs' victories stirs public outrage and fuels activist mobilization. Popular culture can vastly amplify widespread media coverage of insurance coverage controversies." (referring to film version of *The Rainmaker*)).

[84] *See* President Bill Clinton, *supra* note 6 (discussing the subject of Patient's Bill of Rights); Senator Edward M. Kennedy, Statement at the Boston Forum on the Patient's Bill of Rights (July 20, 1998), *available at* www.senate.gov/~kennedy/statements/980720.html (last visited Mar. 29, 2004); Donna E. Shalala, Secretary of Heath and Human Services, Address at the Mayo Clinic Medical School Commencement (May 16, 1998), *available at* www.hhs.gov/news/speeches/980516.html (last visited Mar. 29, 2004).

[85] "The day before [*John Q*] opened, the American Ass[ociation] of Health Plans began running full-page ads in Washington, D.C., and Hollywood newspapers declaring that 'the fictional character John Q. has the wrong answer for America's health care cost crisis.'" Landa, *supra* note 83 (noting that the film "struck a raw nerve with managed care executives, who learned four years ago with the release of 'As Good as It Gets' that slamming their industry can play very well with moviegoers"); Press Release, America's Health Insurance Plans, AAHP's 'John Q' Ad Shines Spotlight on Growing Uninsured Crisis (Feb. 14, 2002) *available*

at tinyurl.com/3xkm8 (last visited May 5, 2004) [herinafter AAHP's 'John Q' Ad] (quoting American Association of Health Plans President and CEO Karen Ignagni, "[t]he real villain in this story is rising health care costs, and the terrible toll exacted on millions of Americans who have been priced out of the health care system. It is time to take a hard look at the runaway litigation system and excessive government regulations that have needlessly helped drive health care affordability out of reach for so many Americans.").

[86] A survey conducted by the Henry J. Kaiser Family Foundation found that most people believe that the refusal of coverage in John Q was an accurate reflection of reality. *See* The Henry J. Kaiser Family Found., Response to the Movie *John Q* 1 (2002), *at* www.kaisernetwork.org/health_cast/uploaded_files/John_Q_Survey_Snapshot.pdf (last visited Mar. 29, 2004) (reporting that 42% say they think health insurers refuse to pay for treatments like those in the movie "a lot;" 30%, "sometimes;" 9%, "rarely;" and 2%, "never").

[87] Critical Care, *supra* note 8. Of course, as noted above, Dr. Butz is portrayed as an incompetent buffoon, and the last scene, in which Dr. Ernst does not hesitate to care for the "rowdy" young rollerblader, undercuts Butz's view. Nonetheless, much of the action in the film bears out Butz's descriptions. *See id.*

[88] *See, e.g.,* Institute of Medicine, Care Without Coverage: Too Little, Too Late 1 (2002), *at* www.iom.edu/includes/dbfile.asp?id=4160 (last visited Mar. 29, 2004); Am. College of Physicians, No Health Insurance? It's Enough to Make You Sick: Scientific Research Linking the Lack of Health Coverage to Poor Health 4 (2000), *at* www.acponline.org/uninsured/lack-paper.pdf (last visited Mar. 29, 2004) (summarizing research over a ten-year period).

[89] Diane Rowland, Executive Director, The Kaiser Commission on Medicaid and the Uninsured, *Low-Income and Uninsured: The Challenge for Extending Coverage*: *Hearing on "Living Without Insurance: Who's Uninsured and Why?"* Statements Before the Senate Committee on Finance (Sept. 10, 2001), *available at* www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13755 (last visited Mar. 29, 2004); *See also* Institute of Medicine, Coverage Matters: Insurance and Health Care 2, *at* www.iom.edu/report.asp?id=4662 (last visited Mar. 29, 2004).

[90] John Budetti et. al, The Commonwealth Fund, Can't Afford to Get Sick: A Reality for Millions of Working Americans: The Commonwealth Fund 1999 National Survey of Workers' Health Insurance 6 (1999), *at* www.abtassoc.com/reports/commfund.pdf (last visited Mar. 29, 2004). *See also* Rowland, *supra* note 89, at 10.

[91] Rowland, *supra* note 89, at 10. The uninsured are twice as likely to experience delay in getting needed medical care as people with insurance. Bradley C. Strunk & Peter J. Cunningham, Treading Water: Americans' Access to Needed Medical Care, 1997-2001, Ctr. for Studying Health System Change Tracking Rep., (Mar. 2002) at 2, *at* www.hschange.org/CONTENT/421/421.pdf (last visited Mar. 29, 2004) ("15.7 percent vs. 8.6 percent"). Kaiser Comm'n on Medicaid and the Uninsured, The Henry J. Kaiser Family Found., *The Uninsured and Their Access to Health Care*, *Key Facts*, Jan. 2003 at 2 [hereinafter The Henry J. Kaiser Family Found., *The Uninsured and Their Access to Health Care*] ("In 2002, over 40% of uninsured adults postponed seeking medical care, and 28% say they needed but did not get medical care in the past year.").

[92] Strunk & Cunningham, *supra* note 91, at 1 (15% versus 4.4%).

[93] *See* Am. Coll. of Physicians, *supra* note 88, at 7, 16 & 18 (summarizing results of studies of children and adolescents); The Henry J. Kaiser Family Found., *The Uninsured and Their Access to Health Care*, *supra* note 91, at 2.

[94] The Henry J. Kaiser Family Found., *The Uninsured and Their Access to Health Care*, *supra* note 91, at 2.

[95] *Id.*

[96] Alliance for Health Reform, Covering Health Issues: Campaign 2000 & Beyond (2000). *See* Institute. of Medicine, *supra* note 88, at 2 (the uninsured are more likely to die during or immediately after a hospitalization for a heart attack).

[97] Institute of Medicine, *supra* note 88, at 3. *See* The Henry J. Kaiser Family Found., *The Uninsured and Their Access to Health Care*, *supra* note 91, at 2 ("Death rates for uninsured women with breast cancer are significantly higher compared to women with insurance.").

[98] John Q, *supra* note 10.

[99] 42 U.S.C. § 1395dd (2004).

[100] *See* Correa v. Hosp. San Francisco, 69 F.3d 1184, 1189 (1st Cir. 1995) (citing H.R. Rep. No. 99-241, pt. 1, at 27 (1986), *reprinted in* 1986 U.S.C.C.A.N. 579, 605). EMTALA applies to hospitals, not to physicians. A physician's duty of care is defined by state law, which traditionally includes a duty of continuous care to an established patient. *See, e.g.*, 61 Am. Jur. 2d *Physicians, Surgeons and Other Healers* § 216 (2003) ("The relation of physician and patient continues until it is ended by the consent of the parties . . . or until his services are no longer needed, and until then the physician is under a duty to continue to provide necessary medical care to the patient.").

[101] "Emergency medical condition" is defined as

> (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
>
> (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
> (ii) serious impairment to bodily functions, or
> (iii) serious dysfunction of any bodily organ or part; or
>
> (B) with respect to a pregnant woman who is having contractions—
>
> (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
> (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

42 U.S.C. § 1395dd(e)(1) (2004). "Stabilized" is defined as "no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to [a pregnant woman who is having contractions], that the woman has delivered (including the placenta)." *Id*. § 1395dd(e)(3)(B).

[102] *Id*. § 1395dd(b)(1).

[103] *See* Bryan v. Rectors and Visitors of the Univ. of Va., 95 F.3d 349, 350 (4th Cir. 1996) (rejecting appellant's argument that EMTALA requires continuous stabilization, "no matter how long treatment [is] required to maintain that condition").

[104] Comm. on the Consequences of Uninsurance, Institute of Medicine, Care Without Coverage: Too Little, Too Late 73 (2002) (summarizing research on impact of uninsured status on emergency and trauma care). *See* Peter Jackson, *The Impact of Health Insurance Status on Emergency Room Services*, 14 J. of Health & Soc. Pol'y 61, 72 (2001) (finding that those without insurance receive less care in the emergency room than similarly diagnosed people with private insurance); David W. Baker et al., *Health Insurance and Access to Care for Symptomatic Conditions*, 160 Archives of Internal Med. 1269 (2000) ("Lack of health insurance is a major barrier to receiving medical care, even for highly serious and morbid symptoms.").

[105] Rowland, *supra* note 89, at 11. ("Among families with at least one uninsured member, only a quarter report they have received this kind of charity in the past year.").

[106] *Id.* at 10 ("When the uninsured are unable to pay the full medical bill in cash at the time of service, they either pay with credit cards (typically with high interest rates) or negotiate a payment schedule with the clinic or hospital. In the case of hospital bills, the debt may take years to repay.").

[107] *Id.* at 12; COMM. ON THE CONSEQUENCES OF UNINSURANCE, INSTITUTE OF MEDICINE, HEALTH INSURANCE IS A FAMILY MATTER 87 (2002) (because "[u]ninsured families are more likely to face high medical bills with less income, savings, and other assets than are insured families," they may struggle with routine medical bills and/or be overwhelmed by a major hospitalization or chronic illness). Even families with some form of insurance often experience medical bills that far exceed their coverage or ability to pay. *See* Melissa B. Jacoby et al., *Rethinking the Debates Over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375, 377 (2001) (about 80% of the more than half-million middle-class families that turned to bankruptcy courts for help after illness or injury in 1999 had some form of medical insurance); MARK MERLIS, THE COMMONWEALTH FUND, FAMILY OUT-OF-POCKET SPENDING FOR HEALTH SERVICES: A CONTINUING SOURCE OF FINANCIAL INSECURITY VII (2002), *at* www.cmwf.org/programs/insurance/merlis_oopspending_509.pdf (last visited Mar. 29, 2004).

[108] *See* Julie Ishida, *Uninsured Pay More for Prescription Drugs, Report Says*, WASH. POST, July 16, 2003, at A02 (according to study by U.S. Public Interest Research Group, uninsured Americans pay 72% more on average that the federal government for prescription drugs); Lucette Lagnado, *Hospitals Urged to End Harsh Tactics for Billing Uninsured*, WALL ST. J., July 7, 2003, at A9; Sara B. Miller, *Probing Disparity in Healthcare Bills*, THE CHRISTIAN SCIENCE MONITOR, May 19, 2003, at A9 (noting that although hospitals are required to disclose official "list prices" for services, insurers are often able to negotiate lower prices while the uninsured are charged the full amount).

[109] *See* CRITICAL CARE, *supra* note 8.

[110] *Id.*

[111] *John Q* also illustrates the consequences of precertification requirements. Instead of performing the surgery and then seeking reimbursement, the hospital was (presumably) required to obtain authorization from John's insurer prior to performing the surgery. When the hospital learned that the insurer would not cover the surgery, it declined to perform the surgery without a down payment. *See* KONGSTVEDT, *supra* note 2 (defining precertification).

[112] JOHN Q, *supra* note 10.

[113] *See* Alain C. Enthoven & Sara J. Singer, *Unrealistic Expectations Born of Defective Institutions*, 24 J. HEALTH POL., POL'Y & L. 931, 931-32 (1999) (discussing studies); Enthoven, *supra* note 54, at 2 (noting that "large amounts of inappropriate surgery and hospital admissions" were among the problems with fee-for-service health insurance, citing W.C. (BILL) WILLIAMS, III, M.D. ET AL., THE AM. COLL. OF MANAGED CARE MED. AND THE NAT'L ASS'N OF MANAGED CARE PHYSICIANS, PAVING THE PATHWAY TO MANAGED CARE MEDICINE 3 (2000)). *See also* David Hemenway et al., *Physicians' Responses to Financial Incentive:Evidence from a For-Profit Ambulatory Care Center*, 322 NEW ENG. J. MED. 1059 (1990) (individual, performance-based financial incentives based on individual performance may induce a group of physicians to increase the intensity of their practice); Douglas A. Conrad et al., *The Impact of Financial Incentives on Physicians Productivity in Medical Groups*, 37 HEALTH SERVS. RES. 885, 885 (2002) (individual financial incentives do increase individual physician productivity).

[114] *See supra* notes 59-61 and accompanying text.

[115] *But see* MARC RODWIN, MEDICINE, MONEY AND MORALS: PHYSICIAN'S CONFLICTS OF INTEREST 55-134 (1993) (analyzing financial arrangements developed as alternatives to fee-for-service that also create a conflict of interest, and specifically an incentive to increase services). Moreover, the abuses noted under the fee-for-service arrangement in private health insurance remain an issue for Medicare. *See* Gina

Kolata, *Patients in Florida Lining Up for All that Medicare Covers*, N.Y. Times, Sept. 13, 2003, at A1.

[116] *See, e.g.*, Rodwin, *supra* note 115, at 135-75 (analyzing financial incentives to decrease services in HMOs and hospitals); Timothy S. Hall, *Bargaining with Hippocrates: Managed Care and the Doctor-Patient Relationship*, 54 S.C. L. Rev. 689, 694-97 (2003).

[117] Rodwin, *supra* note 115, at 145 ("There is little hard data concerning the effects of financial incentives on physicians' clinical decisions.").

[118] *Id.* at 145 (discussing Alan L. Hillman, M.D. et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 New Eng. J. Med. 86 (1989)).

[119] *See* Kevin Grumbach et al., *Primary Care Physicians' Experience of Financial Incentives in Managed Care Settings*, 339 New Eng. J. Med. 1516, 1516 (1998) (finding, among other things, that "[i]ncentives that depend on limiting referrals or on greater productivity apply selective pressure to physicians in ways that are believed to compromise care"). *See also* T. Godsen et al., *How Should We Pay Doctors? A Systematic Review of Salary Payments and Their Effect on Doctor Behaviour*, 92 Q.J. Med. 47, 47 (1999) (review of literature on influence of salaries payment on doctor behavior in UK finding that "payment by salaries is associated with lowest use of tests, . . . and referrals" as well as lower number of procedures per patient, lower number of patients per doctor, longer consultations, more preventative care and different patterns of consultation as compared to fee-for-service payment). A 1994 study published in the *Journal of the American Medical Association*, however, concluded that there was no statistical significant relationship between the method of compensation of a group of 865 primary care physicians in Washington and the use and cost of care. Douglas Conrad et al., *Primary Care Physician Compensation Method in Medical Groups: Does It Influence the Use and Cost of Health Services for Enrollees in Managed Care Organizations?* 279 J.A.M.A. 853 (1998).

[120] Matthew K. Wynia et al., *Do Physicians Not Offer Useful Services Because of Coverage Restrictions?*, 22 Health Affs. 190 (2003).

[121] *See id.* at 191-94 (study notes that there could be several reasons for withholding the information, such as concern about raising expectations, having to explain coverage decisions, or being asked to falsify a claim in order to secure coverage).

[122] *See* G. Caleb Alexander et al., *Support for Physician Deception of Insurance Companies Among a Sample of Philadelphia Residents*, 138 Annals of Internal Med. 472 (2003) ("Participants were asked whether, in response to restriction of health care, a physician should (1) accept restriction, (2) appeal restriction, or (3) misrepresent a patient's condition to obtain the desired service;" results showed that 26% of the respondents approved of option (3), physician misrepresentation.); Rachel M. Werner et al., *The "Hassle Factor": What Motivates Physicians to Manipulate Reimbursement Rules?*, 162 Archives of Internal Med. 1134 (2002) (finding that physicians more likely to sanction misrepresentation of clinical information to secure insurance coverage for patients "when appeals process is longer, the likelihood of a successful appeal is lower, and the health condition is more severe"); Matthew K. Wynia et al., *Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place*, 283 J.A.M.A. 1858 (2000) ("A sizable minority of physicians report manipulating reimbursement rules" by "(1) exaggerating the severity of patients' conditions; (2) changing patients' billing diagnosis; and/or (3) reporting signs or symptoms that patients did not have to help the patients secure coverage for needed care."); Victor G. Freeman et al., *Lying for Patients: Physician Deception of Third-Party Payers*, 159 Archives of Internal Med. 2263 (1999) (finding that many physicians report willingness to use deception to secure insurance coverage for needed care); Dennis H. Novack et al., *Physicians' Attitudes Toward Using Deception to Resolve Difficult Ethical Problems*, 261 J.A.M.A. 2980 (1989) (noting that a majority of

physicians polled "indicated a willingness to misrepresent a screening test as a diagnostic test to secure an insurance payment").

[123] *See* RODWIN, *supra* note 115, at 145 (discussing beliefs of managed care executives and citing Alan L. Hillman et al., *HMO Managers Views on Financial Incentives and Quality*, 10 HEALTH AFFS. 207 (1991)); Steven D. Pearson et al., *Ethical Guidelines for Physician Compensation Based on Capitation*, 339 NEW ENG. J. MED. 689, 689 (1998) (noting that "managed care has triggered fears that necessary health services are being withheld and that decisions about health care are being driven by the financial bottom line"). *See also* Hall, *supra* note 116, at 699-717 (discussing legal challenges to physician incentives under ERISA).

[124] *See* Bush v. Dake, No. 96-25767 NM-2 (Mich. Cir. Ct, County of Saginaw 1989). A claim that HMO's reimbursement system that rewarded physicians for limiting medical care was an inherent or anticipatory breach of fiduciary duty under ERISA was rejected by the Supreme Court in 2000. *See* Pegram v. Herdrich, 530 U.S. 211, 214 (2000).

[125] Pearson et al., *supra* note 123, at 689. *See also* Jerome P. Kassirer, *Managed Care and the Morality of the Marketplace*, 333 NEW ENG. J. MED. 50 (1995); Alan L. Hillman, *Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?*, 317 NEW ENG. J. MED. 1743, 1743 (1987) (survey of physicians suggests that "[c]ertain financial incentives, especially when used in combination, suggest conflicts of interests that may influence physicians' behavior and adversely affect the quality of care").

[126] The Black's policy in *The Rainmaker* is an individual policy—a representative of Great Benefits sold it directly to the Black family. The nature of the insurance policies in *Critical Care* is not discussed. *See* KONGSTVEDT, *supra* note 2, at 32-35 (comparing group health benefits with individual health insurance).

[127] Cathy Schoen & Karen Davis, *Issue Brief: Erosion of Employer-Sponsored Health Insurance Coverage and Quality, at* www.cmwf.org/programs/insurance/schoen_erosion_ib_297.asp (last visited Mar. 29, 2004). *See also* Nat'l Bureau of Economic Research, *Health Insurance Coverage*, *at* www.nber.org/aginghealth/fall02/healthInsurance1.html (last visited Mar. 29, 2004) ("The 1980s and 1990s were marked by two concurrent trends in employer-provided health insurance: a significant decrease in the fraction of workers receiving insurance through their employers and a sharp increase in the insurance premiums paid by workers.").

[128] U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE: 2001, *at* www.census.gov/hhes/hlthins/hlthin01/hlth01asc.html (last visited Mar. 29, 2004); RUSSELL C. COILE, JR., FUTURESCAN, A FORECAST OF HEALTHCARE TRENDS 2002-2006 11 (2002) ("Employer-sponsored health insurance covers approximately 165 million, or 65 percent of working Americans.").

[129] *See, e.g.*, THE HENRY J. KAISER FAMILY FOUND., 2001 EMPLOYER HEALTH BENEFITS, *supra* note 55, at 42-43. *See also* Rowland, *supra* note 89, at i (55% of low-wage workers, making $7 per hour or less, are not offered coverage on the job). Part-time workers are less likely to be eligible for health insurance benefits than full-time workers. EMPLOYEE BENEFIT RESEARCH INSTITUTE, HEALTH BENEFITS DATABOOK, *supra* note 55, at 84.

[130] THE HENRY J. KAISER FAMILY FOUND., 2001 EMPLOYER HEALTH BENEFITS, *supra* note 55, at 42.

[131] Schoen & Davis, *supra* note 127. *See* CATHERINE HOFFMAN & MARIE WANG, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, HEALTH INSURANCE COVERAGE IN AMERICA: 2001 DATA UPDATE 4 (2003) (majority of the uninsured come from families with at least one full time worker); ROBERT WOOD JOHNSON FOUND., GOING WITHOUT HEALTH INSURANCE, *at* www.covertheuninsuredweek.org/media/GoingWithoutReport.pdf (last visited Mar. 29, 2004) (70.7% of people without insurance during 2001-02 were employed); Rowland, *supra* note 89, at 3 ("Most of the uninsured (71%) come from families where at least one person works full-time outside the home and another 12 percent come from families with part-time

employment."); Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the Mar. 1999 Current Population Survey, Employee Benefit Research Institute,* Employee Benefit Research Institute Issue Brief No. 217, *at* www.ebri.org/ibex/ib217.htm (last visited Mar. 29, 2004).

[132] *See* Philip F. Cooper & Barbara Steinberg Schone, *More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996*, 16 Health Affs. 142 (1997); Employee Benefit Research Institute, *Increase in Uninsured is Due to Erosion of Employment-Based Health Benefits* (Nov. 25, 2002), *at* www.ebri.org/prrel/pr614.htm (last visited Mar. 29, 2004) ("In 2001, 62.6% of Americans were covered by employment-based Health Care benefits, down from 63.6% in 2000.").

[133] *See, e.g.,* Iglehart, *supra* note 56, at 960. For example, less-restrictive PPOs are currently the most common type of employer-sponsored health plan, covering over half of employees with employer-sponsored health benefits in 2002. The Henry J. Kaiser Family Found., 2002 Employer Health Benefits, *supra* note 60, at 69.

[134] The Henry J. Kaiser Family Found., 2002 Employer Health Benefits, *supra* note 60, at 12-13 (rates rose by 12.7% in 2002—the largest increased since 1990); Bradley C. Strunk et al., *Tracking Health Care Costs: Growth Accelerates Again in 2001*, Health Affs. Web Exclusive, (Sept. 25, 2002), *at* content.healthaffairs.org/cgi/reprint/hlthaff.w3.266v1.pdf (last visited Mar. 29, 2003) ("Premiums for employment-based insurance increased 12.7 percent from 2001 to 2002. This was the largest increase in premiums since 1990 and the sixth consecutive year of accelerating premium increases.").

[135] *See* Hewitt Associates, *Health Care Costs Continue Double-Digit Pace, But May Start Moderating in 2004, at* was4.hewitt.com/hewitt/resource/newsroom/pressrel/2003/10-13-03_hc.htm (last visited Mar. 29, 2004) (forecasting average rate increases of 13.5% for 2004); Aon Consulting Corp., *supra* note 56 (forecasting average health plan with prescription drug coverage rate increases of 15.7% to 17.2% for 2004).

[136] Average employee contributions for health insurance benefits rose 7.5% in 2001, 10.8% in 2002, and are expected to rise up to 24.2% over 2003. *See* Harris Interactive, *As Corporate Concerns About Health Care Costs Continue to Rise, Many Employers Plan to Shift More Costs to Their Employees*, Health Care News, Oct. 9, 2001, at 1-2 (Humphrey Taylor & Robert Leitman eds.), *available at* www.harrisinteractive.com/news/newsletters/healthnews/HI_HealthCareNews2001Vol1_iss29.pdf (last visited Mar. 29, 2004); Watson Wyatt Worldwide, Creating a Sustainable Health Care Program: Eighth Annual Washington Business Group on Health / Watson Wyatt Survey Report 4, *at* www.watsonwyatt.com/research/resrender.asp?id=W-640&page=1 (last visited Mar. 29, 2004).

[137] *See, e.g.,* Rowland, *supra* note 89, at i ("Although most workers participate in employer health plans when offered, affordability is a major issue. On average, employees contribute 26 percent of premium costs ($1,656 in 2000). For a full-time worker earning $7 per hour, the employee share of premiums represents over 10 percent of the family's annual $14,500 income."); Alliance for Health Reform, Covering Health Issues: A Sourcebook for Journalists, *at* www.allhealth.org/sourcebook2002/index.html (last visited Mar. 29, 2004) (noting that of those workers who are offered insurance but decline, 67% do so because they cannot afford their share of the premium); Cooper & Schone, *supra* note 132, at 142 ("Rising premiums may discourage firms from offering insurance, and higher employee contribution rates may cause some workers to decline coverage when it is offered.").

[138] Iglehart, *supra* note 56, at 958-60 (describing trends toward increased cost-sharing and tiered benefits); Carol Hymowitz, *Benefits: I'll Have What He's Having*, Wall St. J., May 20, 2003, at B1. Chad Terhune, *Thin Cushion: Fast-Growing Health Plan Has a Catch: $1,000-a-Year Cap*, Wall St. J., May 14, 2003, at A1; Angela Galloway, *Insurance Proposals Aim at Small-Business Coverage Treatment Mandates*

Would Be Affected; Goal Is To Offer 'Bare Bones' Plans, SEATTLE POST-INTELLIGENCER, Feb. 21, 2003, at A1 (discussing Washington state's proposal bill allowing small businesses to offer "bare bones" health insurance coverage, to exempt or charge more to certain employees, and to exempt them from specifically mandated services such as mental health and mammograms).

[139] *See* Daniel Costello, *Firms Cut Back Medical Coverage: Faced With Soaring Costs, Many Employers Are Discouraging Workers From Adding Spouses or Children to Their Insurance Plans*, L.A. TIMES, Oct. 6, 2003, at F1.

[140] Title VII of the Civil Rights Act of 1964 (Title VII) prohibits employment practices that "discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex or national origin," including discrimination in employment benefits such as health insurance benefits. 42 U.S.C. § 2000e-2(a)(1) (2004); *Newport News Shipbuilding & Dry Dock Co v. EEOC*, 462 U.S. 669, 670 (1983). In 1978, the Pregnancy Discrimination Act (PDA) amended Title VII to clarify that discrimination "because of sex" included discrimination "because of or on the basis of pregnancy, childbirth, or related medical conditions." 42 U.S.C. § 2000e(k). The PDA requires that "women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work. *Id.*

[141] The Age Discrimination in Employment Act (ADEA) prohibits individuals over forty years of age from discrimination based on age with respect to any term, condition, or privilege of employment, including health insurance benefits. 29 U.S.C. §§ 621-634 (2004). The Older Workers Benefit Protection Act of 1990 (OWBPA) amended the ADEA to specifically prohibit employers from denying benefits to older employees. An employer may reduce benefits based on age only if the cost of providing the reduced benefits to older workers is the same as the cost of providing benefits to younger workers. 29 U.S.C. § 623(f)(1) (2004).

[142] The Americans with Disabilities Act of 1990 (ADA) prohibits, among other things, an employer from discriminating on the basis of disability against a qualified individual with a disability in regard to health insurance benefits. 42 U.S.C. §§ 12101-12213 (2004); 29 C.F.R § 1630.4(f) (2004). There have been, however, reports in the press that employers are terminating disabled workers in order to control the cost of health- and life-insurance benefits. Joseph Pereira, *Parting Shot: To Save on Health-Care Costs, Firms Fire Disabled Workers*, WALL ST. J., July 14, 2003, at A1.

[143] 29 U.S.C. § 1001-1461 (2004).

[144] *Id.* § 1140.

[145] THE HENRY J. KAISER FAMILY FOUND., 2002 EMPLOYER HEALTH BENEFITS, *supra* note 60, at 32; WATSON WYATT WORLDWIDE, *supra* note 136 (in 2002, 33% of employers reported that they planned to reduce or eliminate coverage).

[146] THE HENRY J. KAISER FAMILY FOUND., 2002 EMPLOYER HEALTH BENEFITS, *supra* note 60, at 106 (on average, 17% of covered workers in firms report that they offered employees a lower level of health benefits than in 2001).

[147] "Underinsured" is generally understood as having coverage that is inadequate, either because it includes high co-payments and deductibles or because important costs are not covered. *See, e.g.,* National Conference of State Legislatures, Forum for State Health Policy Leadership, *Frequently Asked Questions*: *Access and the Uninsured,* at 13, *at* www.ncsl.org/programs/health/forum/faqaccess.htm (last visited Mar. 29, 2004).

[148] Terhune, *supra* note 138. Although such plans make health insurance affordable for some workers; they do so by greatly increasing the deductible and/or reducing benefits, creating an obvious risk for any worker who becomes injured

or ill. *See* Sherry Glied et al., *Bare Bones Health Plans: Are They Worth The Money?*, *in* The Commonwealth Fund Issue Brief 1, 1-2 (May, 2002).

[149] *See generally* Towers Perrin, Keeping Employees Engaged About Health Care (2003).

[150] *Id*.

[151] Marie Cocco, *Health Care Puts Everyone on the Picket Line*, Newsday, Jan. 23, 2003, at A33.

[152] *Id*.

[153] David Stires, *Health Costs: The Breaking Point; Worker Health Costs Will Rise a Staggering 24% this year. Companies Can No Longer Afford to Pick Up the Bill. The Battle Is Here,* Fortune, Mar. 3, 2003, at 104.

[154] Based on the depiction of John's workplace, COBRA would apply because the factory appears to have more than twenty employees. 29 U.S.C. § 1161(b) (2003). Termination (for reasons other than misconduct) and reduction in hours that result in the loss of coverage for the employee or a covered beneficiary are defined as "qualifying events" that trigger continuation coverage. *Id.* § 1163 ("qualifying events" include the death of the employee; termination (for reasons other than gross misconduct) or reduction in hours; divorce or legal separation; the employee's entitlement to Medicare; dependent child's loss of dependent status; and employer bankruptcy). If the qualifying event of termination or reduction in hours occurs, continuation coverage is available for 18 months. *Id.*§ 1162(2)(A)(i).

[155] *Id*. § 1162(4) ("[t]he coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability").

[156] *Id.*§ 1162(3).

[157] An individual is eligible if: he has eighteen months of continuous prior coverage, most recently with a group health plan, and without a gap of more than sixty-two days; he is not eligible for private group insurance or a public program such as Medicare or Medicaid and has no other source of coverage; he was not terminated from prior group coverage for fraud or failure to pay premiums; and he has exhausted any available COBRA or similar state continuation period. 29 U.S.C. § 300gg-41(b) (2004).

[158] 42 U.S.C. § 300gg-300gg-92 (2004).

[159] *Id*. § 300gg-42.

[160] *Id*. § 300gg-41(g)(1).

[161] There are no facts to suggest that Mikey was eligible for Medicare, which provides benefits to people over the age of sixty-five who have paid at least forty quarters of payroll taxes, people with disabilities who have received Social Security Disability Income Benefits, and people with end-stage renal disease. 42 USCA § 1395 (2003). *See generally* Ctrs. for Medicaid and Medicare Services, *Medicare Information Resource*, *at* www.cms.hhs.gov/medicare/ (last visited Mar. 29, 2004).

[162] Medicaid is a program funded jointly by the federal and state governments that provides health insurance benefits for a broad range of basic health services to the poorest and most vulnerable Americans. The Henry J. Kaiser Family Found., The Medicaid Program at a Glance (Jan. 2004), *available at* www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30463 (last visited Mar. 29, 2004). To qualify for Medicaid, an individual must meet financial criteria and be a member of one of the eligible categories, including low-income children, pregnant women, the elderly, people with total and permanent disabilities, and some parents. *See generally* Ctrs. for Medicare & Medicaid Services, M*edicaid Site for Consumer Information*, *at* www.cms.hhs.gov/medicaid/consumer.asp (last visited Mar. 29, 2004). Coverage can vary from state to state, as states have discretion to cover individuals beyond the federally mandated minimum coverage requirements. *Id*. According to the Centers for Medicare and Medicaid Services, Medicaid covered 24 million children, 10 million adults, 5 million seniors, and 8 million people with disabilities in

2002. Ctrs. for Medicare and Medicaid Services, An Overview of the U.S. Healthcare System: Two Decades of Change, 1980-2003 (Oct. 2003), *available at* www.cms.hhs.gov/charts/healthcaresystem/ (last visited Mar. 29, 2004).

[163] The Archibald's family income is John's income of $18,200 (although it is unclear whether that represents his salary at full-time employment or at his reduced, part-time hours), plus some additional income from his wife's job as a grocery-store clerk. John Q, *supra* note 10.

[164] The Henry J. Kaiser Family Found., *State Health Facts Online, Income Eligibility Levels of Children Under Medicaid as a Percent of Federal Poverty Level* (Apr. 2003), *available at* www.statehealthfacts.org (last visited Mar. 29, 2004).

[165] The Henry J. Kaiser Family Found., Kaiser Commission on Medicaid and the Uninsured Enrolling Uninsured Low-Income Children in Medicaid and CHIP, Key Facts (May 2002), *available at* www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14045 (last visited Mar. 29, 2004).

[166] The State of Illinois recently raised the eligibility level for the KidCare program to 200% of the federal poverty level or $30,516 for a family of three. *See* Press Release, Office of the Governor of the State of Illinois, *Governor Signs Legislation Expanding KidCare and FamilyCare: Health Care Coverage for 20,000 More Children and 300,000 More Working Parents* (July 1, 2003), *available at* tinyurl.com/yuuuq (last visited Mar. 29, 2004).

[167] Illinois Dep't. of Public Aid, *Bureau of Kidcare, at* www.dpaillinois.com/programs/kidcare.html (last visited Mar. 29, 2004).

[168] Asimow, *supra* note 82.

[169] Paul Joseph, *supra* note 82. *See* Joseph Turow & Rachel Gans, The Henry J. Kaiser Family Foundation, As Seen on TV: Health Policy Issues in TV's Medical Dramas 1 (July 2002), *at* www.kff.org/entmedia/John_Q_Report.pdf (last visited Mar. 29, 2004) ("[r]esearchers have long recognized that new media coverage affects what the general public believes about health care").

[170] Indeed, the health insurance industry was quick to point out inaccuracies in *John Q's* depiction of coverage for heart transplantation. *See* US Newswire, *Blue Cross Blue Shield Warns: "John Q" Probably Not Blue; Blue Cross and Blue Shield Offers Premier Transplant Network* (Feb. 11, 2002), available *at* www.usnewswire.com/topnews/temp/0211-126.html (last visited Mar. 29, 2004) (describing the Blue Cross and Blue Shield Association's Blue Quality Centers for Transplant and quoting Dr. Allan Korn, chief medical officer of BCBSA, "[w]hat the movie-going public needs to know is that state-of-the-art transplant coverage is readily available, and if you are uninsured or your employer doesn't cover transplants, you do have other options available to you other than the violent means glorified in this Hollywood action film").

[171] Landa, *supra* note 83 (quoting Peter Clark, Professor, Preventative Medicine, Keck School of Medicine and Professor, Communication, Annenberg School for Communication, University of Southern California).

[172] Interestingly, the reference to "government sponsored health care" in Great Benefit's closing argument was an invention of the film. *See* Grisham, The rainmaker 396-97 (1995).

[173] John Q, *supra* note 10.

[174] *Id*. After he takes the law into his own hands, John seems unsure of his next move: "I got no moves. . . . I don't know what I'm going to do. I'm waiting on a miracle. I'm waiting on an act of God." *Id*.

[175] Prior to publishing *Critical Care*, his first novel, Richard Dooling worked as a respiratory therapist in intensive care units and as a lawyer. *See* Richard Dooling, *at* members.cox.net/dooling/bio.htm (last visited Mar. 29, 2004).

[176] Critical Care, *supra* note 8. Nurse Stella helps a suffering, terminal patient achieve a peaceful death in defiance of Dr. Hofsteader's orders as well as the potentially legally binding "full code" order imposed by the patient's family. *Id*.

[177] The film did not otherwise focus on the child's insurance arrangements or their impact on his care. Interestingly, none of the other three films enjoyed

the press attention or box office success of *As Good As It Gets*. *See* As Good As It Gets, *supra* note 3.

[178] As Donny Ray's parents sum up the situation, "It's simple . . . they're a bunch of crooks. . . . They think we're simple, ignorant trash with no money to fight'em." The Rainmaker, *supra* note 9. *See* Jerry, *supra* note 30; Widiss, *supra* note 30 (discussing the prevalence, justification, and application of preexisting conditions exclusions).

[179] John Q, *supra* note 10. As noted above, Ms. Payne does raise the issue of cost when she says, "[i]t costs money to provide health care. It's expensive for you, it's expensive for us," but this observation is never explored. *Id*. Interestingly, the American Association of Health Plans did raise the high cost of healthcare in connection with *John Q* ,but appeared to place the blame on trial lawyers and government regulation. *See* AAHP's 'John Q' Ad, *supra* note 85 ("The real villain in this story is rising health costs, and the terrible toll exacted on millions of Americans who have been priced out of the health care system . . . . It is time to take a hard look at the runaway litigation system and excessive government regulations that have needlessly helped drive health care affordability out of reach for so many Americans." (quoting American Association of Health Plans' President and CEO Karen Ignagni.)).

[180] *See* Morawetz, *supra* note 13 ("The health care debates show, perhaps better than other debates in our history, that we cannot address questions about insurance—what options should we have?—what arrangements should be compulsory?—without revisiting all of the main questions of politics: how much freedom should persons have? How much risk should they bear? How should responsibilities and rights be allocated between individuals and the state? How should the liberal ideal of autonomy be reconciled with egalitarian ideals and goals?"). *See also* Carol Weisbrod, *Insurance and the Utopian Idea,* 6 Conn. Ins. L.J. 381 (1999-2000).

[181] Alain C. Enthoven, *Employment-Based Health Insurance Is Failing: Now What?,* Health Affs. Web Exclusive (May 28, 2003), *at* content.healthaffairs.org/cgi/reprint/hlthaff.w3.237v1.pdf (last visited Mar. 29, 2004). The increases appear to be driven largely by prescription drug spending and hospital costs. Stephen Heffler et al., *Health Spending Projections for 2002-2012,* Health Affs. Web Exclusive (Feb. 7, 2003), *at* content.healthaffairs.org/cgi/reprint/hlthaff.w3.54v1.pdf (last visited Mar. 29, 2004); Strunk et al., *supra* note 134.

[182] Heffler et al., *supra* note 181.

[183] U.S. Census Bureau, *supra* note 128. "Uninsured" is generally defined as lacking health insurance, public or private, as well as the ability to pay for healthcare *See, e.g.,* Institute of Medicine, *supra* note 89.

[184] Robert Wood Johnson Found., *supra* note 131.

[185] Institute of Medicine, *supra* note 89.

[186] *See, e.g.,* Thomas S. Bodenheimer & Kevin Grumach, Understanding Health Policy 192 (2002) ("The future of HMOs will be largely determined by the decision of big employers, whose employees make up 63 million of the 80 million enrollees in HMOs.").

[187] *See, e.g.,* Iglehart, *supra* note 56 at 957. As one author has noted, "[i]n some respects, this confluence of events recalls the early 1990s when employers struggled with rapidly rising premiums during an economic downturn and responded by aggressively shifting health benefit offerings to tightly managed care." Cara S. Lesser & Paul B. Ginsberg, Ctr. for Studying Health System Change, *Health Care Cost and Access Problems Intensify*, *in* Issue Brief No. 63 (May 2003), at 2, *available at* www.hschange.org/CONTENT/559/ (last visited Mar. 29, 2004).

[188] Several authors have predicted a shift toward consumer-driven health plans. *See, e.g.,* Paul Fronstin, Employee Benefit Research Institute, *Defined Contribution Health Benefits*, Issue Brief, No. 231 (Mar. 2001), at 3, *available at* www.ebri.org/ibex/ib231.htm (last visited Mar. 29, 2004); Iglehart, *supra* note 56, at 960;

John V. Jacobi, *After Managed Care: Gray Boxes, Tiers and Consumerism*, 47 St. Louis U. L.J. 397, 397 (2003); Peter D. Jacobson, *Who Killed Managed Care? A Policy Whodunit,* 47 St. Louis U. L.J. 365, 377-78 (2003); John V Jacobi & Nicole Huberfeld, *Quality Control, Enterprise Liability, and Disintermediation in Managed Care,* 29 J.L. Med. & Ethics 305, 310-11 (2001). The idea of consumer-driven health plans is not new, but experimentation with these types of plans was encouraged by a 2002 Treasury Department ruling providing tax preferences for health reimbursement arrangements. Rev. Rul. 2002-41, 2002-02 C.B. 75. Indeed, plans like these are now being offered by benefit design companies such as Definity Health and Synhrgy HR Technologies. *See* Ed Kaplan, *Early Results Mixed for Consumer-Centric Plans*, Employee Benefit News, Feb. 3, 2003, *at* www.benefitnews.com/detail.cfm?id=4000&terms=|kaplan| (last visited Mar. 29, 2004); Synhrgy Technologies, Whitepaper, Consumer Driven Health (CDH) Plan Shows Positive Results for Employer (2003), *available at* www.synhrgy.com/pdf/synhrgy_cdh_casestudy.pdf (last visited Mar. 29, 2004) (presenting results of one employer's experience with a CDH product); Michael Taggart, *Research Supports CDH Assumptions*, Employee Benefit News, Sept. 15, 2002 at 12, *at* www.benefitnews.com/detail.cfm?id=3510&terms=|taggart| (last visited Mar. 29, 2004) (President of Synhrgy HR Technologies, Inc., outlining research and experience with Synhrgy's consumer-driven healthcare products).

[189] *See* Fronstin, *supra* note 188, at 11-16 (outlining models of defined contribution plans). Consumer-driven plans go by many names, including defined contribution, DC Health, Defined Health, consumer-driven/directed health insurance, e-health, self-directed plans, and fixed-contribution plans.

[190] *See, e.g.,* Jacobson, *supra* note 188. Any shortfall between the amount of the employer's defined contribution and the cost of the chosen health plan would be borne by the employee. *Id*.

[191] *See, e.g.,* Taggart, *supra* note 188. S*ee also* Jacobi, *supra* note 188, at 404 (describing consumer-driven plans, generally). For example, based on sample figures provided by Definity Health, an employer could place $500 in a personal spending account to be used for an employee's qualifying healthcare expenses. If the employee does not use the $500, he can roll it over into the next year. If he uses the $500, he is responsible for his own healthcare costs up to some specified annual deductible, such as $1,500. After he spends $1,500, the insurance policy begins covering eligible healthcare costs in accordance with its terms for the rest of that year. Kaplan, *supra* note 188.

[192] *See* Sally Trude & Paul B. Ginsberg, Ctr. for Studying Health System Change, *Are Defined Contributions a New Direction for Employer-Sponsored Coverage?,* Issue Brief No. 32 (Oct. 2000), *at* www.hschange.org/CONTENT/273 (last visited Mar. 29, 2004).

[193] Watson Wyatt Worldwide, *supra* note 136.

[194] Fronstin, *supra* note 188, at 22.

[195] Although the United States spends more on healthcare than any other country, it ranks below average on most measures of health services use, suggesting that the difference in spending is caused by higher prices, not increased utilization. Gerard F. Anderson et al., *It's the Prices, Stupid: Why the United States is So Different From Other Countries*, 22 Health AffS. 89, 89-90 (2003), *available at* content.healthaffairs.org/cgi/reprint/22/3/89.pdf (last visited Mar. 29, 2004).

[196] *See* Trude & Ginsberg, *supra* note 192 (discussing how a defined contribution approach could increase the number of people without insurance).

[197] Jacobi, *supra* note 188, at 410; Enthoven, *supra* note 181.

[198] *See* Stone, supra *note* 83 ("The publicity about coverage denials, deaths, suits and plaintiffs' victories stirs public outrage and fuels activates mobilization. Popular culture can vastly amplify widespread media coverage of insurance covered controversies.").

[199] *See, e.g., The Internet Movie Database, at* www.imdb.com; John Q, *supra* note 10.

[200] Certainly, popular films like *The Insider* (Touchstone Pictures 1999), *Erin Brokovich* (Universal Pictures 2000), and even *Legally Blond II* (MGM Studios 2003) critique social problems and point toward legal or legislative solutions. It can be argued that health coverage and care is more complex and difficult to solve than the tobacco litigation, specific instances of environmental pollution, or testing on animals, particularly in the absence of public consensus on solutions.

[201] For example, perhaps the film *As Good As It Gets* received so much press attention, in part, because it offered a sharp, satisfying attack without an examination of the underlying issues or possible solutions.

[202] The concept of "rugged individualism" refers to the belief that most people can and should succeed on their own, without significant help from the government. The phrase is often associated with the policies of the Republican Party, and specifically President Herbert Hoover. *See, e.g.*, Republican Presidential Candidate Herbert Hoover, Campaign Address in New York City (Oct. 22, 1928) (transcript available at Landmark Document in American History; Box 91, Public Statements, Herbert Hoover Library, West Branch, 1A.) (the phrase was later used in scorn by Democratic Presidents, Franklin D. Roosevelt and Harry S. Truman to refer to the disasters of Hoover's administration, including the 1929 stock market crash and the Great Depression). *See generally* The New Dictionary of Cultural Literacy (3d ed. 2002).

[203] *See* Victor R. Fuchs, *What's Ahead for Health Insurance in the United States?*, 346 New Eng. J. Med.1822, 1822 (June 6, 2002) (discussing history and development of health insurance in the United States as a social enterprise).

[204] Stone, *supra* note 83, at 15-16 ("Insurance is a social institution that particularly invites moral contemplation about questions of suffering, compassion, and responsibility. . . . The basic premise of insurance is collective responsibility for harms that befall individuals, because insurance pools people's savings to pay for individuals' losses. Thus, whenever insurance is discussed, questions of allocating responsibility between individuals and society are barely beneath the surface.").

[205] *See generally* Starr, *supra* note 46; Fuchs, *supra* note 203, at 1822.

[206] *See* Karen S. Palmer, *A Brief History: Universal Health Care Efforts in the U.S.*, Address at the Physicians for a National Health Program meeting (Mar. 29, 2003), *at* tinyurl.com/ys6lt (last visited May 5, 2004); *see also* Starr, *supra* note 46 at 235.

[207] The Physicians' Working Group for Single-Payer National Health Insurance, *Proposal of the Physicians' Working Group for Single-Payer National Health Insurance*, 290 J.A.M.A. 798, 798 (2003).

[208] Harris Interactive, *Attitudes Toward the United States' Health Care System*, *supra* note 77; *but see* Harris Interactive, *Fundamental Health Care Values*, Health Care News (Mar. 14, 2003), at 5, *available at* www.harrisinteractive.com/news/newsletters/healthnews/HI_HealthCareNews2003Vol3_Iss03.pdf (last visited Mar. 29, 2004) [hereinafter Harris Interactive, *Health Care Values*] ("While these results show that the public is rather unhappy with the failures of our health care system, they do not suggest that we are close to any potential tipping point in public values which would bring irresistible pressure on the government for fundamental reform.").

[209] Harris Interactive, *Health Care Values*, *supra* note 208, at 4 (75% of respondents agree that "people who are unemployed or poor should be able to get the same amount and quality of medical services as people who have good jobs and are paying substantial taxes," and 69% of respondents disagree that "it's fair that people who pay more in taxes (or in health insurance premiums) should be able to get better medical care than those who pay little or nothing." Regarding subsidizing of the sick by the healthy, 60% of respondents disagree that "it is unfair to take money through taxes from the young and middle-aged who work to pay for the medical care of those who are old and sick" and 57% of respondents disagree that "it's unfair to require the majority of people who are healthy to pay for most of the cost of treating those who are sick and are

heavy users of hospitals and doctors." Regarding subsidizing of the poor by the wealthy, 51% of respondents agree that "the higher someone's income is, the more he or she should expect to pay in taxes to cover the cost of people who are less well off and who are heavy users of medical services.").

[210] *Id*. (emphasis in original).

[211] *Id*. at 2 (Public opinion appears to be split along party lines with regard to the issue of raising taxes to pay for equal access to needed healthcare services. Most Democrat respondents (by 53% to 44%) would favor a substantial tax increase for this purpose, while a larger majority of Republican respondents (by 60% to 35%) would oppose it.).

[212] Morawetz, *supra* note 13, at 6.

[213] Harris Interactive, *Health Care Values*, *supra* note 208, at 4.