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Chuan-Feng Wu, *Can Compulsory Health Insurance Be Justified? An Examination of Taiwan's National Health Insurance*, 26 J.L. & Health 51 (2013)
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CAN COMPULSORY HEALTH INSURANCE BE JUSTIFIED? AN EXAMINATION OF TAIWAN'S NATIONAL HEALTH INSURANCE

CHUAN-FENG WU*

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I. INTRODUCTION

In March 2010, U.S. Congress's enactment of a comprehensive health care reform bill, the Patient Protection and Affordable Care Act,¹ along with the Health Care & Education Affordability Reconciliation Bill of 2010² (collectively referred to herein as the "Health Care Reform Act"), adopted the "individual mandate," a requirement that every American possess a certain level of health insurance³ through which universal access to health care can be achieved.⁴ The individual mandate no doubt is the most important yet most controversial linchpin of the U.S. Health Care Reform Act. The mandate drew scrutiny regarding its constitutionality because a direct and unconditional requirement for an individual to transfer money to one or more health insurance programs⁵ for health or economic purposes seems to violate

¹ Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010). The Act was passed by the House of Representative on March 21, 2010 and signed into law by President Barack Obama on March 23, 2010. *Patient Protection and Affordable Care Act (PPACA)*, ENCYCLOPEDIA BRITANNICA, available at <http://www.britannica.com/EBchecked/topic/1673534/Patient-Protection-and-Affordable-Care-Act-PPACA/295483/Final-passage> (last visited Feb. 1, 2013).

² Health Care & Education Affordability Reconciliation Act of 2010, Pub. L. No. 111-152 (codified as amended in scattered sections of U.S.C. § 20 and U.S.C. § 42).

³ The individual mandate is essential to the effectiveness of the U.S. Health Care Reform because lack of health insurance in the American health care system was the main problem to be rectified in the pre-March 2010 insurance system. Karen Tumulty, Kate Pickert & Alice Park, *America, The Doctor Will See You Now*, TIME, Apr. 5, 2010, at 18, 20. According to information provided, 32 million Americans were uninsured in March 2010. Jill Jackson and John Nolen, *Health Care Reform Bill Summary: A Look at What's in the Bill*, CBS (last updated Mar. 23, 2012, 5:00 PM), http://www.cbsnews.com/8301-503544_162-20000846-503544.html. In 2008, the U.S. Centers for Disease Control and Prevention (CDC) also estimated that there were about 43.8 million Americans (14.7% of total population) uninsured, of which 15.25% were under age 18 (6.6 million) and over 65 years old (0.2 million). HEALTH INSURANCE, CENTERS FOR DISEASE CONTROL AND PREVENTION, <http://www.cdc.gov/nchs/fastats/hinsure.htm> (last updated Aug. 20, 2012).

⁴ See Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010) Section 5000A(a) states: "Requirement to Maintain Minimum Essential Coverage. An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month."

⁵ There are two main types of universal health care systems. One is the single-payer coverage system, such as the English National Health Service, the Canadian Health Care System, and Taiwan's National Health Insurance, in which health care would be financed through taxation, thereby eliminating private insurance companies (because private health insurance is prohibited except to finance items not covered by the governmental plans). Adam Oliver, *The Single-Payer Option: A Reconsideration*, 34 J. HEALTH POL. POL'Y & L. 509, 527 (2009). The second system is the multiple-payer system, such as French National Health Insurance and the German health insurance system, which contains competitive health

individual liberties (or individual autonomy),⁶ especially the “disenrollment freedom” (the freedom to refuse to enroll in a health care program).⁷ Still today, there is much disagreement about whether the individual mandate could be considered justified as “regulating” individual liberties.

Therefore, a systematic examination of Taiwan’s health care reform, which is a single-payer system based upon regulated competition but has a compulsory scheme that contains a mandate, might interest U.S. policymakers and scholars who either support or oppose universal coverage. First, similar to the new U.S. Health Care Reform Act,⁸ Taiwan’s National Health Insurance (NHI) also requires all citizens to

insurers under clear and strong federal guidelines. PETER ZWEIFEL, DISCUSSION PAPER: MULTIPLE PAYERS IN HEALTH CARE: A FRAMEWORK FOR ASSESSMENT, HEALTH NUTRITION AND POPULATION FAMILY, HUMAN RESOURCES DEVELOPMENT NETWORK, WORLD BANK 1 (2004), available at <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/2816271095698140167/ZweifelMultiPayersinHealthCareFinal.pdf>. Generally speaking, the single-payer system generates far less administrative costs than the multiple-payer system, but the former also takes away the patient’s choice of provider. See *infra* Section VI. On the contrary, the multiple-payer system may have an advantage in designing payment systems in a way that reinforces incentives for providers to do the right thing for their patients, resulting in more value for money spent. Aftab Hussain & Patrick A. Rivers, *Policy Challenges in US Health Care System Reform*, 36(3) J. HEALTH CARE FIN. 34, 41 (2010).

⁶ Mark A. Hall, *The Constitutionality of Mandates to Purchase Health Insurance*, 37 J.L. MED. & ETHICS 40, 40 (2009).

⁷ “Disenrollment freedom” means recipients can freely decide to disenroll in a health care plan while their health care needs are few, and to enroll when their health care needs escalate. *Disenrollment*, THE FREE DICTIONARY, <http://medicaldictionary.thefreedictionary.com/Disenrollment> (last visited Oct. 4, 2012).

⁸ According to sections 1501(b), 1513, and 1511 of the Patient Protection and Affordable Care Act, the Internal Revenue Code of 1986 is amended by adding sections 5000A (maintenance of minimum essential coverage) and 4980H (shared responsibility for employers regarding health coverage), and the Fair Labor Standards Act of 1938 is amended by adding section 18A (automatic enrollment for employers of large employers). Amended section 5000A of the Internal Revenue Code first states that, in 2014, individuals will be required to purchase health insurance or face a \$95 annual fine (via income taxes), which will increase to \$350 in 2015 and \$750 in 2016. 26 U.S.C. § 5000A(b)(1). There are only a few exceptions. § 5000A(d)(2) (for religious objectors); § 5000A(e)(1) (for those who cannot afford health insurance); § 5000A(e)(2) (taxpayers with incomes less than 100% of the Federal Poverty Line (FPL)); § 5000A(e)(3) (American Indian tribe members); § 5000A(k) (those with a hardship waiver); § 5000A(d)(3) (individuals not lawfully present); § 5000A(d)(4) (incarcerated individuals); § 5000A(e)(4) (those not covered for less than three months). For those under age 18, most of which are dependents of other taxpayers, the amount of the penalty for not having health insurance will be one-half the amount for adults and should be paid by such other taxpayers. § 5000A(c)(3)(C); § 5000A(b)(3)(A). For those with incomes at or below 133% of the FPL, the Patient Protection and Affordable Care Act also creates a new mandatory Medicaid eligibility category and requires the federal government to devote more resources and assistance. §1331. In addition, according to amended section 4980H of the Internal Revenue Code of 1986, employers with more than 50 employees (large employers) are required to offer fulltime employees (and their dependents) the “opportunity” to enroll in minimum essential coverage under an eligible employer-sponsored plan. 26 U.S.C. § 4980H(d)(1)(A) (LexisNexis 2012). Failing doing so, employers would face a payment of \$750 per full-time employee. § 4980H(a). Amended section 218a of the Fair Labor Standards

subscribe to health insurance.⁹ Basically, all residents are required to subscribe to the public mandatory health insurance¹⁰ or are subject to a fine of no less than NT\$3,000 (about US \$94.25) and no more than NT\$15,000 (about US \$471.25).¹¹ Second, similarly to the U.S., Taiwan also faced intense debate about the constitutionality and morality of the individual mandate when the NHI was launched in 1995.¹²

No doubt, Taiwan's NHI system seems to satisfy most citizens' needs because the participation rate (otherwise known as the enrollment rate or coverage rate) is high,¹³ and public satisfaction with the NHI has always been high since its inception

Act of 1938 further states that employers with 200 or more full-time employees are required to "automatically" enroll new full-time employees in employer-sponsored health insurance plans. 29 U.S.C. § 218a (LexisNexis 2012). Therefore, the individual mandate under the Patient Protection and Affordable Care Act basically requires all Americans to purchase health insurance if it is not provided by their employer, and if they are self-employed, they must buy it as well, regardless of whether a citizen needs it, wants it, or can afford it.

⁹ Under the Patient Protection and Affordable Care Act, all citizens are also required to maintain "minimum essential coverage" and to subscribe to health insurance. See Bruce Moyer, *Unconstitutional Health Care Reform?*, 57-FEB FED. LAW. 8, 8 (2010). The difference is, Taiwan citizens must subscribe only to the NHI (which provides comprehensive health care coverage) while citizens in the U.S. can choose different health care programs. See *infra* section I.

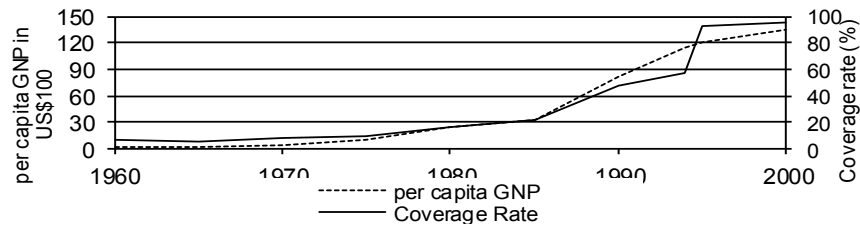
¹⁰ Chapter II, Article 11-1 of the National Health Insurance Act (Taiwan): "Except for the circumstances prescribed in Article 11, all the beneficiaries qualified under Article 10 shall subscribe to this Insurance." National Health Insurance Act ch. II, art. 11-1 (Taiwan) (1994), available at http://www.nhi.gov.tw/English/webdata/webdata.aspx?menu=11&menu_id=295&WD_ID=295&webdata_id=1865 (last visited Oct. 4, 2012). The following persons are not covered by this Insurance and shall be withdrawn from it if they have subscribed: (1) those who are confined in the detention centers or in prisons because of criminal punishment, rehabilitative disciplines, or reformatory education, unless their terms are less than two months. (2) those who are subject to a protective restriction order, however, are still covered by this Insurance; (3) those who have been missing for six months or more; (4) those who have lost the qualifications as prescribed in the preceding Article." National Health Insurance Act. ch. II, art. 11.

¹¹ Chapter 2, Article 69-1 of the National Health Insurance Act (Taiwan): "If a beneficiary who, in violation of the provisions of this Act, has not subscribed to this Insurance, he/she shall be subject to a fine of no less than three thousand and no more than fifteen thousand New Taiwan Dollars and shall subscribe to this Insurance retrospectively from the date on which the beneficiary is qualified for insurance. The benefits shall be suspended before the fines and premium are fully paid." National Health Insurance Act ch. II, art. 69-1.

¹² Tsung-Mei Cheng, *A Brief History of Taiwan's Individual Mandate*, GLOBAL PUBLIC SQUARE BLOG, (Mar. 28, 2012, 4:00 PM), <http://globalpublicsquare.blogs.cnn.com/2012/03/28/how-taiwan-learned-to-love-the-individual-mandate/>.

¹³ The following figure shows the relationship between coverage rate of the NHI and per capita GNP in Taiwan. This figure also shows that the coverage rate rose sharply after the implementation of the NHI in 1995. T. L. Chiang, Dean of School of Public Health, Nat'l Taiwan U., Address at The National Taiwan University Center for Ethics, Law, and Society in Biomedicine and Technology 2010 Bioethics Conference: Ethical Issues in Public Health and Resource Allocation, Health Care Reforms in Taiwan: What Worked and What Didn't? (Oct. 9, 2010) (transcript available in the Center for Ethics, Law and Society in Biomedicine and Technology, National Taiwan University).

in 1995.¹⁴ In addition, the system also has one of the lowest administrative costs in the world¹⁵ and still maintains a relatively high perception of quality¹⁶ by using proper regulations and monitoring mechanisms.¹⁷ However, Taiwan's Grand Justices



¹⁴ “The NHI system faced considerable challenges and resistance when it was first put in place, and public satisfaction with the program at its inception stood at below 40%. Today, nearly 80% of local residents are satisfied with the system, a reflection of the public's recognition of the Bureau's efforts over the past 15 years. Although the system's satisfaction rating plummeted in 2002 when premiums and copayments were raised, it quickly recovered to 77% a year later and has remained near 80% the past two years.” BUREAU OF NATIONAL HEALTH INSURANCE, NATIONAL HEALTH INSURANCE IN TAIWAN: 2011 ANNUAL REPORT 41 (2011), available at http://www.nhi.gov.tw/Resource/webdata/13767_1_NHI%20IN%20TAIWAN%202011%20ANNUAL%20REPORT.pdf.

¹⁵ The NHI's administrative burden was 2.2 % of the program's budget in 2001, although Chapter 7, Article 68 of the NHI allows the BNHI to spend as much as 3.5% of its annual budget for administration. National Health Insurance Act. ch. VII, art. 68 (1994) (Taiwan), available at http://www.nhi.gov.tw/English/webdata/webdata.aspx?menu=11&menu_id=295&WD_ID=295&webdata_id=1865 (last visited Oct. 4, 2012). In 2008, the NHI's administrative burden further decreased to 1.51%. Tsung-Mei Cheng, *Taiwan's New National Health Insurance Program: Genesis and Experience So Far*, 22(3) HEALTH AFFAIRS 64 (2003).

¹⁶ See, e.g., Li Chuang, *The Effect of Cost Containment and Quality After the National Health Insurance System In Taiwan* (June 30, 2007) (unpublished Ph.D. dissertation, National Central University) (on file with the National Central University Library Electronic Theses & Dissertation System) (Taiwan).

¹⁷ For example, to both control medical expenditures and respect physician's professional autonomy, the BNHI developed the “hospital excellence program,” which places individual hospital budgeting (or spending), rather than hospital budgeting, in the center of control of medication costs for each hospital. See, e.g., Lih-Wen Mau, *Effect Assessments of the Hospital Excellent Program on Hospital Finance and Medical Care Quality from the Perspective of Game Theory—Based on Regional Hospitals and Medical Centers in Kaohsiung-Pingtung Areas* (June 30, 2004) (Ph.D. dissertation, Kaohsiung Medical University) (on file with the National Digital Library of Theses and Dissertations in Taiwan) (Taiwan); YUNG-I HO, *HOSPITAL'S ADMINISTRATIVE PERSPECTIVES—AN EXAMPLE OF THE “GLOBAL BUDGET SYSTEM” AND “HOSPITAL EXCELLENCE PROGRAM”* (June 30, 2007) (master thesis, Hsuan Chuang University) (on file with the National Digital Library of Theses and Dissertations in Taiwan) (Taiwan); Meng-Shiun Li, *A Study on the Relationship between the Quality of Care and the Performance of Health Care Organizations among Hospitals in Taipei Medical Region under the National Health Insurance System* (June 30, 1998) (unpublished master thesis, National Taiwan University) (on file with the National Digital Library of Theses and Dissertations in Taiwan) (Taiwan). In addition, the BNHI has tried to build a nationwide dataset of quality indicators and foster excellence in hospitals with guidance from these quality indicator outcomes. See, e.g., Lih-Wen Mau, *Effect Assessments of the Hospital*

Council (the Constitutional Court) expressed concerns about the constitutionality of compulsory national health insurance because the individual mandate would significantly deprive individuals from freely allocating their resources and from choosing their own insurance.¹⁸ Therefore, even though the Court agreed that compulsory subscription of health insurance conforms to the constitutional purposes of “improving national health”¹⁹ and “promoting national health insurance,”²⁰ it nonetheless required authorities to “conduct at [the] appropriate time [a] full-range evaluation and implement improvement measures in aspects of the insurance operations [i.e., regulated competition,] including diversification of the insurers.”²¹ In other words, the Court implied that the individual mandate might be constitutionally justified,²² while the individual mandate for regulated competition might not be justified.²³

In the U.S., individual liberty is also central to the health care reform debate and has generated constitutional challenges.²⁴ Constitutional challenges to the individual mandate came also from other perspectives, such as limits on federalism,²⁵ taxation and spending powers,²⁶ religious objections,²⁷ due process,²⁸ and under the

Excellent Program on Hospital Finance and Medical Care Quality from the Perspective of Game Theory—Based on Regional Hospitals and Medical Centers in Kaohsiung-Pingtung Areas (June 30, 2004) (Ph.D. dissertation, Kaohsiung Medical University) (on file with the National Digital Library of Theses and Dissertations in Taiwan) (Taiwan).

¹⁸ In other words, when the Health Care Act requires individuals to buy health insurance, it also prevents individuals from spending their own resources to buy goods other than health insurance. *Healthcare in Taiwan*, TAIWAN HEALTHCARE REFORM FOUNDATION, http://www.thrf.org.tw/EN/Page_Show.asp?Page_ID=124 (last visited Oct. 4, 2012).

¹⁹ Article 157 of the Taiwanese Constitution: “The State, in order to improve national health, shall establish extensive services for sanitation and health protection, and a system of public medical service.” MINGUO XIANFA art. 157, (1947) (Taiwan).

²⁰ Article 10, Paragraph 5 of the Taiwan Constitution, “The State shall promote universal health insurance and promote the research and development of both modern and traditional medicines.” MINGUO XIANFA art. 10(5), (1947) (Taiwan).

²¹ Const. Ct. Interp. No. 472, The Republic of China Constitutional Court (Grand Justices Council) Reporter, *Shizi (Judicial Yuan Interpretation) No. 472* (January 29, 1999) (Taiwan), available at http://www.judicial.gov.tw/constitutionalcourt/EN/p03_01.asp?expno=472.

²² It is worth noting that John B. Crosby and David L. Heidorn also agree that the individual mandate for health insurance might survive the political process. John B. Crosby & David L. Heidorn, *Achieving Full Access: It's Already Being Done*, 3 KAN. J.L. & PUB. POL'Y 31, 33 (1993).

²³ Chuan-Feng Wu & Wen-Hong Huang, *A Study of the Problem with Article 11-1 (Mandatory Insurance) in National Health Insurance Law – from the Aspect of the Rights to Health Care*, 77 TAIWAN L. REV. 112, 115-16 (2001).

²⁴ See, e.g., John B. Crosby & David L. Heidorn, *supra* note 22; Mark A. Peterson, *From Trust to Political Power: Interest Groups, Public Choice, and Health Care*, 26 J. HEALTH POL. POL'Y & L. 1145, 1154 (2003).

²⁵ See Moyer, *supra* note 9.

²⁶ For example, David S. Caroline argues that the solution to health care problems in the U.S. is to explore other market-based mechanisms for providing health care rather than mandating individuals to buy health insurance. David S. Caroline, *Employer Health-Care*

Commerce Clause.²⁹ Scholars across political and philosophical spectrums propose different theories to defy or to defend the individual mandate.³⁰ Further, a segment of American society still believes that the individual mandate threatens the very fabric of America's cherished liberties³¹ and is "liberty-crushing" by invading the area of individual autonomy.³² Thus, a growing list of states filed legal challenges to the U.S. Health Care Reform Act³³ based on the constitutional legitimacy of the

Mandates: The Wrong Answer to the Wrong Question, 11 U. PA. J. BUS. L. 427, 445-46 (2009).

²⁷ For example, based upon the First Amendment's Free Exercise Clause, Mark A. Hall argued that "one potential basis for an individual-rights challenge to compulsory health insurance is a religious objection under the First Amendment's Exercise of Free Speech Clause." See Hall, *supra* note 6, at 45.

²⁸ Mark A. Hall argued that the individual mandate might be unconstitutional because requiring individuals to spend money to buy health insurance they do not want to spend could be viewed as a deprivation of property or liberty, "which the Fifth Amendment allows only with 'due process.'" See Hall, *supra* note 6, at 45.

²⁹ For example, after examining the Supreme Court's modern Commerce Clause jurisprudence, David Rivkin and Lee Casey conclude that the individual mandate is unconstitutional and likely to be struck down by courts. According to Rivkin and Casey, the individual mandate would give the government "the power to direct the use of people's resources, combined with the fact that the government's taxing and spending powers already transfer a large amount of resources away from the private sector and into public channels, would turn everybody into a ward of the state, unable to exercise individual choices." David B. Rivkin, Jr., Lee A. Casey, & Jack M. Balkin, *A Healthy Debate: The Constitutionality of An Individual Mandate*, 158 U. PA. L. REV. 93, 101-118 (2009).

³⁰ Wendy E. Parmet, *The Individual Mandate: Implications for Public Health Law*, 39 J. L. MED. & ETHICS 401, 401-413 (2011), available at <http://onlinelibrary.wiley.com/doi/10.1111/j.1748-720X.2011.00610.x/pdf>.

³¹ For example, in 1917 *The New York Times* argued that the American way of life (individualism) was threatened by the compulsory health insurance scheme, which represents "German collectivism." BEATRIX HOFFMAN, *THE WAGES OF SICKNESS* 55 (2001).

³² See, e.g., Karl Manheim & Jamie Court, *Not So Fast On The Mandates: Clinton's and Obama's Health Proposals May Not Pass Constitutional Muster*, LOS ANGELES TIMES, March 24, 2008, <http://articles.latimes.com/2008/mar/24/opinion/oe-court24>; David B. Rivkin Jr. & Lee A. Casey, *Mandatory Insurance Is Unconstitutional: Why An Individual Mandate Could Be Struck Down by the Courts*, WALL ST. J., Sept. 18, 2009, <http://online.wsj.com/article/SB10001424052970204518504574416623109362480.html>; Katharine Q. Seelye, *A Constitutional Debate Over a Health Care Mandate*, N.Y. TIMES, September 26, 2009, <http://prescriptions.blogs.nytimes.com/2009/09/26/the-right-the-duty-to-bear-insurance-cards>; Andrew Jensen, *Alaska Joins 19 States Suing Federal Government Over Health Insurance Reform*, ALASKA JOURNAL OF COMMERCE (last updated April 20, 2010 5:50 PM), http://www.homernews.com/stories/042010/news_aq.shtml.

³³ As of April 14, 2010, eighteen states, including Alabama, Arizona, Colorado, Georgia, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Pennsylvania, South Carolina, South Dakota, Texas, Utah, and Washington, sued the federal government concerning the constitutionality of the Patient Protection and Affordable Care Act. They assert that the lawsuit aims "to prevent the unprecedented expansion of federal powers, impact upon state sovereignty and encroachment on our freedom." *Georgia Joins Health Care Reform Lawsuit*, SOUTH FLORIDA BUSINESS JOURNAL (April 13, 2010), <http://southflorida.bizjournals.com/southflorida/stories/2010/04/12/daily24.html>.

individual mandate.³⁴ On the other hand, justifications for the individual mandate have also been explored.³⁵ For example, Edward Lee argues that universal access to health care requires more than just the market-based distribution of health insurance,³⁶ and that one essential component of universal access is requiring each citizen to enroll in the same or similar health insurance program.³⁷ Jack Balkin argues that if the tax system is constitutional, the individual mandate should be as well, because both act as incentives to engage citizens in socially desirable behavior (e.g., to purchase health insurance) and to reduce the costs of government programs.³⁸ On fairness grounds, Norman Daniels³⁹ agrees that “mandatory coverage and participation” should be the first criterion of a universal health care system,⁴⁰ even when coercing people into participation might violate certain liberties.⁴¹ He argues that a universal health care system is moral⁴² because society would fail to protect fair equality of opportunity if people have no universal access to an appropriate array of medical resources regardless of their individual ability to pay.⁴³ Furthermore, since health care, which protects fair equality of opportunity, is extremely important, “the obligation to contribute to its support is more important than any supposed liberty not to.”⁴⁴

Since a great paradox lies beneath the universal health insurance mandate debate in both Taiwan and the U.S., Taiwan’s experience clarifying the constitutionality of its compulsory universal health insurance program then might provide valuable lessons to the U.S. The goal of this Article is to provide a theoretical basis, based upon the human rights impact assessment in public health policies⁴⁵ and a Rawlsian

³⁴ These states contend that the Patient Protection and Affordable Care Act violates states’ constitutional rights because only states — not the federal government — can require citizens to purchase health insurance. See Moyer, *supra* note 9.

³⁵ Note, *Universal Access to Health Care*, 108 HARV. L. REV. 1323, 1328-29 (1995).

³⁶ *Id.* at 1328.

³⁷ *Id.* at 1336-37.

³⁸ Balkin agrees that the individual mandate might deter certain conduct that creates negative externalities and is socially undesirable, but he argues that it is unavailing to contend that the individual mandate is unconstitutional under existing law. Rivkin et al., *supra* note 29, at 105.

³⁹ Firstly, Norman Daniels did not want to discuss the issue about whether the premium purchase should be compulsory because he has argued that this issue is better raised “when fair shares are clearly large enough to purchase a reasonable insurance package.” Norman Daniels, *Health-Care Needs and Distributive Justice*, 10(2) PHIL. & PUB. AFF. 146, 149 n.2 (1981).

⁴⁰ NORMAN DANIELS, DONALD W. LIGHT, & RONALD L. CAPLAN, BENCHMARKS OF FAIRNESS FOR HEALTH CARE REFORM 37-39 (1996).

⁴¹ *Id.* at 38.

⁴² *Id.* at 21-22.

⁴³ NORMAN DANIELS, HASTINGS CENTER REPORT, RESCUING UNIVERSAL HEALTH CARE 3 (2007).

⁴⁴ DANIELS, *supra* note 40, at 38.

⁴⁵ According to Lawrence Gostin and Jonathan Mann, the human rights impact assessment is “an instrument to help evaluate the effects of public health policies on human

theory of justice, to decide whether the restriction on individual liberty imposed by Taiwan's compulsory NHI is constitutionally justified. An analytic four-step assessment is established to evaluate the NHI's burden on individual liberties: (1) examine the importance, legitimacy, and contents of the freedom to purchase or decline health insurance in social health programs, (2) clarify the NHI's proposed policy purposes, (3) evaluate likely policy effectiveness, and (4) apply the "importance test," based upon Rawls' liberty and priority principles, to assess the trade-offs between the restricted liberty and the pursued social benefits in the case of NHI.

II. TAIWAN'S NATIONAL HEALTH INSURANCE (NHI)

A. Background

Before March 1995, Taiwan had three major public medical insurance programs covering approximately 54% of its residents: Labor Insurance, Government Employee Insurance, and Farmers Insurance.⁴⁶ Each program was supervised and administered by a different government agency.⁴⁷ In addition, military personnel, who comprise about 2.3% of Taiwan's population due to conscription, were given free medical services at national armed forces hospitals and clinics.⁴⁸ Because consumer demand for health insurance was so low that the market for private insurance essentially did not exist, Taiwan had virtually no private health insurance programs.⁴⁹ Therefore, 43.7% of the population in Taiwan was uninsured.⁵⁰

On March 1, 1995, the centralized, universal National Health Insurance program replaced the three existing health insurance programs.⁵¹ It was extended to cover military officers in 2001.⁵² Taiwan's Constitutional Court has deemed the NHI as

rights" (including freedoms and entitlements) and dignity. Lawrence Gostin & Jonathan M. Mann, *Towards the Development on a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies*, HEALTH AND HUMAN RIGHTS: A READER 54 (Jonathan M. Mann et al. eds., 1999).

⁴⁶ Tsung-Mei Cheng, *supra* note 15, at 62.

⁴⁷ See Tsung-Mei Cheng, *supra* note 15, at 62. Labor Insurance was supervised and administered by Bureau of Labor Insurance; Government Employee Insurance was supervised and administered by Ministry of Civil Service; Farmers Insurance was supervised and administered by Taiwan Provincial Government. Tsung-Mei Cheng, *supra* note 15, at 62.

⁴⁸ See Tsung-Mei Cheng, *supra* note 15, at 62.

⁴⁹ Ching-Lung William Hsiao & Jui-Fen Rachel Lu, Taiwan's Health Care System and Its Challenge for Future Development 10 (1989) (unpublished research paper, Harvard University) (on file at Harvard University School of Public Health Library).

⁵⁰ *Id.*

⁵¹ National Health Insurance Act. ch. IX, art. 87-4 (1994) (Taiwan), available at http://www.nhi.gov.tw/English/webdata/webdata.aspx?menu=11&menu_id=295&WD_ID=295&webdata_id=1865 (last visited Oct. 4, 2012). The Taiwan government argued that a centralized and universal health insurance program could save administrative costs, improve health care efficiency, and include the 43.7% of Taiwanese people who were uninsured. *Id.*

⁵² See Tsung-Mei Cheng, *supra* note 15, at 62.

realizing fundamental national policies mandated by the Taiwanese Constitution.⁵³ According to Article 155 of the Constitution, “[t]he State, in order to promote social welfare, shall establish a social insurance system”⁵⁴ Article 157 also states that “[t]he State, in order to improve national health, shall establish extensive services for sanitation and health protection, and a system of public medical service.”⁵⁵ Furthermore, Article 10(5) of the Constitution states that “[t]he State shall promote universal health insurance”⁵⁶

Covering “all” medical services provided by physicians,⁵⁷ the NHI pays for medical care necessitated by illness, injury, and maternity (i.e. pregnancy and infant delivery).⁵⁸ In addition to the 54% of the population who were covered by the three predecessor health care plans, the main beneficiaries of the NHI were the 42% of the population, mostly the elderly and children, who were not covered by any of the three predecessor public insurance plans.⁵⁹ Today the NHI covers 96% of the population classified into six types of insureds:⁶⁰ (1) civil servants and government

⁵³ Const. Ct. Interp. No. 472, The Republic of China Constitutional Court (Grand Justices Council) Reporter, *Shizi (Judicial Yuan Interpretation) No. 472* (January 29, 1999) (Taiwan), available at http://www.judicial.gov.tw/constitutionalcourt/EN/p03_01.asp?expno=472.

⁵⁴ MINGUO XIANFA art. 155 (1946) (Taiwan).

⁵⁵ MINGUO XIANFA art. 155 (1946) (Taiwan).

⁵⁶ MINGUO XIANFA art. 10(5) (1991) (Taiwan).

⁵⁷ It is different from the U.S. Patient Protection and Affordable Care Act, in which individuals are merely required to be covered under “minimum essential coverage.” Troy J. Oechsner & Magda Schaler-Haynes, *Keeping It Simple: Health Plan Benefit Standardization and Regulatory Choice under the Affordable Care Act*, 74 ALB. L. REV. 241, 280-81 (2010-11).

⁵⁸ “During the insured term, in case of illness, injury or maternity occurred to the beneficiary, benefits shall be provided under the provisions of this Act.” National Health Insurance Act. ch. I, art. 2 (1994) (Taiwan), available at http://www.nhi.gov.tw/English/webdata/webdata.aspx?menu=11&menu_id=295&WD_ID=295&webdata_id=1865 (last visited Oct. 4, 2012).

⁵⁹ Ching-Lung William Hsiao & Jui-Fen Rachel Lu, *Taiwan’s Health Care System and Its Challenge for Future Development* 18 (1989) (unpublished research paper, Harvard University) (on file at Harvard University School of Public Health Library).

⁶⁰ Article 8, paragraph 1 of the National Health Insurance Act (Taiwan) classifies the insured into six categories: “(1) Civil servants or full-time and regularly paid personnel in governmental agencies and public/private schools; employees of publicly or privately owned enterprises or institutions; employees other than the insured prescribed in the preceding two subparagraphs but are otherwise employed by particular employers; employers or self-employed owners of business; and independently practicing professionals and technicians; (2) Members of an occupational union who have no particular employers, or who are self-employed; and seamen serving on foreign vessels, who are members of the National Seamen's Union or the Master Mariners' Association; (3) Members of the Farmers Association or the Irrigation Association, or workers aged over fifteen who are actually engaged in agricultural activities; and members of the Fishers Association who are either self-employed or have no particular employers, or workers aged over fifteen who are actually engaged in fishery activities; (4) Military servicemen whose compulsory service terms are over two months or who are summoned to serve in military for more than two months, military school students who receive grants from the government, military servicemen's dependents who lost their support recognized by the Ministry of Defense, and military decedent's families who are

agency personnel and public and private schools, employees of publicly or privately owned enterprises or institutions, employers or self-employed owners of businesses, and independently practicing professionals and technicians; (2) seamen (fishermen) and occupational union members who have no particular employers, or who are self-employed; (3) farmers; (4) voluntary military officers; (5) members of low-income families as defined by the Social Support Law; and (6) veterans and wives of veterans – and their children and dependents.⁶¹ The dependents of the insured include unemployed spouses, lineal blood ascendants, and lineal blood descendants who are under twenty years old and not employed, or who are over twenty years old, but are incapable of making a living, or are in school without employment.⁶² The two largest categories of the uninsured, about 4% of the population, are prisoners and missing persons.⁶³

According to National Health Insurance Act (“NHI Act”) Articles 11-1⁶⁴ and 69-1,⁶⁵ all residents who qualify for NHI are required to enroll in the NHI’s mandatory insurance, which charges premiums proportionate to the annual income of the insured.⁶⁶ If a beneficiary does not enroll in the scheme after becoming eligible to do so, he or she is subject to a fine ranging from NT\$3,000 (about US \$95) to NT\$15,000 (about US \$470).⁶⁷ Benefits are withheld or suspended until the fines and

receiving pensions due to the death of their decedents; and men at the age for enlisting in the military, who are currently in military-substitute service; (5) Members of a household of low-income families as defined by Social Support Law; (6) Veterans, household representatives of survivors of veterans; representatives or heads of household other than the insured or their dependents prescribed in previous categories.” National Health Insurance Act. ch. II, art. 8.

⁶¹ “The beneficiary of this Insurance includes the insured and his/her dependents.” National Health Insurance Act. ch. II, art. 8

⁶² “The dependents of the insured . . . are prescribed as follows: (1) The insured’s spouse who is not employed; (2) The insured’s lineal blood ascendants who are not employed; (3) The insured’s lineal blood descendants within second degree of relationship who are either under twenty years of age and not employed, or are over twenty years of age but incapable of making a living, including those who are in school without employment.” National Health Insurance Act ch. II, art. 9.

⁶³ “The following persons are not covered by this Insurance and shall be withdrawn from it if they have subscribed to this Insurance: Those who are confined in the detention centers or in prisons because of criminal punishment, rehabilitative disciplines, or reformatory education, unless their terms are less than two months. Those who are subject to a protective restriction order, however, are still covered by this Insurance.” National Health Insurance Act ch. II, art. 11(1).

⁶⁴ “Except for the circumstances prescribed in Article 11, all the beneficiaries qualified under Article 10 shall subscribe to this Insurance.” National Health Insurance Act ch. II, art. 11-1.

⁶⁵ “If a beneficiary who, in violation of the provisions of this Act, has not subscribed to this Insurance, he/she shall be subject to a fine of no less than three thousand and no more than fifteen thousand New Taiwan Dollars and shall subscribe to this Insurance retrospectively from the date on which the beneficiary is qualified for insurance. The benefits shall be suspended before the fines and premiums are fully paid.” National Health Insurance Act ch. VIII, art. 69-1.

⁶⁶ National Health Insurance Act ch. III, art. 27.

⁶⁷ National Health Insurance Act ch. VIII, art. 69-1.

premiums are fully paid.⁶⁸ As a result, 99% of those eligible participate, and the NHI covers almost all of the island's twenty-three million people.⁶⁹

Taiwan's NHI is financed by employers, employees, and the government.⁷⁰ Employers and employees contribute based on a sliding income-based scale while the government funds a portion of services through its general budget.⁷¹ Employers pay sixty percent of the premiums, employees pay thirty percent, and the government pays ten percent.⁷² In addition, employers are required to enroll their employees and employees' dependents in the NHI within three days from the date on which employees become eligible.⁷³ If an employer fails to enroll an eligible employee in the NHI, he or she can be fined a sum equal to twice the amount of the unpaid premiums; premiums range from NT\$911 (about US \$28.62) to a maximum of NT\$9,598 (about US \$301.54) per month.⁷⁴

Taiwan's NHI covers specific health care services provided by most health care institutions, is a centralized single-payer system with standardized medical fees and charges for medicines, procedures and checkups.⁷⁵ While the NHI Act does not prohibit private health insurers from offering alternative health care insurance plans, the Ministry of Finance issued an order in 1995 "advising" private health insurers not to provide similar health care services and coverage as provided by the NHI.⁷⁶ Although this means that individuals are compelled to buy insurance through the NHI, they have the liberty to freely choose physicians and hospitals themselves.⁷⁷

B. Debates on the Constitutionality of the Compulsory NHI

On the one hand, Taiwan's NHI advances the public health interests by treating Taiwan's citizens' diseases and disabilities and protecting and promoting their health. On the other hand, the NHI grants the government the authority to compel

⁶⁸ *Id.*

⁶⁹ See T. L. Chiang, *supra* note 13.

⁷⁰ Tsung-Mei Cheng, *supra* note 15 at 62.

⁷¹ Tsung-Mei Cheng, *supra* note 15 at 62.

⁷² "The insured and their dependents referred to in items 2 and 3 of subparagraph 1, paragraph 1 of Article 8 pay 30 percent of the premiums, and the group insurance applicants pay 60 percent of them. For the other 10 percent of premium, it is subsidized by the central government if they register in the provincial jurisdiction, or 5 percent subsidized by the central government and another 5 percent subsidized by the municipal government if they register in the municipal jurisdictions." National Health Insurance Act ch. III, art. 27.

⁷³ "The group insurance applicants shall subscribe to the Insurer for coverage within three days from the date on which the beneficiaries meet the conditions of this Insurance and shall withdraw from the coverage within three days from the date of occurrence of the cause for withdrawal." National Health Insurance Act ch. I, art. 16.

⁷⁴ "If a group insurance applicant, which fails to carry out subscription to this Insurance pursuant to Article 16 for the insured or their dependents, it shall be punished with an amount equivalent to two times of the payable premiums in addition to the unpaid premium." National Health Insurance Act ch. VIII, art. 69.

⁷⁵ Tsung-Mei Cheng, *supra* note 15 at 64.

⁷⁶ *The Ministry of Finance, Tai-Cai-Bao No. 840123987* (1995.3.8.) (Taiwan).

⁷⁷ *See id.*

almost all citizens to enroll in the NHI and imposes upon citizens obligatory premium payments into the NHI. This health care program is no doubt coercive because it (1) limits citizens' freedom to purchase health care plans or to choose to go uninsured under the compulsory insurance clause, and (2) restricts citizens from enrolling in other private health insurance plans under the universal insurance clause.⁷⁸ Despite this tension between the legitimate public interests served by the NHI and the duties it imposes on citizens, it is clear from legislative discussions that took place during the process of drafting and enacting the NHI Act that, in the government's view, the benefits of efficiency, universalism and solidarity of social insurance⁷⁹ outweigh the values of pluralism and the loss of freedom caused by the individual mandate.⁸⁰

This view has been tested and explored in several cases⁸¹ that were ultimately brought before Taiwan's constitutional court, which is known as the Council of

⁷⁸ See generally National Health Insurance Act (1994) (Taiwan), available at http://www.nhi.gov.tw/English/webdata/webdata.aspx?menu=11&menu_id=295&WD_ID=295&webdata_id=1865 (last visited Oct. 4, 2012). Even though the Taiwanese government does not forbid NHI members to buy a second health insurance plan (similar to the German health care system), most citizens, especially middle class laborers or low wage earners, cannot afford to buy an additional health insurance due to their limited resources. But under the regulations of the NHI, health care resources are distributed by the NHI, and the individual is compelled to use his or her limited resources to subscribe the NHI or to pay a fine. In this case, the freedom to choose a health care plan is substantially influenced. On the contrary, if an affluent individual or family has the financial ability to buy more than one health insurance plan, the compulsory regulations of the NHI would influence his or her less in terms of his or her freedom to choose health care plans. Thus, the rich individual has relatively more income to support the values embedded in liberty. This issue is related to the worth of liberty rather than liberty per se, thus I will not discuss this issue at length in this paper.

⁷⁹ In short, "[t]he principle of universalism is . . . rooted in the . . . welfare state, in which . . . taxes are combined with public provision and a compulsory social insurance system that has allowed . . . benefit levels to compensate for income losses at every stage of life." Peter Garpenby, *Health Care Reform in Sweden in the 1990s: Local Pluralism Versus National Coordination*, 20 J. HEALTH POL. POL'Y & L. 695, 713 (1995).

⁸⁰ See, e.g., THE LEGISLATIVE YUAN GAZETTE: NATIONAL HEALTH INSURANCE ACT 55, 342, 350, 358, 794, 805-07, 941-45, 951-52, 962 (The Legislative Yuan Secretariat ed., 1994) (Taiwan).

⁸¹ See, e.g., *Taiwan Taichung District Court Civil Judgment of (86) Bao Sian Jiang Shan Zhi No. 2* (1997) (Taiwan). In this case, because the plaintiff refused to subscribe to the NHI, the National Health Insurance Bureau in accordance with Article 69-1 of the NHI Act imposed monetary fines on him. *Id.* The plaintiff then sued the Bureau for a violation of property rights. *Id.* The Taiwan Taichung District Court held that the NHI regulations, including the individual mandate and the monetary punishment, are justified. *Id.* In addition, legislators of not only the opposition party (Democratic Progressive Party, DPP) but also the government party (Kuomintang, KMT) also request (separately) the Grand Justices Council to examine the constitutionality of the NHI's individual mandate clauses (Articles 11-1 and 69-1), in accordance to Article 5, Paragraph 1, Subparagraph 3, of the Constitutional Interpretation Procedure Act ("[t]he grounds on which the petitions for interpretation of the Constitution may be made are as follows: . . . [w]hen one-third of the Legislators or more have doubt about the meanings of a constitutional provision governing their functions and duties, or question on the constitutionality of a statute at issue, and have therefore initiated a petition.") Constitutional Interpretation Procedure Act ch. II, art. 5(1) (1993) (China).

Grand Justices. In particular, the Council was asked to determine whether the NHI's individual mandate was unconstitutional as violating citizens' individual liberty.⁸² In 1999 the Council held in Judicial Yuan Interpretation No. 472 (Shizi No. 472) that the individual mandate provisions in Articles 11-1 and 69-1 of the NHI Act are not unconstitutional because the restriction on individual liberty is justified as a means to promote social welfare and to improve national health.⁸³ However, the Council also stated that "the authorities concerned shall ... conduct at an appropriate time a full-range evaluation and implement improvement measures in aspects of the insurance operations (including diversification of the insurers), categories of the insured, the insured amount, premium rates, payment of medical insurance, austerity measures and the appropriateness of temporary suspension of insurance benefits."⁸⁴ In other words, the Council agreed that the universal compulsory health insurance serves the constitutional objective of establishing a system of social security and the public policy goal of allowing the state to meet the health care needs of the disadvantaged.⁸⁵ It also placed the individual mandate under a constitutional scrutiny to explore whether its implementation meets those policy objectives.⁸⁶

Although the Council held that the NHI's individual mandate did not significantly restrict individual liberty as to outweigh the state's constitutional and public policy objectives, it failed to analyze the extent of those restrictions in depth.⁸⁷ In the joint concurring opinion, Grand Justice Jyun-hsyong Su expressed concerns that, when it examined the constitutionality of the NHI's individual mandate the Council failed to consider how the individual mandate, as enacted, might undervalue individual autonomy and ignored less intrusive alternative policies that might achieve the public health objectives as well as or better than the individual mandate.⁸⁸ For example, the Council analyzed the individual mandate by simply concluding that the utility principle applied: "[p]rovisions ... regarding compulsory subscription of insurance and premium payment are based on considerations over mutual social support, risk-sharing and public interests, and therefore conform to the constitutional purpose of promoting national health insurance."⁸⁹ It did not discuss the issues of individual liberty, nor did it explore how the individual mandate might affect individual liberty if imposed in conjunction with different policy instruments (e.g., single-payer or multiple-payer

⁸² Const. Ct. Interp. No. 472, The Republic of China Constitutional Court (Grand Justices Council) Reporter, *Shizi (Judicial Yuan Interpretation) No. 472* (Jan. 29, 1999) (Taiwan), available at http://www.judicial.gov.tw/constitutionalcourt/EN/p03_01.asp?expno=472.

⁸³ *Id.*

⁸⁴ *See id.*

⁸⁵ In addition to improving national health, the social benefits the NHI Act sought to pursue also include controlling administrative costs and enhancing economic efficiency. *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ The Grand Justice Council further argued that the compulsory mechanism is necessary for the public national health insurance because without such a mechanism public health insurance would be unfairly placed at a "competitive disadvantage." *Id.*

system).⁹⁰ Moreover, the Council also failed to require the state to assess important aspects of the NHI's operations, such as the effects of diversifying the insurers beyond a state-administrated single-payer. This type of assessment in particular cases might lead Taiwan to revise its appreciation of the NHI's individual mandate.⁹¹

III. THE SIGNIFICANCE OF THE FREEDOM TO PURCHASE OR DECLINE HEALTH INSURANCE

The lacunae in the Council of Grand Justice's decision is attributed in part to an absence of tenable criterion to accurately assess the trade-offs between the compulsory NHI's restrictions on individual liberty and the state's pursued public policy objectives. This absence of criterion occurs because of the vagueness and the undecided nature of the significance of the freedom to purchase or decline health insurance. There has been debate over whether the freedom to purchase or decline health insurance without government intrusion is a "basic liberty."⁹² This debate also questions whether this same freedom is relevant to individuals' use of reason to form their own conceptions of the good and their ability to judge and regulate the basic social structure. Wei-In Tsai, amongst others,⁹³ argue that if the freedom to purchase or decline health insurance is a basic liberty, social solidarity—promoting social welfare and improving national health—might not be a strong enough justification for the restrictions the NHI's individual mandate imposes.⁹⁴ However, when assessing the individual mandate, the significance of the freedom to purchase or decline health insurance was ignored, increasing health insurance coverage for all citizens was clearly the priority.

⁹⁰ Taiwan's compulsory health insurance adopts the single-payer system. Peter Hussey & Gerard Anderson, *A Comparison of Single- and Multi-Payer Health Insurance Systems and Options for Reform*, 66 HEALTH POL'Y 215, 215 (2003). Generally speaking, single payer systems can effectively distribute risks throughout one larger risk pool and offer governments a high degree of control over the total expenditure on health. *See infra* Part VIII. On the other hand, multi-payer systems would sacrifice this control for a greater ability to meet the diverse preferences of beneficiaries. *See infra* Part VIII.

⁹¹ *See generally* Const. Ct. Interp. No. 472, The Republic of China Constitutional Court (Grand Justices Council) Reporter, *Shizi (Judicial Yuan Interpretation) No. 472* (Jan. 29, 1999) (Taiwan), available at http://www.judicial.gov.tw/constitutionalcourt/EN/p03_01.asp?expno=472.

⁹² According to Rawls, basic liberties are a primary social good that every rational person is presumed to want (no matter what he or she may hope or plan to get out of life) because these liberties are the background institutional conditions necessary for the development and the full informed exercise of moral powers (the capacity for a conception of the good and the capacity for a sense of justice). JOHN RAWLS, *A THEORY OF JUSTICE* 53, 176-80, 266 (2003); JOHN RAWLS, *POLITICAL LIBERALISM* 310-24 (Columbia University Press ed., 1996). Therefore, it is important to guarantee each person an equal right to the most extensive system of equal basic liberties compatible with a fully adequate system of liberty for all.

⁹³ WEIYIN CAI, *ANALYZING BASIC ELEMENTS OF FINANCIAL STRUCTURE OF NATIONAL HEALTH INSURANCE FROM THE LEGAL PERSPECTIVE* 49, 66-76 (Taibei Xian Tucheng Shi ed., 2008) (Chinese).

⁹⁴ For example, according to Rawls, "a basic liberty can be limited or denied only for the sake of one or more other basic liberties, and never for a greater public good understood as a greater net sum of social and economic advantages for a society as a whole." JOHN RAWLS, *JUSTICE AS FAIRNESS: A RESTATEMENT* 111 (2001).

This ignorance may be illustrated by comparing the alternative approach adopted by the Japanese Constitutional Court and the conclusions of the Taiwanese Council of Grand Justices. In 1958, the Japanese Constitutional Court held that the individual mandate for health insurance did not violate fundamental constitutional rights because the freedom to decline health insurance was not a basic liberty.⁹⁵ The Court argued that fundamental constitutional rights (or basic liberties) should be limited to the “core values,” related to the formation or revision of an individual’s personality and integrity. In terms of the freedom of thought and conscience,⁹⁶ the core values are normally established within, and interpreted by, certain religious, philosophical, or moral doctrines in light of how the various aims of those values are understood and ordered.⁹⁷ Since the proposed freedom to decline health insurance cannot be found in any of the religious, philosophical, or moral doctrines recognized by the Court, it did not satisfy the requirements for being a core value.⁹⁸ The freedom to decline health insurance was thus not recognized as a basic liberty within constitutional pantheon and, therefore, was denied any special or priority status for protection.⁹⁹ Namely, if the state could prove that denying individuals the freedom to decline health insurance actually helped those individuals realizing their interest in mutual social support and risk-sharing, then the individual mandate for the Japanese Medical Care Insurance System was constitutionally justified.¹⁰⁰

Taiwan’s Council of Grand Justices concluded that denying the freedom to decline health insurance by the NHI Act was justified as a means to promote social welfare and national health.¹⁰¹ Unlike the Japanese Constitutional Court, the majority of Taiwan’s Grand Justices thought that the freedom to refuse to enroll in the NHI was a fundamental constitutional freedom, or a basic liberty, vital to every person’s rights to develop his or her own personality and to self-determination.¹⁰² According to Grand Justice Jyun-hsyong Su, the freedom to decline health insurance is strongly related to an individual’s right to freely decide how to use benefits, receive benefits, and dispose of resources needed for their livelihood.¹⁰³ Furthermore, even though the freedom to decline health insurance is a “non-enumerated freedom” under the Taiwanese Constitution,¹⁰⁴ Grand Justice Chen-Shan Li argued that this freedom

⁹⁵ See generally Saiko Saibansho [Sup. Ct.] Jan. 12, 1958, Hei 12(2) SAIKŌ SAIBANSHŪ MINJI HANREISHŪ [MINSHŪ] 190 (Japan); see also Yi An Chen, Patient-Physician Relationships Under the National Health Insurance Act 44 (1996) (unpublished LL.M. thesis, Soochow University) (on file with the National Library) (Taiwan).

⁹⁶ NIHONKOKU KENPŌ [KENPŌ] [CONSTITUTION], art. 19 (Japan).

⁹⁷ Yi An Chen, *supra* note 95.

⁹⁸ Yi An Chen, *supra* note 95.

⁹⁹ Yi An Chen, *supra* note 95.

¹⁰⁰ Yi An Chen, *supra* note 95.

¹⁰¹ Const. Ct. Interp. No. 472, The Republic of China Constitutional Court (Grand Justices Council) Reporter, *Shizi (Judicial Yuan Interpretation) No. 472* (Jan. 29, 1999) (Taiwan) available at http://www.judicial.gov.tw/constitutionalcourt/EN/p03_01.asp?expno=472.

¹⁰² *Id.*

¹⁰³ *Id.*; see also WEIYIN CAI, *supra* note 93.

¹⁰⁴ According to the Taiwanese Constitution, the enumerated constitutional rights include: (1) personal freedom (Article 8), (2) freedom of residence and of change of residence (Article

could still be recognized as a legally enforceable fundamental constitutional freedom¹⁰⁵ if: (1) it shares characteristics relevant to identification of fundamental freedoms and rights;¹⁰⁶ (2) it relates to intimate and important decisions about one's life or relationships;¹⁰⁷ (3) it does not interfere with the survival of society or the functioning of important institutions within it;¹⁰⁸ and (4) its existence does not violate or restrict the fundamental rights of others.¹⁰⁹ In other words, although the

10), (3) freedom of speech, teaching, writing and publication (Article 11), (4) freedom of privacy of correspondence (Article 12), (5) freedom of religious belief (Article 13), (6) freedom of assembly and association (Article 14), (7) right to equal protection (Article 7), (8) right of existence, the right of work, the right of property, (9) right of presenting petitions, lodging complaints, or instituting legal proceedings (Article 16), (10) right of election, recall, initiative and referendum (Article 17), (11) right of taking public examinations and of holding public offices (Article 18), (12) right of receiving citizens' education (Article 21). MINGUO XIANFA (1947) (Taiwan).

¹⁰⁵ Chen-Shan Li, *The Multiple Dimensions of Non-Enumerated Constitutional Rights: Focusing on the Article 22 of the R.O.C. Constitution*, PLURALITY, TOLERANCE, AND THE PROTECTION OF HUMAN RIGHTS: FOCUSING ON THE PROTECTION OF NON-ENUMERATED RIGHTS 33-40 (Chen-Shan Li ed., 2005) (Chinese). In addition, according to Article 22, non-enumerated (unnamed) freedoms or rights "that are not detrimental to social order or public welfare shall be guaranteed under the Constitution." MINGUO XIANFA (1947) (Taiwan).

¹⁰⁶ For example, in Shizi No. 399 the Grand Justices Council argued that the right of an individual to select his or her own name is a type of personal right because the name of an individual signifies an aspect of his or her personality. CONST. CT. INTERP. No. 399, The Republic of China Constitutional Court (Grand Justices Council) Reporter, *Shizi (Judicial Yuan Interpretation) No. 399* (March 22, 1996) (Taiwan), available at http://www.judicial.gov.tw/constitutionalcourt/EN/p03_01.asp?expno=399. Therefore, the right to choose one's own name is a physical freedom safeguarded under Article 22 of the Constitution because the name of an individual, which this right intends to protect, signifies an aspect of his or her personality. *Id.*

¹⁰⁷ For example, in Shizi No. 585 the Grand Justices Council argued that, even though the right of privacy is not enumerated constitutional rights, the right should be regarded as a fundamental right protected under Article 22 of the Constitution because it is a necessary tool for the protection of human dignity, the full development of personality, and the guarantee of an individual's ability to autonomously make his or her own decisions in the private sphere without psychological pressure, which comes from the objections or control of other people. CONST. CT. INTERP. No. 585, The Republic of China Constitutional Court (Grand Justices Council) Reporter, *Shizi (Judicial Yuan Interpretation) No. 585* (December 15, 2004) (Taiwan), available at http://www.judicial.gov.tw/constitutionalcourt/EN/p03_01.asp?expno=585.

¹⁰⁸ For example, in Shizi No. 242 the Grand Justices Council argued that if a restriction on freedoms or rights would "significantly disrupt the family life and human relations and lead to social disorder," such a restriction would be "in conflict with Article 22 of the Constitution which provides that people's freedoms and rights shall be protected." CONST. CT. INTERP. No. 242, The Republic of China Constitutional Court (Grand Justices Council) Reporter, *Shizi (Judicial Yuan Interpretation) No. 242* (June 23, 1989) (Taiwan), available at http://www.judicial.gov.tw/constitutionalcourt/EN/p03_01.asp?expno=242.

¹⁰⁹ According to John Stuart Mill's harm principle, "the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection." JOHN STUART MILL, ON LIBERTY 9, 79 (Elizabeth Rapaport ed., 1978). Therefore, the only circumstance under which the state may restrict the liberty and

freedom to decline health insurance is not an enumerated constitutional freedom, this fact alone should not be a sufficient justification for restricting this freedom.¹¹⁰ The constitutional significance of the freedom to decline health insurance should be decided independently on the basis of whether such a freedom is a harmless and necessary means for an individual to pursue his own ends in planning his life.¹¹¹ Unfortunately, the Council did not analyze the extent of the freedom to decline health insurance in depth, nor did the Council assess the burdens on freedom imposed by the compulsory NHI.¹¹² The Council also did not thoroughly analyze the trade-off between the need to protect the freedom to decline health insurance and the utility of Taiwan's universal individual mandate.

While the Japanese Constitutional Court and the Taiwanese Council of Grand Justices disagreed on whether the freedom to decline health insurance was a fundamental constitutional freedom, both courts agreed that the "core values" – the essential conditions for the adequate development of personality and integrity – would be dispositive to the question of whether the state could justifiably deny or restrict the freedom to decline health insurance.¹¹³ However, the Taiwanese Council recognized that restricting the freedom to decline health insurance could significantly violate core constitutional values but failed to explore whether it violated those values. In contrast, the Japanese Court concluded that the alleged absence of the freedom to decline health insurance from any recognized moral, religious, or philosophical system precluded it from being such a value.¹¹⁴ In other words, both courts failed to give serious consideration to the constitutional significance, or core values, of the freedom to purchase or decline health insurance when analyzing the constitutionality of compulsory health care plans.

coerce an individual is if such a restriction will prevent harm from befalling persons other than the individual. It is because "when ... a person is led to violate a distinct and assignable obligation to [others], the case is taken out of the self-regarding class and becomes amenable to moral disapprobation." Nils Holtug, *The Harm Principle*, 5 *ETHICAL THEORY & MORAL PRACTICE* 357, 357-89 (2002).

¹¹⁰ The 9th Amendment of the U.S. Constitution also assumes the existence of certain unnamed rights. It argues that "[t]he enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people." U.S. CONST. amend. IX.

¹¹¹ According to Amartya Sen, the inflexible (or fixed) fundamental freedoms index might wrongfully assume that everyone has shared purposes (or common ends), and ignore the fact that individuals vary in their ability to convert fundamental freedoms into what is important to them. AMARTYA SEN, *INEQUALITY REEXAMINED* 80-82 (1992); AMARTYA SEN, *CHOICE, WELFARE, AND MEASUREMENT* 365-66 (1982).

¹¹² See generally Const. Ct. Interp. No. 472, The Republic of China Constitutional Court (Grand Justices Council) Reporter, *Shizi (Judicial Yuan Interpretation) No. 472* (Jan. 29, 1999) (Taiwan), available at http://www.judicial.gov.tw/constitutionalcourt/EN/p03_01.asp?expno=472.

¹¹³ *Id.*; Saiko Saibansho [Sup. Ct.] Jan. 12, 1958, Hei 12(2) SAIKŌ SAIBANSHŪ MINJI HANREISHŪ [MINSHŪ] 190 (Japan).

¹¹⁴ See generally Const. Ct. Interp. No. 472, The Republic of China Constitutional Court (Grand Justices Council) Reporter, *Shizi (Judicial Yuan Interpretation) No. 472* (Jan. 29, 1999) (Taiwan), available at http://www.judicial.gov.tw/constitutionalcourt/EN/p03_01.asp?expno=472.

A number of prominent thinkers on the nature of justice and liberty have argued that a liberty should be recognized as a core value if that liberty is essential to an individual's basic capability to formulate and express intimate and important decisions about his or her life or relationships.¹¹⁵ For example, according to John Rawls, a liberty is more or less significant depending on whether it is more or less involved in the full and informed exercise of the moral powers (so-called "the central range of application" of a liberty).¹¹⁶ For Rawls, the moral powers are the capacities for the conception of the good and a sense of justice.¹¹⁷ In other words, the "core values" (or those values with constitutional significance) of a liberty should be defined by the central range of application and related to an individual's fundamental interests—maintaining the basic capabilities to exercise moral powers as a free and equal member of the society.¹¹⁸ Therefore, when evaluating the core values of the freedom to purchase or decline health insurance, society should consider not only the free advocacy of religious, philosophical, or moral doctrines as the Japanese Constitutional Court did, but also the essential social conditions for the adequate development and full exercise of moral powers. Furthermore, if the freedom to purchase or decline health insurance is essential to the moral powers, then it is not only a core value, but also a fundamental constitutional freedom that can be recognized and enforced when the state decides to trade off liberty to pursue its constitutional and public policy goals.

For these reasons, the following sections will delineate why the compulsory NHI should be carefully assessed for its impact on individual liberty based upon a human rights impact assessment.¹¹⁹ This assessment could be used to introduce criterion to evaluate the significance of the freedom to purchase or decline health insurance and to show how the NHI compulsory health insurance scheme affects this freedom.

IV. HUMAN RIGHTS IMPACT ASSESSMENT FOR THE COMPULSORY NHI

Taiwan's and Japan's experiences show that, even though the individual mandate for health insurance can achieve valid constitutional public health policy objectives, the constitutionality of the individual mandate should nonetheless be carefully evaluated. To clarify the constitutionality of Taiwan's compulsory NHI by means of an assessment of the impact this mandate has on human rights, I propose the

¹¹⁵ JOHN RAWLS, *JUSTICE AS FAIRNESS: A RESTATEMENT* 18-19, 111, 168-70 (2001); Martha Nussbaum, *Human Capabilities, Female Human Beings*, *WOMEN, CULTURE, AND DEVELOPMENT: A STUDY OF HUMAN CAPABILITIES* 85-86 (Martha Nussbaum & Jonathan Glover eds., 1995); AMARTYA SEN, *ON ETHICS AND ECONOMICS* 63-64 (1987); Saiko Saibansho [Sup. Ct.] Jan. 12, 1958, Hei 12(2) SAIKŌ SAIBANSHŪ MINJI HANREISHŪ [MINSHŪ] 190 (Japan). In other words, fundamental freedoms (or basic liberties) are those freedoms that can protect and fulfill an individual's basic capabilities because these capabilities would consist of many distinct and essential interests in the individual's rational life plan - interests that could not simply be reduced to quantities.

¹¹⁶ RAWLS, *supra* note 115, at 113.

¹¹⁷ RAWLS, *supra* note 115, at 18-19.

¹¹⁸ An individual's fundamental interests are consistent with the full exercise of moral powers to develop a conception of the good and a sense of justice because these moral powers are necessary institutional means for individuals to become engaged in social cooperation as a free and equal member of society. RAWLS, *supra* note 115, at 111, 113, 168-70.

¹¹⁹ Gostin & Mann, *supra* note 45, at 55.

following four analytic steps, with a series of questions designed to balance the public benefits of the NHI against its burdens on individual liberty¹²⁰ (see Figure 1):

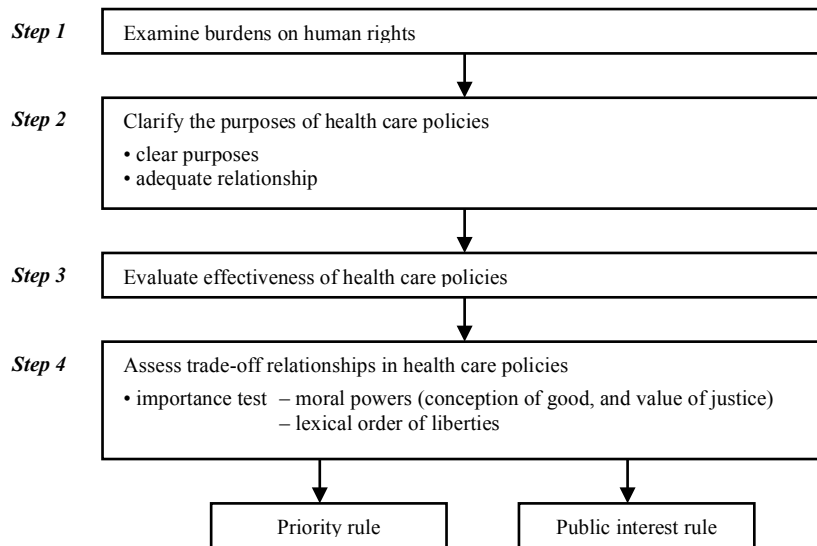
- (1) First, the burden NHI imposes upon human rights and individual liberty should be examined, thus determining whether the compulsory NHI restricts a given liberty and what aspects of that liberty may have been infringed (see *infra*, Section V).
- (2) Second, the NHI's policy goals should be clarified in order to assess whether the NHI could or does achieve its objectives. (see *infra*, Section VI).
- (3) Third, the effectiveness of the NHI should be evaluated in order to assess whether the NHI provides the least restrictive means to achieve its proposed purpose. (see *infra*, Section VII).
- (4) Fourth, the trade-off between restrictions on individual liberty and the proposed public order realized by the NHI should be analyzed (the importance test). The court should carefully consider whether there is an acceptable trade-off between the restricted liberty and the policy objectives served by the NHI's individual mandate. The importance test is based upon John Rawls' analytical approach (the liberty principle and the priority principle) in the theory of justice (see *infra*, Section VIII), and is applied to assess these trade-offs. Two separate but related policy elements, the compulsory scheme and the single-payer system, and their influences on the central application range of individual liberty, are further analyzed in this step (see *infra*, Sections VIII(C) and (D)).

If the answer to any one of these issues raised in steps 2 thru 4 is "no", enacting the compulsory NHI and restricting individual liberty is unjustified.¹²¹

¹²⁰ This assessment is modified on the basis of the human rights impact assessment for the formulation and evaluation of public health policies, proposed by Lawrence Gostin and Jonathan Mann in 1994. See Gostin & Mann, *supra* note 45, at 54-77. I also proposed to apply a similar assessment to evaluate restrictions on the right to health under the international trade regime. See generally Chuan-Feng Wu, *Raising the Right to Health Concerns Within the Framework of International Intellectual Property Law*, 5 ASIAN J. WTO & INT'L HEALTH L. & POL'Y 141, 184-95 (2010).

¹²¹ Arguments about whether compulsory health insurance is justified in restricting citizens' property rights would not be considered here. My aim is to resolve the tension between individuals' liberty and public order on the basis of the human rights impact assessment and the priority of basic liberties.

Figure 1. Human Rights Impact Assessment for the Health Care Policy



After conducting a careful analysis, this Article concludes that, even though Taiwan's compulsory NHI has a clear and achievable policy purpose of pursuing economic efficiency,¹²² the compulsory scheme is unjustified because it is not the least restrictive means to achieve the intended purpose¹²³ because it substantially restricts individuals' freedom to purchase or decline health insurance.¹²⁴ Limited compulsory health insurance (requiring only segments of the population to enroll in social health insurance) is less intrusive and will achieve a similar purpose. In addition, the NHI's individual mandate alone does not fail the importance test because it does not hinder individuals from developing a conception of the good or a sense of justice. However, accompanied by the single-payer system, the NHI's compulsory scheme impinges the central application range of individual liberty, imposes restrictions on the exercise of moral powers, infringes upon the priority of liberty, and fails the importance test.¹²⁵

V. STEP 1: EXAMINE HUMAN RIGHTS BURDENS OF THE COMPULSORY NHI

Even in a well-designed health care policy, the burdens on human rights and individual liberty may outweigh social benefits and economic interests.¹²⁶ Therefore, it is important to identify and evaluate all potential infringements on human rights.¹²⁷ Defining human rights burdens requires a fact-finding process in order to examine different perspectives regarding what human rights are affected by health care

¹²² See *infra* Part VI.

¹²³ See *infra* Part VII.

¹²⁴ See *infra* Part V.

¹²⁵ See *infra* Part VIII.

¹²⁶ Gostin & Mann, *supra* note 45, at 69-70.

¹²⁷ Gostin & Mann, *supra* note 45, at 70.

policy. The nature and contents of restricted human rights and the degree of invasiveness should be clarified in the assessment. For example, in order to assess burdens on individual liberty imposed by Taiwan's universal compulsory NHI, first we need to explore whether individual liberty includes an individual's self-determination to purchase or to refuse to enroll in a health care plan and outline what aspect of the liberty is impacted. International human rights documents and domestic statutes and cases may be considered the source of basic rights and liberties. Even though these documents merely provide a cursory basis, in this step it is sufficient to provide a starting point to recognize what rights and liberties might be infringed upon. In other words, if there is "reasonable doubt" about whether the compulsory NHI violates individual rights and liberties, we can then move from this initial examination to the next step. Whether the restriction on these rights and liberties is justified will be evaluated later.

One debate regarding the relationship between individual insureds and health insurers,¹²⁸ especially in governmental health insurance programs, is whether individuals have the freedom to autonomously choose to enroll in health insurance or not, and which health insurance plans are included in this freedom. For example, respect for individualism and pluralism and a fear of the seemingly limitless governmental authority are the main reasons why the U.S. had no universal national health insurance program.¹²⁹ Even though this perspective has been challenged with the passage of the Patient Protection and Affordable Care Act. Due to rising medical costs and health care market failures in the country, American society continues to seek a balanced relationship between individual autonomy and public interests.¹³⁰ Western European countries with well-developed public social insurance also debate whether the governmental authority in social insurance has excessively intervened with individual autonomy.¹³¹ Unfortunately, there is no international declaration or

¹²⁸ Individuals' liberty (or patient autonomy) in the relationship between individuals and health insurers have received more attention over the past 20 years because health insurance and publicly-funded health care programs have become an important part of the social welfare system (e.g., the U.S. Medicaid and U.S. Medicare program, the U.K. National Health Service (NHS), Taiwan's NHI, Germany's Public Contract Model, and Japan's Public Medical Care Insurance System). ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, THE REFORM OF HEALTH CARE: A COMPARATIVE ANALYSIS OF SEVEN OECD COUNTRIES 57, 113-15 (1992). For example, the 2005 U.S. Patients' Bill of Rights focuses not only on traditional patients' rights (between the patients and their physicians and hospitals) but also on medical consumers' rights (between patients and health insurers). ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, THE REFORM OF HEALTH CARE SYSTEMS: A COMPARATIVE REVIEW OF SEVENTEEN OECD COUNTRIES 208-09 (1994); Patients' Bill of Rights Act of 2005, H.R. 2259, 109th Cong. (2005).

¹²⁹ It appears that American society places more value on pluralism than on universalism, and requires the states to respect free market mechanisms and democracy even in health care issues. DANIELS ET AL., *supra* note 40, at 4-9; HOFFMAN, *supra* note 31, at 45-60.

¹³⁰ HOFFMAN, *supra* note 31.

¹³¹ See, e.g., Kaiser Family Foundation, *Cost Sharing for Health Care: France, Germany, and Switzerland* (Jan. 2009), <http://www.kff.org/insurance/upload/7852.pdf>; Anna Dixon, Martin Pfaff & Jean Hermesse, *Solidarity and Competition in Social Health Insurance Countries*, SOCIAL HEALTH INSURANCE SYSTEMS IN WESTERN EUROPE 179-80 (Richard B. Saltman, Reinhard Busse & Josep Figueras eds., 2004); Jorine Muiser, *The New Dutch Health Insurance Scheme: Challenges and Opportunities for Better Performance in Health*

domestic law directly protecting the freedom to purchase or decline health insurance. Therefore, this freedom can only be exercised on the basis of the historical development of patients' rights and upon the more general liberties such as civil and political rights. Readers must remain cognizant that the reorganization of the freedom to purchase or decline health insurance is not equivalent to supporting a free market in health care. Even if the individual has the freedom to refuse to enroll in a health care plan, such a freedom ought not to be taken as an absolute principle in health care policymaking, and can be regulated in order to pursue the greater social benefits or to strengthen the total system of liberty shared by all.¹³²

There are four different perspectives on the status of the freedom to purchase or decline health insurance in social health insurance systems.

A. Taiwanese Constitution

First, in Taiwan, the freedom to purchase or decline health insurance can be derived from Article 22 of the Constitution, which states that “[a]ll other freedoms and rights of the people that are not detrimental to social order or public welfare shall be guaranteed under the Constitution.”¹³³ In other words, the only purpose for which power can be justifiably exercised over any member of a civilized society against his or her will to interfere with liberty is to prevent harm to others.¹³⁴ In Shizi No. 472, Grand Justices Sen-Yen Sun and Jyun-hsyong Su argued that compulsory health insurance, especially the individual mandate clause, would significantly restrict individuals' liberty. Such restrictions especially include the freedom of personality development and self-determination,¹³⁵ which is generally protected in the Constitution.¹³⁶ In other words, in Taiwan, the freedom to purchase or decline

Financing, WORLD HEALTH ORGANIZATION (2007), available at http://www.who.int/health_financing/documents/dp_e_07_3-new_dutch_healthinsurance.pdf; Romke van der Veen, *Managed Competition and Managed Care in Dutch Health Care Reform: A Sociological Analysis Of Organisational And Policy Developments In Dutch Health Care* (2008), http://www.sps.ed.ac.uk/_data/assets/pdf_file/0017/13553/van_der_veen__2008_organisational_and_policy_developments.pdf.

¹³² When exploring the relationship between the power of the classical liberal and the modern social welfare model, Richard Epstein also argues that “one must examine these issues from a comprehensive perspective that understands the profound interaction between public health and private wealth creation.” Richard A. Epstein, *In Defense of the “Old” Public Health: The Legal Framework for the Regulation of Public Health*, 69 BROOK. L. REV. 1421, 1470 (2004).

¹³³ MINGUO XIANFA art. 22 (1946) (Taiwan).

¹³⁴ Similar conceptions can be found in John Stuart Mill's harm principle, which asserts that the state cannot restrict behavior (individuals' liberty) when that behavior does not harm others. JOHN STUART MILL, *ON LIBERTY* 9 (Elizabeth Rapaport ed., 1978).

¹³⁵ Const. Ct. Interp. No. 472, The Republic of China Constitutional Court (Grand Justices Council) Reporter, *Shizi (Judicial Yuan Interpretation) No. 472* (January 29, 1999) (Taiwan), available at http://www.judicial.gov.tw/constitutionalcourt/EN/p03_01.asp?expno=472.

¹³⁶ For example, in Shizi Nos. 603 and 664, the Taiwanese Grand Justice Council established that the freedom of personality development should be regarded as the core value of the constitutional structure of free democracy, and is an indispensable fundamental right protected under Article 22 of the Constitution for purposes of preserving human dignity, individuality, and moral integrity. Const. Ct. Interp. No. 603, The Republic of China Constitutional Court (Grand Justices Council) Reporter, *Shizi (Judicial Yuan Interpretation)*

health insurance is regarded as a constitutional fundamental freedom and should be respected on the basis of individualism and pluralism. Taking this into consideration, the NHI's compulsory health insurance scheme is a coercive program that substantially regulates an individual's liberty.

B. Individual Autonomy

Second, from the libertarian perspective, individuals should have the right to opt-out of health care plans on autonomy-based grounds. Libertarians believe that "greater consumer choice in the purchase of health insurance would better line up the interests of the buyers and insurers."¹³⁷ Libertarians also argue that individual liberties should be respected by allowing purchasers the freedom to choose insurance contract terms.¹³⁸ Because using a person to benefit others "does not sufficiently respect and take into account of the fact that he is a separate person,"¹³⁹ the individual mandate for health insurance, which requires some individuals to sacrifice their good for the benefit of others,¹⁴⁰ would violate the principle of individual liberty.¹⁴¹ In addition, the individual mandate seems paternalistic,¹⁴² in that it fails to respect individuals' incommensurable conceptions of the good regarding health care, which in turn reflects or indicates the diversity of their final ends and aspirations that they have formulated in their life plans.

The patient autonomy theory also expresses concerns about guaranteeing the liberty of every adult person of sound mind to determine what shall be done with his or her own body.¹⁴³ Since patient autonomy implies self-determination, self-rule, and liberty in the health care field,¹⁴⁴ the doctrine of autonomous decision-making should

No. 603 (September 28, 2005) (Taiwan); Const. Ct. Interp. No. 664, The Republic of China Constitutional Court (Grand Justices Council) Reporter, *Shizi (Judicial Yuan Interpretation) No. 664* (July 31, 2009) (Taiwan).

¹³⁷ Regina E. Herzlinger, *Finding "Truth" About Managed Care*, 24 J. HEALTH POL. POL'Y & L. 1077, 1080 (1999).

¹³⁸ Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, U. ILL. L. REV. 1361, 1385 (2007).

¹³⁹ According to Robert Nozick, "there is no moral outweighing of one of our lives by others so as to lead to a greater overall social good" and "[t]here is no justified sacrifice of some of us for others." ROBERT NOZICK, *ANARCHY, STATE, AND UTOPIA* 33 (1974).

¹⁴⁰ The main reason to prompt the individual mandate is to prevent adverse selection because adverse selection, a phenomenon that occurs when high-risk patients select a particular health care plan and cause major financial hardships, would induce premium increases and financial burdens on the poor. *See infra* Part VI. In other words, by sacrificing some individuals' monetary assets, others would be able to receive more affordable health insurance.

¹⁴¹ Monahan, *supra* note 138.

¹⁴² Epstein, *supra* note 132.

¹⁴³ *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129 (1914) (supporting the claim that patients have the right to make nonconforming medical decisions).

¹⁴⁴ For example, patient autonomy can be directly applied to support informed consent or informed choice, and the right to refuse medical treatment. Marshall B. Kapp, *Patient Autonomy in the Age of Consumer-Driven Health Care: Informed Consent and Informed Choice*, 28 J. LEGAL MED. 91, 93 (2007).

be expanded to apply to health care choices across the board—including both clinical and non-clinical aspects of one's own health care.¹⁴⁵ On the one hand, patients have a clear right to make their own clinical decisions to determine what medical treatments they want (e.g., the right to decide to or not to undergo medical treatments, and the right to choose diagnostic or screening tests, therapeutic procedures or medications, and research protocols).¹⁴⁶ On the other hand, it also follows from patient autonomy that patients have the right to make non-clinical decisions regarding general health care issues such as health care plans, immunization policies, and health education (e.g., choosing health care financial packages from among an array of personal savings, private insurance, and public health care programs) because of the influence these non-clinical decisions have on the accessibility, affordability, and quality of health care.¹⁴⁷ Therefore, it logically follows that individuals have a liberty, grounded in patient autonomy, to freely decide to (or not to) purchase a health care plan, and what health care plan to purchase.¹⁴⁸

Though some argue that the state should grant the exclusive authority to mandate health benefits¹⁴⁹ and such a mandate is necessary for the uninsured,¹⁵⁰ nonetheless many do not deny that coercing people into purchasing health insurance would restrict certain liberties.¹⁵¹ Instead of denying the existence of the freedom to purchase or decline health insurance (as revealed in the Japanese Constitutional Court's decision¹⁵²), some try to justify the individual mandate and its restrictions on individual liberty by arguing that “the obligation to contribute to [mandatory coverage of health insurance] is more important than any supposed liberty not to” because the public good at issue here is extremely important.¹⁵³ Thus, even those who argue in favor of the universal compulsory health insurance admit that the freedom to purchase or decline health insurance should be recognized and respected as embedded in the liberal notions of autonomy.

¹⁴⁵ *Id.*

¹⁴⁶ *Id.* at 92.

¹⁴⁷ *Id.*

¹⁴⁸ The Association of American Physicians and Surgeons also recognized patients' freedom to “use their own resources to purchase the care of their choice.” Association of American Physicians and Surgeons, Inc., *The Principles of Medical Ethics of the Association of American Physicians and Surgeons*, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS (Jan. 1991), available at <http://www.aapsonline.org/brochures/princip.htm>.

¹⁴⁹ Carol S. Weissert, *Promise and Perils of State-Based Road to Universal Health Insurance in the U.S.*, 7 J. HEALTH CARE L. & POL'Y 42, 42 (2004).

¹⁵⁰ *Id.* at 46-50; Daniel Gottlieb, *You can Take this Health Insurance and ... Mandate It?* 33 Seton Hall Legis. J. 535, 540-43 (2009); DANIELS ET AL., *supra* note 40, at 142-144.

¹⁵¹ Weissert, *supra* note 149, at 38. PAT ARMSTRONG, HUGH ARMSTRONG & CLAUDIA FEGAN, *UNIVERSAL HEALTHCARE: WHAT THE UNITED STATES CAN LEARN FROM THE CANADIAN EXPERIENCE* 123 (1998).

¹⁵² Saiko Saibansho [Sup. Ct.] Jan. 12, 1958, Hei 12(2) SAIKŌ SAIBANSHŪ MINJI HANREISHŪ [MINSHŪ] 190 (Japan).

¹⁵³ DANIELS ET AL., *supra* note 40.

C. Moral Powers

Third, the freedom to purchase or decline health insurance should be regarded as fundamental because it protects individuals' ability to make autonomous health care decisions, which are value-laden, dependent on one's perceived final ends, and related to the individual's own conceptions of the good.¹⁵⁴ This point is further supported by Rawls's model of justice, in which a list of basic rights and liberties can be drawn up analytically: "we consider what liberties provide the political and social conditions essential for the adequate development and full exercise of the two moral powers (capacities for the conception of the good and the sense of justice) of free and equal persons."¹⁵⁵ Thus, the freedom to purchase or decline insurance is fundamental because it enables individuals to exercise moral powers in forming, revising and rationally pursuing their own conceptions of the good regarding health care. Without this freedom, individuals can hardly make choices—which reflect the profound and sometimes irreconcilable differences in their moral and philosophical values¹⁵⁶—among reasonable alternatives (e.g., different medical interventions) proposed by different health care programs.

More specifically, medical interventions reflect the integrated physical and mental functions that the individual expects to reap by receiving such interventions, and these functions (e.g., restoring the body's functional parts from a disease) reflect the individual's own conception of the good (e.g., having functional body parts).¹⁵⁷ Therefore, the freedom to make health care decisions permits an individual not only to freely choose between different medical interventions, but also to choose between different conceptions of the good.¹⁵⁸ In short, when an individual chooses between different health care programs, at the same time he or she is also making choices

¹⁵⁴ According to Rawls, "[the conception of the good] is an ordered family of final ends and aims which specifies a person's conception of what is of value in human life or, alternatively, of what is regarded as a fully worthwhile life. The elements of such a conception are normally set within, and interpreted by, certain comprehensive religious, philosophical, or moral doctrines in the light of which the various ends and aims are ordered and understood." RAWLS, *supra* note 94, at 19. Because healthcare decisions are value-laden (on the basis of one's perceived final ends) and are related to the individual's conception of the good, such decisions then reflect individuals' conceptions of the good. RAWLS, *supra* note 94, at 19.

¹⁵⁵ RAWLS, *supra* note 94, at 44-45.

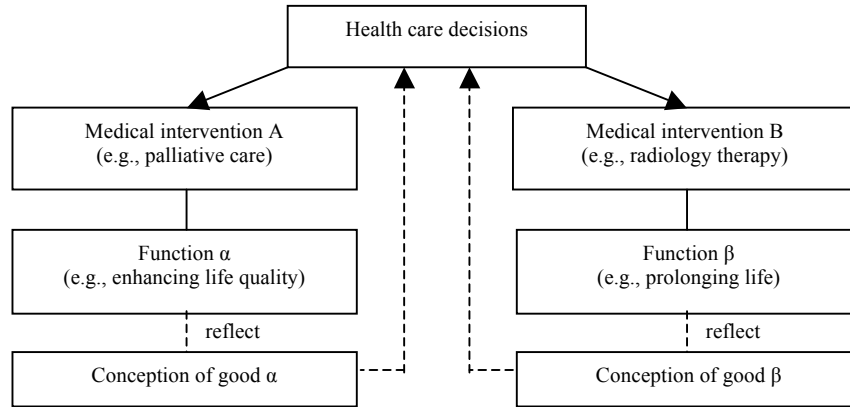
¹⁵⁶ For example, some societal subgroups (such as Jehovah's Witnesses) might have distinctive views on health care, and their health care decisions are strongly related to their religious values rather than to their perceived individual physical and mental benefits. *See, e.g., Stamford Hosp. v. Vega*, 674 A.2d 821 (Conn. 1996) (involving refusal of blood transfusion by Jehovah's Witness); *In re Dubreuil*, 629 So. 2d 819 (Fla. 1993) (linking the constitutional right of freedom of religion and the right to refuse medical treatment).

¹⁵⁷ Here I treat the fulfillment of health care needs as a valuable good in the life plan. I believe that Rawls would agree with this, because he also argues that the fulfillment of basic human needs could be regarded as goodness. *See* RAWLS, *supra* note 115, at 141.

¹⁵⁸ Furthermore, in addition to the micro perspective, the macro perspective also verifies that health care decisions are value laden. Because sometimes people make healthcare decisions as members of a group (e.g., as Catholics), healthcare decisions then not only respond to an individual's preference of utility (or function), but also reflect an individual's moral or religious values flowing from his or her general commitments to the group. *See generally, Vega*, 674 A.2d at 824, 825; *In re Dubreuil*, 629 So. 2d at 822.

between different medical interventions, which reflect the individual’s own conceptions of the good.¹⁵⁹ Therefore, the freedom to purchase or decline health insurance—which assures that an individual can freely form carefully considered goals and desires, as well as the ability to fulfill such goals and desires¹⁶⁰—then becomes a necessary means for the individual to fully and freely exercise the moral power to pursue the conceptions of the good.¹⁶¹

Figure 2. The Health Care Decision-Making Process



D. Historical Development

Fourth, the development of health care policies worldwide also shows continuing emphasis on individual liberty to purchase or decline health care insurance. For example, even though European countries generally believe there are good reasons for compulsory health insurance, they have faced challenges to this view based on individual liberty.¹⁶² In Germany, trade unions believed that compulsory health insurance (proposed in the Health Insurance Act in 1883) would be a paternalistic reform creating a system of state supervision of the peoples’ health.¹⁶³ As a result of this concern, even today those with an income above a certain threshold (€48,150 per year in 2008)¹⁶⁴ are still allowed to choose whether to opt out of the statutory health insurance.¹⁶⁵ Thus, the extent of compulsoriness within the social health insurance

¹⁵⁹ See *infra* Figure 2.

¹⁶⁰ TOM BEAUCHAMP & JAMES CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 58-61 (2001).

¹⁶¹ This research focuses mainly on the relationship between the disenrollment freedom and the capacity to conceptualize what is good because such a freedom is irrelevant to the capacity for the sense of justice.

¹⁶² PAUL V. DUTTON, *DIFFERENTIAL DIAGNOSES: A COMPARATIVE HISTORY OF HEALTH CARE PROBLEMS AND SOLUTIONS IN THE UNITED STATES AND FRANCE* (2007).

¹⁶³ The trade unions later changed their opinions after realizing that workers were able to exert influence in managing the sickness funds. Stefan Gress et al., *The Social Transformation of American Medicine: A Comparative View from Germany*, 29 J. HEALTH POL. POL’Y & L. 679, 686 (2004).

¹⁶⁴ See Kaiser Family Foundation, *supra* note 131, at 12.

¹⁶⁵ See Dixon et al., *supra* note 131, at 179.

might be limited due to the protection of individuals' liberty.¹⁶⁶ In the Netherlands in 2006, health care reform, which made health insurance compulsory for the entire population,¹⁶⁷ was also criticized for limiting the freedom of choice both within the health care market and within insurance markets.¹⁶⁸ This struggle shows the endeavor to balance individual liberty and social welfare. On the one hand, social health insurance departed from liberalism by expanding the role of the state and demanding compulsory contributions.¹⁶⁹ On the other hand, it also departed from paternalism by obligating the state to prove that restricted individual liberties are not out of proportion to the benefits received under the mandatory duties imposed by such a scheme.

In the U.S., several states (such as Virginia, Arizona, and Missouri) have proposed variations of a Health Care Freedom Act, in which the right not to be forced or coerced into joining a government-approved health care program is regarded as a basic right of medical autonomy.¹⁷⁰ State legislation in the U.S. shows a high interest in protecting individual choice in coverage and service under health care insurance plans. This interest is a continuing balancing act between providing services for the truly needy with the American desire for a lightly governed health care delivery system.¹⁷¹

¹⁶⁶ See Dixon et al., *supra* note 131, at 179.

¹⁶⁷ Before 2006, in the Netherlands, those with an income above certain amount (e.g., €31,750 in 2003) are excluded from the social insurance scheme. In other words, The Dutch health care system consisted in two different forms of insurance (two tier scheme): compulsory insurance for those with an income level under a certain level of income and voluntary insurance for those earning more than this ceiling. However, after the Health Care Insurance Act (*Zorgverzekeringswet*) entered into force in 2006, all persons residing in the Netherlands are required by law to be insured under the National Insurance Schemes. See Dixon et al., *supra* note 131, at 179; See Muiser, *supra* note 131, at 9.

¹⁶⁸ But Romke Van der Veen also argued "these limitations are necessary in order to maintain solidarity in health care insurance and provisions and in order to create cost-control." Romke van der Veen, *supra* note 131, at 5.

¹⁶⁹ Paul Starr then argued that the development of social health presents an extension of obligations as well as freedom because it constitutes an extension to social welfare on liberal principle of civil and political rights. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY* 238 (1982).

¹⁷⁰ *Id.* For example, House Bill 10 of the Virginia Health Care Freedom Act states that, "No law shall restrict a person's natural right and power of contract to secure the blessings of liberty to choose private health care systems or private plans. No law shall interfere with the right of a person or entity to pay for lawful medical services to preserve life or health, nor shall any law impose a penalty, tax, fee, or fine, of any type, to decline or to contract for health care coverage or to participate in any particular health care system or plan, except as required by a court where an individual or entity is a named party in a judicial dispute. Nothing herein shall be construed to expand, limit or otherwise modify any determination of law regarding what constitutes lawful medical services within the Commonwealth." 2010 Va. Acts. H.B. 10.

¹⁷¹ See Weissert, *supra* note 149, at 66.

VI. STEP 2: CLARIFY THE POLICY PURPOSES OF THE COMPULSORY NHI

It is important to identify health care policy purposes because health care policy requires different means to achieve various purposes and some means impact human rights. There are two reasons for this. First, clearly articulated goals for health care policies can help “to identify the true purposes of the intervention, to facilitate public understanding and debate about legitimate purposes, and to reveal prejudice (or pre-judice), stereotypical attitudes, or irrational fear.”¹⁷² Without a clear policy purpose, it is difficult to explicitly identify what policy instruments influence human rights, and to evaluate whether the means to execute certain policies are adequate to achieve their purpose.¹⁷³ Second, in addition to addressing a clear purpose, in this step the state also needs to prove that the means used by a coercive health care policy are reasonably likely to achieve the proposed purpose, and that there is an adequate and direct connection between the state’s actions and the policy’s purposes.¹⁷⁴ In other words, the existence of a valid compelling purpose alone cannot justify a health care policy because the real issue here is not “what the state does” but “whether the health care policy adequately leads to an effective outcome.”

In assessing the human rights impacts of Taiwan’s compulsory NHI, policy purposes should be clearly evaluated because they can help identify the true purposes and inform the debate about legitimate health care purposes.¹⁷⁵ According to Taiwan’s Department of Health¹⁷⁶ and Council of Grand Justices,¹⁷⁷ Taiwan’s NHI adopts an individual mandate as an instrument to achieve multiple goals:¹⁷⁸ (1) increasing the participation rate and enrollees to increase the financial resources of the NHI; and (2) preventing negative effects caused by adverse selection (also termed “reverse selection” or “enrollee bias”).¹⁷⁹ The needs for invasive interventions

¹⁷² Gostin & Mann, *supra* note 45, at 61.

¹⁷³ Gostin & Mann, *supra* note 45, at 61.

¹⁷⁴ This principle has been generally applied based on First Amendment protections in U.S. Constitution. In *Rice v. Paladin Enterprises, Inc.*, for example, the Fourth Circuit argued that if a publication could be found to have no other use than to facilitate unlawful conduct, the speech creating a significant societal harm is enough to give rise to a compelling governmental interest in proscribing such speech. *Rice v. Paladin Enters, Inc.*, 128 F.3d 233, 247 (4th Cir. 1997).

¹⁷⁵ See Gostin & Mann, *supra* note 45, at 61.

¹⁷⁶ See THE LEGISLATIVE YUAN, THE LEGISLATIVE YUAN GAZETTE: NATIONAL HEALTH INSURANCE ACT 11.1 (The Legislative Yuan Secretariat ed., 1994) (Taiwan).

¹⁷⁷ Taiwan’s Grand Justice Council argued that the constitutional purposes of the NHI are providing mutual social support, advancing risk-sharing, and promoting public interests. Const. Ct. Interp. No. 472, The Republic of China Constitutional Court (Grand Justices Council) Reporter, *Shizi (Judicial Yuan Interpretation) No. 472* (January 29, 1999) (Taiwan), available at http://www.judicial.gov.tw/constitutionalcourt/EN/p03_01.asp?expno=472.

¹⁷⁸ THE LEGISLATIVE YUAN GAZETTE: NATIONAL HEALTH INSURANCE ACT 2 (The Legislative Yuan Secretariat ed., 1994).

¹⁷⁹ See generally THE LEGISLATIVE YUAN GAZETTE: NATIONAL HEALTH INSURANCE ACT 11.1 (The Legislative Yuan Secretariat ed., 1994) (mandating the types of groups who must enroll in healthcare).

imposed by the NHI on individual autonomy are then assessed differently for different public health purposes in this section.¹⁸⁰

The NHI's individual mandate is reasonably likely to achieve the first policy purpose—increasing the participation rate—because requiring all citizens to subscribe the NHI creates a single, national pool and broadens the revenue base, thereby providing comprehensive coverage for all Taiwanese people.¹⁸¹ Different countries' experiences (such as Taiwan, Japan, Germany, The Netherlands, U.K., and Canada)¹⁸² also show that the compulsory health care system did improve actual population coverage,¹⁸³ establish a self-financing mechanism,¹⁸⁴ and significantly lowered financial barriers that prevent the poor from receiving health care.¹⁸⁵

The second policy purpose of the NHI's individual mandate is to prevent adverse selection, which is “a phenomenon that occurs within a mix of covered lives for a plan, when patients with high health care utilization habits select a particular plan, in greater numbers than are otherwise representative of the population as a whole.”¹⁸⁶ The individual mandate achieves this end by prohibiting the exclusion of people from coverage because of preexisting conditions or anticipated health risks.¹⁸⁷ Because social health insurance systems are required to cover individuals and their

¹⁸⁰ *Id.*

¹⁸¹ Daniels also argued that health care institutions must provide appropriate, effective services to everyone in order to protect equality of opportunity. Norman Daniels et al., *Fairness and National Health Care Reform*, HEALTH CARE REFORM: ETHICS AND POLITICS 245 (Timothy H. Engström & Wade L. Robison eds., 2006). In other words, excluding certain groups from coverage and leaving significant gaps in insurance coverage would violate the basic principle of the universal coverage.

¹⁸² See, e.g., ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, THE REFORM OF HEALTH CARE: A COMPARATIVE ANALYSIS OF SEVEN OECD COUNTRIES (1993); ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, THE REFORM OF HEALTH CARE: A COMPARATIVE ANALYSIS OF SEVENTEEN OECD COUNTRIES (1994).

¹⁸³ For example, before 1995 about 57% of the population in Taiwan was insured through three separate programs. Likwang Chen et al., *The Effects of Taiwan's National Health Insurance on Access and Health Status of the Elderly*, 16(3) HEALTH ECON. 223, 223-24 (2007). By the end of 1995, when the NHI was launched, 97% of the population had enrolled in the NHI, and the coverage rate has reached almost 99% in 1997 and has remained at that level ever since. *Id.* In Netherlands, even though the population coverage (the proportion of the population that is financially protected by a certain health financing scheme) before health care reform in 2006 was already practically universal, the new model still attempts to achieve true universal coverage by requiring all citizens to register for an insurance fund at the sanction of a fine worth 130% of the premium. Muiser, *supra* note 131, at 14.

¹⁸⁴ AVIVA RON ET AL., HEALTH INSURANCE IN DEVELOPING COUNTRIES: SOCIAL SECURITY APPROACH 25 (1990); Muiser, *supra* note 131, at 16.

¹⁸⁵ PAT ARMSTRONG ET AL., UNIVERSAL HEALTHCARE: WHAT THE UNITED STATES CAN LEARN FROM THE CANADIAN EXPERIENCE 62 (1998); Muiser, *supra* note 131, at 16; ShouHsia Cheng, *The Effect of Universal Health Insurance on Health Care Utilization in Taiwan*, 278(2) JAMA 89, 89 (1997).

¹⁸⁶ RICHARD ROGNEHAUGH, THE MANAGED HEALTH CARE DICTIONARY 7 (1998).

¹⁸⁷ Mario Loyola, *Anti-Obamacare Brief, Explained*, NATIONAL REVIEW ONLINE (Jan. 6, 2012), <http://www.nationalreview.com/corner/287435/anti-obamacare-brief-explained-mario-loyola>.

pre-existing health conditions, nothing prevents a healthy individual from forgoing purchasing insurance until he or she is sick.¹⁸⁸ But studies showed that people would not likely enroll in health insurance unless they expected illness or an accident in the near future or they were already sick or disabled.¹⁸⁹ Therefore, without a mandate to purchase health insurance, healthy individuals would leave the health insurance to only the costliest individuals (who are mainly the sick and the old).¹⁹⁰ Adverse selection would then lead to severe financial hardships for the social health insurance scheme¹⁹¹ because it would be covering only those sick or high-risk individuals.¹⁹²

In addition, adverse selection also undermines the whole point of social health insurance, which is to protect people by sharing risks as widely as possible.¹⁹³ Private health insurers tend to target healthy individuals and to exclude those who face abnormally high risks due to their poor health behaviors (e.g., lung cancer caused by smoking).¹⁹⁴ Therefore, without a compulsory mechanism, high risk and sick individuals and groups would be “unproportionately” distributed between social health insurance and private health insurance. Thus, disadvantaged minority groups (e.g., the poor and the sick) would comprise the majority of social health insurance subscribers,¹⁹⁵ and social health insurance would end up with large expenses and be unfairly placed at a competitive disadvantage. The disadvantaged then might be denied coverage or given reduced coverage with higher premiums because of the expected costs of health care services.¹⁹⁶ Furthermore, in a vicious spiral, more and more healthy people would withdraw from social health insurance due to the excess

¹⁸⁸ *Id.*

¹⁸⁹ R. L. Archer, *Adverse Selection in the Health Care Financing System*, 79(6) BESTS REV. LIFE HEALTH. INSUR. ED. 10 (1978); K. Drummer, *Controlling Adverse Selection*, 2(1) HEALTH COST MANAGE 1 (1985).

¹⁹⁰ Citizens might not want to buy any health insurance or might choose to join private health insurance with a lower premium (but with less medical coverage) when they are healthy. But, citizens who are seriously sick, or at an advanced age when they would more like face serious illnesses, would be more willing to join social health insurance because private insurance would charge extremely high premiums due to their conditions or advanced age.

¹⁹¹ See Gottlieb, *supra* note 150, at 543. Gottlieb also argues that in the U.S. the proposals for health care reform are insufficient to reach the goal of universal coverage because they fail to prevent adverse selection. Gottlieb, *supra* note 150, at 543.

¹⁹² See Gottlieb, *supra* note 150, at 546.

¹⁹³ See Daniels et al., *supra* note 181, at 246.

¹⁹⁴ It must be noted that adverse selection is not limited to patients or purchasers because “insurers can also engage in adverse selection by marketing insurance to individuals less likely to need medical services than average or by excluding high risk individuals and groups.” Marc A. Rodwin, *The Metamorphosis of Managed Care: Implications for Health Reform Internationally*, 38 J.L. MED. & ETHICS 352, 654 n.13 (2010).

¹⁹⁵ James Cardon & Mark Showalter, *Insurance Choice and Tax-Preferred Health Savings Accounts*, 26(2) J. HEALTH ECON. 373, 389 (2007).

¹⁹⁶ See Daniels et al., *supra* note 181, at 246; Richard A. Garcia, *Equity for All? Potential Impact of the Mental Health Parity and Addiction Act of 2008*, 31 J. LEGAL MED. 137, 149 (2010).

financial burden, and this would further worsen the financial viability of social health insurance.¹⁹⁷

The formula for determining social health insurance premiums (see *infra*, Table 1¹⁹⁸) can help clarify whether a compulsory health insurance scheme could prevent (or reduce) the negative effects caused by adverse selection.¹⁹⁹ In this formula, the social health insurance premium rate (P_A) is calculated and set in accordance with the average disease risk (R_A). In the first case, if an individual has a lower disease risk (R_L), he or she would have a lower premium rate (P_L). Since the social health insurance premium (P_A) is determined by an average disease risk (R_A) and $R_A > R_L$, the individual using public health care insurance is required to pay a higher premium P_A (a fixed average insurance premium rate) instead of P_L . Thus, if the compulsory health insurance scheme is unregulated, and citizens are allowed to freely withdraw from the insurance at any time, healthier citizens would likely not enroll in social health insurance because they would need to pay relatively high premiums.²⁰⁰ In the second case, for an individual with a higher risk of disease (R_H), the premium rate (P_H) would be high in relation to R_H . Because $R_A < R_H$, the social health insurance premium (P_A) is lower than P_H . Consequently, citizens with a higher disease risk would likely enroll in social health insurance because they only need to pay a relatively low premium.²⁰¹

Table 1. Formula for Setting Health Insurance Premiums²⁰²

$$R_A = \beta R_H + (1 - \beta) R_L$$

R_A : average disease risk

R_H : high disease risk

R_L : low disease risk

($R_H > R_A > R_L$)

β : percentage of people with high disease risk in population

Therefore, social health insurance plans would be greatly weakened by adverse selection if they allow recipients unlimited disenrollment freedom after the program is enacted.²⁰³ The compulsory health insurance scheme then becomes an appropriate and valid solution to avoid negative effects of adverse selection because it can help healthcare authorities successfully adjust the diversified risks of diseases (and the corresponding premium rates). It is also likely to reduce selection bias.

In conclusion, increasing the participation rate, maintaining financial efficiency, and preventing adverse selection are clear and achievable policy purposes of Taiwan's compulsory NHI. Thus, it would be difficult to challenge their constitutionality.

¹⁹⁷ See Loyola, *supra* note 187.

¹⁹⁸ GI-RUI XIE, HEALTH ECONOMICS 221 (1996).

¹⁹⁹ *Id.*

²⁰⁰ See Loyola, *supra* note 187.

²⁰¹ See GI-RUI XIE, *supra* note 198.

²⁰² See GI-RUI XIE, *supra* note 198.

²⁰³ Charles Tiefer & Heather Akehurst-Krause, *Risky Business: Medicare's Vulnerability to Selection Games of Managed Care Providers*, 28 U. BALT. L. REV. 319, 325-26 (1999).

VII. STEP 3: EVALUATE THE EFFECTIVENESS OF THE COMPULSORY NHI

If a health care policy is proven to be “reasonably” able and “likely” to achieve its proposed purposes, the state should then compare the policy with other alternatives. If other policy instruments would burden basic rights and liberties to a lesser extent while still providing a likelihood of achieving the proposed purposes, a coercive health care policy would be unjustified. It would be unjustified because it fails to adopt the least restrictive alternative to achieving the same purpose.²⁰⁴ Given this standard (step 3) and the evaluation of the effectiveness (step 2), the state would not be permitted to resort to restrictions on individual liberty if it could achieve the proposed purpose through less drastic and coercive means.

Therefore, after proving that the compulsory NHI can reasonably and likely achieve its proposed purposes, the state then has the burden to prove such a coercive program is the least restrictive alternative that burdens individual liberty to a lesser extent, while still having a likelihood of achieving its proposed purpose. More specifically, society should question whether requiring all citizens rather than only some, or a substantial portion thereof, to participate in one particular social health insurance plan is the least restrictive policy. However, the reality in Taiwan has been that the executive, the legislature, and the courts have never carefully evaluated the degree of invasiveness implicit in the NHI’s individual mandate.

Although studies have shown that a compulsory health insurance scheme is a decent policy instrument²⁰⁵ that effectively prevents adverse selection in social health care programs,²⁰⁶ minimizes the cost of health care services,²⁰⁷ and reduces entry barriers to receiving health care,²⁰⁸ the NHI’s requirement that all citizens participate in the plan is not the least restrictive alternative to achieve these policy objectives. Health economic studies²⁰⁹ and experiences of some countries (including Germany

²⁰⁴ In United States, the “least restrictive means test” reflects the spirit of this principle. The court in *Lake v. Cameron* held that mentally ill patients should not be subject to deprivations of liberty beyond what is necessary to protect them, and that the court should be authorized to consider and evaluate the alternatives to hospitalization of patients with mental illness because “alternative courses of treatment or care should be fashioned as the interests of the person and of the public required” in each particular case. *Lake v. Cameron*, 364 F.2d 657, 660 (D.C. Cir. 1966).

²⁰⁵ See *infra* Parts VII & VIII. Regarding the objectives of compulsory health insurance, there are other alternatives that can achieve the same objectives. For example, the state can offer incentives such as reducing employment taxes or providing financial subsidies to encourage, instead of force, the young and the healthy to enroll in the public health insurance. But these alternatives not only influence other basic liberties (such as property rights) but also fail to efficiently achieve the policy purposes as the compulsory health insurance scheme does, because citizens with lower disease risks still have a great chance to refuse to enroll in public health care programs.

²⁰⁶ ZHI-LIANG YANG, HEALTH INSURANCE 11 (1996); MU-XING KE, SOCIAL INSURANCE 60-61 (1994); GAO-GIAO XIE, THE SOCIAL IMPACTS OF NATIONAL HEALTH INSURANCE 147-52 (1990).

²⁰⁷ MARK PAULY ET AL., RESPONSIBLE NATIONAL HEALTH INSURANCE 3-4 (1992).

²⁰⁸ PAUL FELDSTEIN, HEALTH POLICY ISSUES: AN ECONOMIC PERSPECTIVE 267-70 (3d ed. 2003).

²⁰⁹ ZHI-LIANG YANG, HEALTH INSURANCE 11-13 (1996); GI-RUI XIE, HEALTH ECONOMICS 222-23 (1996).

and the Netherlands) show that a high participation rate suffices to create a large scale market sufficient to include both healthy and unhealthy people and to circumvent adverse selection.²¹⁰ Therefore, compared to Taiwan's universal compulsory NHI, a health plan with an opt-out system for a minority of citizens could be a less restrictive alternative for Taiwan if it restricted individual liberty less but still had a predetermined large number of participants.

The opt-out system no doubt has its own problems,²¹¹ and the Netherlands eventually adopted an individual mandate requiring individuals to purchase health insurance. However, studies have shown that these problems can be diminished through proper regulations (such as "must-cover" legislation²¹² and the ban on risk selection²¹³) instead of a compulsory individual mandate for "all" citizens. In other words, with proper regulations the opt-out system may still be able to achieve compelling policy purposes while burdening individual liberties to a lesser extent.

For example, Germany's public compulsory health care plan does not require all citizens to participate.²¹⁴ Instead, only laborers and workers²¹⁵ whose salaries are under a certain level (€48,150 per year in 2008)²¹⁶ are compelled by law to enroll in the state-sponsored health insurance. Citizens whose income is higher than a certain level are allowed to opt out, and all civil servants and the self-employed are excluded from the state's mandatory health insurance.²¹⁷ These excluded citizens have the freedom to choose to enroll in either the state-sponsored health insurance or a private health insurance plan.²¹⁸ The state agrees to give the wealthy and the self-employed more liberties because it is neither necessary nor urgent to provide health insurance for the high-salary earners, who ostensibly have enough financial ability to pay for their own medical care. On the contrary, the state assumes it should provide more health care to

²¹⁰ See Muiser, *supra* note 131, at 14

²¹¹ Martina Grunow & Robert Nuscheler, *Public and Private Health Insurance in Germany: The Ignored Risk Selection Problem 2-3* (Institute for Economics, Universitaet Augsburg, Discussion Paper No. 312, 2010), available at <http://www.wiwi.uni-augsburg.de/vwl/institut/paper/312.pdf>. For example, in Germany, due to risk selection between public and private branches of health care financing, private patients are able to escape income redistribution so that health care financing does not follow the ability-to-pay principle. See Muiser, *supra* note 131, at 9; In Netherlands, the two-tier system (mandatory and voluntary health insurance) before 2006 also sustained a level of inequity "due to differences in the benefit packages of the mandatory and voluntary scheme." *Id.*

²¹² See Gottlieb, *supra* note 150, at 545.

²¹³ Judith D de Jong, Atie van den Brink-Muinen & Peter Groenewegen, *The Dutch Health Insurance Reform: Switching Between Insurers, a Comparison Between the General Population and the Chronically Ill and Disabled*, 8 BMC HEALTH SERVS. RESEARCH 58, 59 (2008).

²¹⁴ ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, *THE REFORM OF HEALTH CARE: A COMPARATIVE ANALYSIS OF SEVEN OECD COUNTRIES 57-72* (1992).

²¹⁵ See *id.* The insured includes (a) the employees whose monthly salary is lower than certain amount, (b) the workers or members who belong to the occupational groups or unions, and (3) the beneficiaries of the annuity. *Id.*

²¹⁶ See Kaiser Family Foundation, *supra* note 131, at 12.

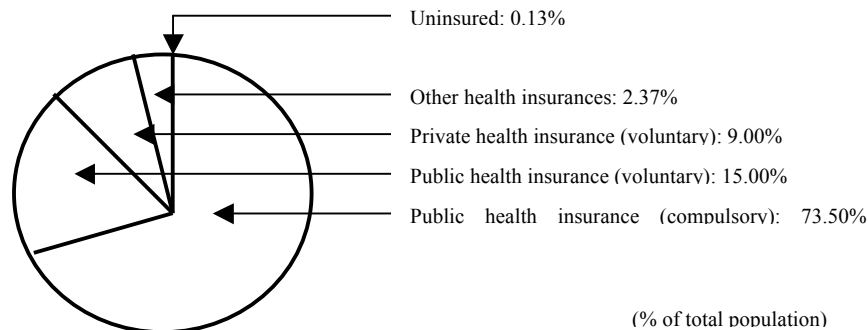
²¹⁷ See Dixon et al., *supra* note 131, at 179-80.

²¹⁸ See Dixon et al., *supra* note 131, at 179-80.

laborers because social risks, such as the spread of disease, impact low-wage earning citizens. These social risks curtail salaries of low-wage earners and have far more serious influences on the low wage-earner and the disadvantaged than on the employers and the self-employed.²¹⁹

Even though the German government does not require all citizens to participate in its public health insurance, the participation rate in health insurance is still significantly high to prevent (or adjust) adverse selection.²²⁰ In 1993, the participation rate in Germany’s public health insurance was 88.5%.²²¹ Only 73.5% of the insured were compelled by law to subscribe to public health insurance, while 15% of the insured voluntarily enrolled in public health insurance.²²² The rate has remained high and fairly stable for decades; 72% and 74% are compulsorily insured, 14% and 14% are voluntarily insured with social insurance, and 9% and 14% had private health insurance in 2001 and 2005.²²³ Therefore, even when the German government requires only a substantial portion of citizens to enroll in public health insurance, the participation rate is not substantially influenced. There is no adverse selection because the healthy and the young are still willing to enroll in public health insurance.

Figure 3. Germany’s Participation Rates in Health Care Plans (1993)



²¹⁹ For example, David Moss believed that the country’s salvation lay in creating a system of protection for wage earners — a security state. DAVID MOSS, *SOCIALIZING SECURITY: PROGRESSIVE-ERA ECONOMISTS AND THE ORIGINS OF AMERICAN SOCIAL POLICY* 4-6 (1996). The American Association for Labor Legislation (AALL) also argued that the state should provide proper health care programs (in labor legislation) to protect workers from the worst excesses of industrial capitalism. *Id.*; HOFFMAN, *supra* note 31.

²²⁰ See Muiser, *supra* note 131, at 14.

²²¹ See ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, *supra* note 214, at 58.

²²² ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, *supra* note 214, at 58; see *infra* Figure 3.

²²³ Markus Schneider, *Structure and Experience of German Opt-Out System of Statutory Health Insurance (GKV)* 9 (World Bank Human Development Sector Unit, Working Paper, 2003), available at http://siteresources.worldbank.org/INTRUSSIANFEDERATION/Resources/German_Opt-Out_eng.pdf; George France, *The Form and Context of Federalism: Meanings for Health Care Financing*, 33 J. HEALTH POL. POL'Y 649, 652 (2008).

Similarly, the participation rate in social health insurance was high in the Netherlands before the 2006 health care reform.²²⁴ This was true even when the state required only some groups (e.g., the low wage-earner, the unemployed, and the handicapped) to enroll in the state-sponsored health insurance program.²²⁵ More specifically, the previous Dutch social health insurance system was divided into four categories:²²⁶

- (1) The exceptional medical expenses scheme, which paid for catastrophic health care and required all citizens to enroll,²²⁷
- (2) The sickness funds insurance,²²⁸ which required citizens whose annual income was less than €32,600 (US \$44,475 in 2003) and those receiving social security service or remedies (the unemployed and the handicapped) to participate. In 2003, these two groups comprised 63% of the population,²²⁹
- (3) The state-funded insurance for public servants, which required public employees (3% of the population in 2003) to sign up for coverage that included benefits similar to those provided by sickness funds,²³⁰ and
- (4) Self-employed and employees earning over a certain income limit could voluntarily buy the supplementary health insurance program (private insurance).²³¹

Excluding the exceptional medical expenses scheme, even though only 66% (63% + 3%) of the population was required to enroll in Dutch social health insurance plans;²³² in 2003, the participation rate was 96% of the Dutch population.²³³ In terms of actual coverage, the opt-out scheme left little room for improvement and was able to achieve the proposed policy purposes (increasing the participation rate and preventing adverse selection) of the compulsory NHI, without imposing broad and profound restrictions on individual liberties.²³⁴

²²⁴ See Muiser, *supra* note 131, at 14.

²²⁵ See ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, *supra* note 214, at 87-101.

²²⁶ JI-CYONG LUO, NATIONAL HEALTH INSURANCE 227-314 (2006).

²²⁷ See ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, *supra* note 214, at 89-90. This scheme pays mainly for long-term care in nursing homes, in psychiatric institutions and in general hospitals when the duration of stay exceeds 365 days.

²²⁸ See ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, *supra* note 214, at 89-90. This is a compulsory health insurance administrated by numerous independent and non-profit insurance funds.

²²⁹ JOAN C. LO, NATIONAL HEALTH INSURANCE: EXPERIENCES OF JAPAN, GERMAN, FRANCE AND NETHERLANDS 235 (2006).

²³⁰ See *id.*

²³¹ See *id.* In 2003, 5% of the population was buying private health insurance.

²³² See Muiser, *supra* note 131, at 14. The Dutch social health plan includes both public health insurance and private health insurance, which has the same medical coverage with public health insurance.

²³³ See Lo, *supra* note 229, at 234-35.

²³⁴ See Muiser, *supra* note 131, at 14.

Even though the 2006 Dutch health care reform abandoned the opt-out system in favor of the individual mandate for health insurance, increasing the participation rate (as proposed by the NHI) is not the reason why the new Dutch health care model requires all citizens to register for a health insurance.²³⁵ The health insurance coverage in the Netherlands was already practically universal before the new model was implemented.²³⁶ The new system's policy objective aims to eliminate health inequity caused by differences between the benefit packages offered under the mandatory and voluntary health care schemes respectively,²³⁷ rather than to maximize the participation rate or to increase financial resources.

This comparison amongst Taiwan's, Germany's, and the Netherlands' national health care programs reveals that Taiwan's actual enrollment rate of 99.48% of the population (in 2008),²³⁸ is slightly higher than the German and Dutch rates of 87.8%²³⁹ and 96%²⁴⁰ (in 2003). However, Taiwan requires 100% of its citizens to enroll while Germany required 75% to do so in 2005 and the Netherlands just 67% in 2003.²⁴¹ Yet, since the actual German and Dutch enrollment rates were well above 80%, it is clear that requiring all citizens to register for social health insurance is not the least restrictive alternative that may be employed to efficiently achieve a high participation rate and to avoid the negative impacts of adverse selection. The German and Dutch experiences show that, instead of all-inclusive compulsory health insurance, there are different alternatives (e.g., the opt-out system) that achieve compelling policy objectives. The state should be obligated to adopt the least restrictive alternative, which is to require only certain segments of citizens to enroll in compulsory social health insurance. Taiwan's universal compulsory NHI, which requires all citizens to register, is not the least restrictive alternative and is therefore not justified in restricting an individual's freedom to purchase or decline health insurance.

VIII. STEP 4: ASSESS TRADE-OFF RELATIONSHIPS IN COMPULSORY NHI (IMPORTANCE TEST)

In order to justify a coercive health care policy, in addition to evaluating its adequacy (step 2) and effectiveness (step 3), the state also has the burden to prove that the weight of restricted rights and liberties is not out of proportion with the pursued public order (or social benefits).²⁴² Assessing trade-off relationships in

²³⁵ See Muiser, *supra* note 131, at 10-11.

²³⁶ See Muiser, *supra* note 131, at 14.

²³⁷ See Muiser, *supra* note 131, at 9; Pauline Vaillancourt Rosenau et al., *An Experiment with Regulated Competition and Individual Mandates for Universal Health Care: The New Dutch Health Insurance System*, 33 J. HEALTH POL. POL'Y & L. 1031, 1033 (2008).

²³⁸ The National Health Insurance Statistics, 2008, BUREAU OF NAT'L HEALTH INS. (August 1, 2008), http://www.nhi.gov.tw/English/webdata/webdata.aspx?menu=11&menu_id=296&webdata_id=3109.

²³⁹ See Dixon et al., *supra* note 131.

²⁴⁰ See Lo, *supra* note 229, at 234-35.

²⁴¹ See Muiser, *supra* note 131, at 14.

²⁴² United States courts also emphasize that societal harm manifests itself in its assessment of the magnitude of governmental interest; thus, the greater the harm, the stronger the interest. See *Sherbert v. Verner*, 374 U.S. 398 (1963) (citing *Braunfeld v. Brown*, 366 U.S. 599, 607

health care policy is important²⁴³ because this assessment provides a procedural and substantive standard to determine whether the state has retained considerable discretion when pursuing its health care policy purposes.²⁴⁴ Taiwan's Constitution also requires that any trade-off between restricted freedoms and pursued public benefits in a coercive policy should be assessed. This requirement is derived from Article 23 of the Constitution which states: "[a]ll the freedoms and rights enumerated in the preceding articles shall not be abridged by law except such as may be necessary to prevent infringement upon the freedoms of others, to avert an imminent danger, to maintain social order or to advance public welfare."²⁴⁵

A. The Importance Test

In order to assess the trade-off in the NHI's compulsory health insurance scheme, I propose to apply the "importance test" on the basis of Rawls' analytical approach in his political conception of justice²⁴⁶ and to outline the scope of invasiveness and the burden the NHI imposes on human rights. The "importance test" emphasizes that the burden on a liberty (e.g., individual autonomy) imposed by a coercive health care policy (e.g., compulsory health insurance) is unjustified if the burden restricts the central application range (the exercise of moral powers) of that liberty.

According to Rawls' moral powers approach,²⁴⁷ full and informed exercise of moral powers (capacities for the conception of the good and the sense of justice)²⁴⁸ is crucial for the protection of basic liberty in a coercive (health care) system. The

(1961)) For example, the U.S. Supreme Court in *Sherbert* held that "if [the] purpose or effect of a law is to impede observance of one or all religions or is to discriminate invidiously between religions, that law is constitutionally invalid even though the burden may be characterized as being only indirect." *Id.* at 404. In another case the Supreme Court noted that "[w]hen clear and present danger of riot, disorder, interference with traffic upon the public streets, or other immediate threat to public safety, peace, or order, appears, the power of the State to prevent or punish is obvious." *Cantwell v. State of Connecticut*, 310 U.S. 296, 308 (1940).

²⁴³ For example, according to the Universal Declaration of Human Rights (UDHR), the limitations of human rights must be "determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society." Universal Declaration of Human Rights art 29, ¶ 2, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) (Dec. 10, 1948).

²⁴⁴ In order to make an individual determination of a proper trade-off relationship, Gostin and Mann propose to apply the "significant risk standard" in the human rights impact assessment for public health policies, which permits coercive measures only to avert likely harm (a significant risk) to the health or safety of the society. Gostin & Mann, *supra* note 45, at 75

²⁴⁵ MINGUO XIANFA art. 23, (1946) (Taiwan), available at <http://www.taiwandocuments.org/constitution01.htm#C003>.

²⁴⁶ Rawls also proposed two fundamental cases, which are connected with capacities for the conception of the good and the sense of justice (moral powers), as a criterion to identify truly essential liberties and to assign them priority. RAWLS, *supra* note 94, at 45, 112-13.

²⁴⁷ RAWLS, *supra* note 94, at 18-19, 196; RAWLS, LIBERALISM, *supra* note 92, at 19, 81, 108.

²⁴⁸ RAWLS, *supra* note 94, at 18-19.

exercise of these powers is crucial because without them rational deliberators can neither become engaged in social cooperation nor be free and equal members of society.²⁴⁹ In order to address this issue, this section briefly reviews Rawls' responses to the questions of (1) whether the list of basic liberties is flexible enough to adjust and expand, and (2) how to assess the significance of a particular liberty.²⁵⁰ Rawls agrees that simply offering a broad and imprecise list of basic liberties cannot answer the difficult question of which liberties are basic. This list might conflict with the viewpoints of the rational-representative deliberators in the original position,²⁵¹ and might not sufficiently satisfy their rational interests.²⁵² Thus, Rawls proposed a criterion to assess the significance of basic liberties on the basis of "the central range of application."²⁵³ The central range of application states that basic liberties are those liberties providing essential political and social conditions (institutional protections) for the adequate development and full exercise of an equal and free person's moral powers.²⁵⁴ This argument stems from the need to protect individuals' ability to develop and to realize the final ends that they value in their worthwhile life plans:

- (1) Because rational deliberators behind the veil of ignorance cannot know whether their views about final ends would put them in the majority or minority, they likely would not leave it to others to decide the final ends for them. They would like to maintain "the capacity for the conception of the good"²⁵⁵ to make decisions and to regard the basic liberty, which is necessary to allow individuals to exercise this capacity, as non-negotiable so they can follow their own moral, religious, and philosophical values.²⁵⁶
- (2) In addition, even if a social institution were publicly known to satisfy justice principles and to advance citizens' conceptions of the good, the absence of an effective public sense of justice would still make this social

²⁴⁹ RAWLS, *supra* note 94, at 111, 169-70.

²⁵⁰ RAWLS, *supra* note 94, at 168-69.

²⁵¹ John Rawls, *The Basic Liberties and Their Priority*, THE TANNER LECTURES ON HUMAN VALUES 46 (April 10, 1981), available at <http://tannerlectures.utah.edu/lectures/documents/rawls82.pdf>. Rawls admitted that there are two different and conflicting criteria to determine the basic liberties in a theory of justice. RAWLS, *supra* note 94, at 112. One is to specify those liberties so as to achieve the most extensive scheme of the liberties; while another takes up the point of view of the rational representative equal citizen, and then to specify the scheme of liberties in the light of that citizen's rational interests. RAWLS, *supra* note 94, at 112. But the idea of the extent of a basic liberty is useful only in the least important cases, and citizens' rational interests are not sufficiently explained. RAWLS, *supra* note 94, at 112.

²⁵² See H.L.A. Hart, *Rawls on Liberty and its Priority*, READING RAWLS: CRITICAL STUDIES ON RAWLS' "A THEORY OF JUSTICE" 233-39 (Norman Daniels ed., 1989).

²⁵³ RAWLS, *supra* note 94, at 111.

²⁵⁴ RAWLS, *supra* note 94, at 112-13.

²⁵⁵ The capacity for a conception of the good means the ability to have, to receive, and to rationally pursue a conception of good. RAWLS, *supra* note 94, at 19. And the conception of the good is an ordered family of final ends and aims which specifies a person's conception of what is of value in human life or, alternatively, of what is regarded as a fully worthwhile life. RAWLS, *supra* note 94, at 19.

²⁵⁶ RAWLS, LIBERALISM, *supra* note 92, at 311.

institution unstable.²⁵⁷ Therefore, when sketching basic liberties and assigning them priority, rational deliberators prefer to take “the capacity for the sense of justice”²⁵⁸ into consideration in order to ascertain whether citizens will act upon the principles agreed to with the effectiveness and regularity of which human nature is capable.²⁵⁹

Therefore, a rational deliberator would oppose the imposition of legal and other restrictions on a liberty if such a restriction would influence the full and informed exercise of capacities for the conception of the good and/or the sense of justice. The rational deliberator would oppose such restrictions because he or she needs these moral powers to develop his or her own conception of the good and to equally negotiate distributive justice principles irrespective of income, social status, political allegiance, or other arbitrary factors. Since the lesser or greater significance of a liberty depends upon “whether it is more or less essentially involved in . . . the full and informed exercise” of two moral powers,²⁶⁰ these moral powers should be carefully observed and tracked when evaluating the trade-off between restricted liberties and pursued public order in a coercive health care policy. Therefore, if the central application range of a basic liberty is not secured in a coercive health care policy, the priority of the liberty is infringed and the liberty is “restricted” rather than “regulated.”²⁶¹

B. The Importance Test Revisited

Basic liberties are not absolute. In accordance with Rawls’ priority principle, basic liberties (which are closely related to the exercise of moral powers) should be given priority over other social benefits and cannot be sacrificed for the sake of economic or social benefits. However, according to Rawls, they may still be limited for the sake of

²⁵⁷ RAWLS, LIBERALISM, *supra* note 92, at 315-16. According to Rawls, it is a great advantage to everyone’s conception of the good if the public acknowledges that everyone has an effective sense of justice and can be relied upon as a fully cooperating member of society. RAWLS, LIBERALISM, *supra* note 92, at 315.

²⁵⁸ The capacity for a sense of justice means the ability to understand, to apply, and to act based on the principles of political justice that specify the fair terms of social cooperation. RAWLS, *supra* note 94, at 18-19.

²⁵⁹ RAWLS, LIBERALISM, *supra* note 92, at 316.

²⁶⁰ RAWLS, *supra* note 94, at 113.

²⁶¹ RAWLS, LIBERALISM, *supra* note 92, at 296. According to Rawls, in adjusting basic liberties, “regulation” can be distinguished from “restriction”: regulations are those that do not restrict the central application range while restrictions do. RAWLS, *supra* note 94, at 109.

liberty²⁶² in order to be combined into one coherent scheme of liberties.²⁶³ Rawls' liberty and priority principles read as follows:²⁶⁴

(1) Liberty principle: Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all.²⁶⁵

(2) Priority principle: The principles of justice are to be ranked in lexical order and therefore liberty can be restricted only for the sake of liberty. There are two cases: (a) a less extensive liberty must strengthen the total system of liberty shared by all, and (b) a less than equal liberty must be acceptable to those citizens with the lesser liberty.²⁶⁶

Rawls' priority principle then can provide an abstract, yet idealized, analytical way to determine the proper balanced trade-off relationship between restricted liberties and pursued public order in a coercive health care policy.²⁶⁷ The statement

²⁶² RAWLS, THEORY, *supra* note at 92, at 216-219. For example, a freedom such as the religious liberty of an intolerant religious sect could be restricted only when the public has sincere reason to believe that the institution of basic liberty (such as liberty of conscience or religious liberty), or the security of such liberty, are in danger. RAWLS, THEORY, *supra* note 92, at 217-218. In other words, limiting the freedom of an intolerant sect (banning their intolerant beliefs) is justified, not because of greater social gains but because of the protection of everyone's equal liberties. RAWLS, THEORY, *supra* note at 92, at 217-218.

²⁶³ RAWLS, *supra* note 94, at 104.

²⁶⁴ See RAWLS, THEORY, *supra* note 92, at 250; RAWLS, LIBERALISM, *supra* note 94, at 294-99, 310-24; RAWLS, *supra* note 94, at 104-106.

²⁶⁵ RAWLS, THEORY, *supra* note 92, at 250.

²⁶⁶ RAWLS, THEORY, *supra* note 92, at 250.

²⁶⁷ Because I apply Rawls' priority principle to evaluate the restricted liberty in the coercive health care policy, it is necessary to briefly respond to the major objections to Rawls' original theory in 1971. The first objection to the priority of basic liberty, originally voiced by Hart, can be formulated by charging Rawls with an incomplete conception of fundamental liberty or an overblown view of its importance. Hart, *supra* note 252, at 237-39, 50-51. Second, Hart also argued that Rawls' priority principle is plausible only in simple and less controversial cases, in which basic liberties obviously contribute more than other liberties. Hart, *supra* note 252, at 238. Third, there is no clear reason why a surrender of liberties, which people may desire purely for a large increase in material welfare (such as economic interests or social benefits), should be forbidden by the priority rule. Hart, *supra* note 252, at 237. However, Rawls has taken Hart's viewpoint into consideration (as revealed in Rawls' later revised liberty principle) and answered Hart's critics by applying moral powers to evaluate the central application range of basic liberties. According to Rawls, no priority should be assigned to any liberty on the basis of a preeminent value. RAWLS, LIBERALISM, *supra* note 92, at 296-97; RAWLS, *supra* note 94, at 44-45, 111-14. The priority of basic liberties should be debated and established via the analytical perspective, meaning liberties should be considered fundamental when and only when they provide the essential political and social conditions (the central application range) for a free and equal person to fully exercise the basic capacities (moral powers) to form, revise, and pursue the sense of justice and the conception of the good. RAWLS, LIBERALISM, *supra* note 92, at 296-97. Furthermore, according to this analytical approach, the revised priority principle is able to distinguish marginal from substantial influences on basic liberties. RAWLS, *supra* note 94, at 44-45. In addition, Amartya Sen also argued that it is unreasonable to give "absolute priority" to basic liberties over all the other socio-economic needs. AMARTYA SEN, DEVELOPMENT AS FREEDOM 64 (2000). Rawls basically

of the importance test discussed in an earlier section can be further modified and extended. They should now read:

(1) The burden on a liberty (e.g., individual autonomy) imposed by a coercive health care policy (e.g., compulsory health insurance) is unjustified if the burden significantly restricts the central application range of that liberty, unless the public order that the policy intends to pursue relates to the protection or improvement of liberties rather than to economic or social well-being (the priority rule).²⁶⁸

(2) On the contrary, if the coercive health care policy has no significant impact on the exercise of moral powers, to justify the burden on human rights the state merely needs to prove that there is public order concerns involving either the protection of liberty or the pursuit of economic or social gains, for the policy to be pursued (the public interest rule).

There are two constituent elements in the revised important test: moral powers and lexical order (comparative importance) of liberties. More specifically, in the first case (the priority rule), in order to protect the inviolability of basic liberties, which are related to the exercise of moral powers, merely the pursuit of economic or social benefits would not be sufficient to justify a coercive policy. In that case the policy would not be justified unless the state can prove that such a restriction is necessary for the defense of a liberty itself or the best total system of liberty.²⁶⁹ On the one hand, a free and equal rational deliberator in the original position would agree to give priority to preserving basic liberties because sacrificing basic liberties for the sake of material benefits might render the deliberator unable to apply practical reason and judgment to develop his or her own conception of the good.²⁷⁰ On the

agreed with Sen's criticism and proposed that the realization of rational deliberators' fundamental interests (protection of moral powers) needs more than the protection of basic liberties. It also necessitates "certain social conditions and a degree of fulfillment of needs and material [benefits]." RAWLS, *THEORY*, *supra* note 92, at 132. In other words, when failing to fulfill certain socio-economic needs would obstruct the full establishment of basic liberties, equal liberties can be denied in order to "change the quality of civilization so that in due course everyone can enjoy these freedoms." ROBERT S. TAYLOR, *RESTRUCTURING RAWLS: THE KANTIAN FOUNDATIONS OF JUSTICE AS FAIRNESS* 168 (2011).

²⁶⁸ RAWLS, *LIBERALISM*, *supra* note 92, at 295-96.

²⁶⁹ RAWLS, *THEORY*, *supra* note 92, at 232, 239. In other words, society needs to evaluate justifications for restricting liberty by exploring whether the less extensive freedom is or is not sufficiently outweighed by the greater security and extent of other liberties.

²⁷⁰ Rawls proposed that the priority of the basic liberty principle is more effective than the principle of average utility in guaranteeing equal basic liberties in meeting three essential requirements for a stable constitutional regime. RAWLS, *supra* note 94, at 115. The first requirement, given the fact of pluralism, is to fix the basic liberties and to assign them a special priority. RAWLS, *supra* note 94, at 115. The fulfillment of such a requirement would put the political agenda beyond the calculus of social interests, thus securing clearly and firmly the terms of social cooperation on a footing of mutual respect. RAWLS, *supra* note 94, at 115. The second requirement is that its political conception should specify not only shared but if possible, a clear basis of public reason, and one that can publicly be seen to be sufficiently reliable in its own terms. RAWLS, *supra* note 94, at 116. The priority principle (and the liberty principle) would satisfy this requirement by providing independent and precedent status of the basic liberties in the theory of justice.

other hand, if a fully adequate system of liberty for all (which guarantees rational individuals' full exercise of moral powers and enjoyments of liberties) is in danger, rational deliberators would agree to forgo part of their liberties (and sacrifice part of their moral powers) to transform a less fair society into one in which all liberties can be fully enjoyed.²⁷¹

In the second case (the public interest rule), the trade-off would be evaluated less strictly because restricted liberties are not directly related to moral powers. The state merely has the burden to prove that there is a compelling interest, in either the protection of liberty or of the pursuit of economic or social gains that is substantially furthered by restricting liberties.

Based upon the proposed distinctive justifications as a criterion in the revised importance test, the trade-off between the restricted liberty and the pursued social benefits in the compulsory NHI case then can be identified and evaluated. One possible objection to this importance test is that the value and the priority of liberty should not be the ultimate determinant in matters of health care programs.²⁷² For example, H.L.A. Hart argued that if there are still people who may desire purely for a large increase in material benefits and would be willing to surrender some liberties to get them, there is no clear reason why a surrender of liberties should be forbidden by the priority rule.²⁷³

My short response to this objection is based upon the protection of moral powers. Generally speaking, allowing an individual to choose between liberties and material welfare is established on the premise that the individual should have basic capabilities to: (1) decide what material benefits he or she wants to pursue; (2) to rationally evaluate the trade-off between restricted liberties and pursued benefits; and (3) to decide whether he or she want to trade liberties for benefits. Therefore, if the compulsory NHI would cripple individuals' full and informed exercises of moral powers (e.g. forcing individuals to trade liberties for benefits), this premise would also be rejected. It is then unreasonable for rational individuals to abandon the priority of the liberty and concur with the justifiability of this coercive health care policy. In this case, in order to prevent the state from coercively restricting the exercise of moral powers, individuals would agree with the priority rule. On the contrary, if individuals' moral powers are preserved and the central application range is not restricted, it would be justified and acceptable to trade liberties for economic and social benefits (if rational deliberators approve), as proposed by the public interest rule.

*C. The Importance for the Individual Mandate without Insurance Package Option
(Taiwan's Case)*

According to the importance test, whether the compulsory health insurance is justified depends upon (1) whether it restricts the central application range (the exercise of moral powers) of individual liberty, and (2) whether there exists a proper, balanced trade-off between restricted liberty and pursued public order.²⁷⁴ The

²⁷¹ RAWLS, THEORY, *supra* note 92, at 217.

²⁷² Hart, *supra* note 252, at 250.

²⁷³ *Id.* at 250-51.

²⁷⁴ See generally James W. Nickel, *Rethinking Rawls's Theory of Liberty and Rights*, 69 CHI.-KENT L REV. 763, 772-779 (1993).

delineation of a proper trade-off is decided based upon the priority rule or the public interest rule:

- (1) If the compulsory health insurance would substantially restrict the central application range and individuals' exercise of moral powers (e.g., citizens only have one single choice assigned by the state), according to Rawls' priority rule, the compulsoriness is an impermissible and unjustifiable restriction unless the state can prove that such a restriction is necessary for the defense of a liberty itself or the best total system of liberty, rather than for economic or social well-being.
- (2) If the compulsory health insurance has no significant impact on the central applications range (e.g., individuals can still choose between different health care plans in a free health care market), according to the public interest rule, this coercive health care policy is a justified regulation of individual liberty when the state can prove that there is public order, either of the protection of liberty or of pursuit of economic or social gains, for the policy to pursue.

For the argument's sake, I carefully distinguish the human rights burdens on individual liberty imposed by the compulsory health insurance into two different but equally important cases – (1) a compulsory health insurance scheme with a universal standardized medical coverage (Taiwan's universal compulsory NHI), and (2) a compulsory health insurance scheme with a number of options in terms of insurance packages (America's Health Care Reform).²⁷⁵ These cases are distinguished because interactions between two policy instruments - the individual mandate for health insurance and the single payer system - are complicated and would affect the results of the importance test.²⁷⁶ Firstly, this Article will examine Taiwan's universal compulsory NHI based upon the importance test.

1. The Compulsory NHI's Impacts on Moral Powers

In the first case, the central application range of the freedom to purchase or decline health insurance is restricted because the compulsory NHI, which adopts a single-payer system with a universal standardized medical coverage, would prevent individuals from pursuing their own and incommensurable conceptions of the good in health care.²⁷⁷

As discussed earlier in Section II(A), the compulsory NHI's single-payer program is a type of financing system in which one governmental entity, the Bureau of National Health Insurance (BNHI), acts as an administrator to collect all health care fees, to pay for all health care costs, and to set up the universal standardized

²⁷⁵ See *supra* Part VII(D).

²⁷⁶ For example, compare the following two cases: (1) Government A requires all citizens to enroll in a national health insurance (a compulsory health care program) that covers only certain services designed by health care authorities (a universal standardized medical coverage); and (2) Government B also requires all citizens to enroll in a national health insurance, but allows citizens to negotiate with health insurers and choose between different medical coverage. It is obvious that the human rights burden on the disenrollment freedom in the first case is much greater than in the second case. I will discuss more about the difference between these two cases in this section and the sections following.

²⁷⁷ See *supra* Part I.

medical coverage and payment rules.²⁷⁸ Because the Taiwanese Ministry of Finance forbids private insurance companies to provide any health insurance coverage similar to the NHI's medical coverage,²⁷⁹ citizens, without another choice, are practically forced to buy the NHI's universal standardized medical coverage.²⁸⁰ Therefore, the Taiwanese government basically monopolizes the health insurance business and arbitrarily decides what diseases and medical treatments are paid by the public health insurance.

Under this compulsory NHI's single-payer system, individuals with incommensurable conceptions of the good about what kinds of integrated bodily functions they prefer to obtain or to regain are forced to accept the universal standardized medical coverage determined by the BNHI.²⁸¹ More specifically, under the NHI's single-payer system, whether or not a medical intervention is included in the NHI's medical coverage is decided by the BNHI on the basis of a shared common basis to distribute health care without respecting individuals' moral, religious, and philosophical values. Thus, rational deliberators with different values are forced to give up the liberty of making autonomous choices regarding health care benefit packages (non-clinical decisions), which are value-laden (on the basis of one's perceived final ends) and are strongly related to their own conceptions of the good. For example, different medical treatments for disease D_1 (e.g., terminal cancer) provide different types of goodness — treatment X_1 (e.g., the radiology therapy) can prolong a patient's life but also cause serious side effects, while treatment Y_1 (e.g., the palliative care) can enhance a patient's quality of life but cannot extend his or her life. Given the patient's circumstances and life plan, different patients will value the goodness provided by different medical treatments differently. However, if the BNHI arbitrarily decides to provide medical coverage including only treatment X_1 rather than treatment Y_1 for terminal cancer, individuals who prefer treatment Y_1 can only accept that decision.²⁸²

On the one hand, due to the NHI's single payer system, individuals with different conceptions of the good have no freedom to decide the contents of the NHI's medical coverage.²⁸³ On the other hand, due to the NHI's individual mandate, individuals are forced to accept this coercive NHI's medical coverage, which they might disagree with.²⁸⁴ The dual restrictions then drastically confine individuals' capacities to pursue their own conceptions of the good through health care, and

²⁷⁸ Cheng, *supra* note 15, at 67.

²⁷⁹ Tai-Cai-Bao-Zi No. 840123987 (The Ministry of Finance, March 8, 1995)(Taiwan).

²⁸⁰ In addition, by forbidding private health insurance companies from providing similar health insurance coverage, the Taiwanese government further strengthens its bargaining power in the health insurance business, which it basically monopolizes.

²⁸¹ See National Health Insurance Act ch. VI-VII, art. 56-67 (1994) (Taiwan), available at http://www.nhi.gov.tw/English/webdata/webdata.aspx?menu=11&menu_id=295&WD_ID=295&webdata_id=1865 (last visited Oct. 24, 2012).

²⁸² Here, I put the discussions about financial ability and/or tax compensation aside, and assume that the patient can afford both radiology therapy and palliative care.

²⁸³ Cheng, *supra* note 15, at 67.

²⁸⁴ National Health Insurance Act ch. VIII, art. 70-71 (1994) (Taiwan), available at http://www.nhi.gov.tw/English/webdata/webdata.aspx?menu=11&menu_id=295&WD_ID=295&webdata_id=1865 (last visited Oct. 24, 2012).

violate the central application range of the freedom to purchase or decline health insurance.

Furthermore, according to a Taiwanese Finance Ministry regulation, if the compulsory NHI has provided at least “one” treatment for a disease, private insurance companies are forbidden to provide “any” medical treatment for this disease.²⁸⁵ Namely, if health care treatment falls outside the NHI’s universal benefits package because it is not cost effective, according to the Finance Ministry’s ban, an individual has neither the opportunity nor the freedom to purchase private insurance for it, even if he or she has different conceptions of the good about this health care treatment.²⁸⁶ For example, if the NHI has provided health insurance coverage including medical treatments Y_2 (rather than medical treatment X_2) for disease D_2 , according to the Financial Ministry’s ban, private insurance companies are forbidden to provide treatment X_2 in their benefits package because the NHI has provided at least one treatment (treatment Y_2) for the disease. Therefore, even if an individual regards treatment X_2 as a good treatment based upon his or her own conception of the good (which is different from the BNHI’s), and is willing to pay extra for private insurance package with this treatment, the Financial Ministry’s ban would prevent the individual from doing so. In other words, even though the NHI Act does not forbid individuals buying additional private health insurance, the Finance Ministry’s ban has imposed extreme and substantial limitations on individuals’ choices of health care. Such a strict ban, which is rare worldwide,²⁸⁷ burdens individuals’ health care choices in a much broader extent and imposes a significant restriction on the central application range of individual liberty.

One possible response from the BNHI to my argument is that, since the NHI provides almost all health care treatments, an individual’s diverse conceptions of the

²⁸⁵ The Taiwanese Ministry of Finance argued that this regulation is necessary for maintaining the NHI’s competitive advantages. And the Taiwanese Department of Health recognized maintaining the NHI’s competitive advantages is a justified policy objective, which I do not agree with. *The Ministry of Finance, Tai-Cai-Bao No. 840123987* (1995.3.8.) (Taiwan).

²⁸⁶ *Id.*

²⁸⁷ For example, Spece argued that he has not been able to “find reports of any nation that prohibits both the purchase of “private” or “supplement” insurance and direct purchase of such care.” Roy G. Spece, *A Fundamental Constitutional Right of the Monied to “Buy Out Of” Universal Health Care Program Restrictions Versus the Moral Claim of Everyone Else to Decent Health Care: An Unremitting Paradox of Health Care Reform?* 3 J. HEALTH & BIOMED. L. 1, 37 (2007). Furthermore, some governments even expand private health insurance to substitute for publicly financed coverage (e.g., the statutory health insurance) where groups of people are allowed to opt out of it and purchase private coverage instead. SARAH THOMPSON ET AL., FINANCING HEALTH CARE IN THE EUROPEAN UNION: CHALLENGES AND POLICY RESPONSES 57-58 (2009); see also ORGANIZATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, THE REFORM OF HEALTH CARE: A COMPARATIVE ANALYSIS OF SEVEN OECD COUNTRIES 122 (1993). For example, the British government has tried to introduce the concept of the free market to the National Health Service (NHS), and to move away from the centralized (integrated) model towards a contract model for health care services (i.e., there was to be a separation of the purchasing and provision of hospitals services, mediated by contracts — that is, district health authorities would become purchasers of hospital services while public hospitals would be freed from the control of district health authorities and would be allowed to become “self-governing”). *Id.*

good regarding health care then can be well protected.²⁸⁸ For example, according to Article 39 of the NHI Act, all kinds of medical treatments (including traditional Chinese medicines)²⁸⁹ are covered by the NHI except (1) treatment of drug addiction, cosmetic surgery, non-post-traumatic orthodontic treatment, preventative surgery, artificial reproduction, and sex conversion surgery; (2) over-the-counter drugs and non-prescription drugs which should be used under the guidance of a physician; (3) human-subject clinical trials; and (4) dentures, artificial eyes, spectacles, hearing aids, wheelchairs, canes, and other treatment equipment not required for positive therapy.²⁹⁰ This broad range of the NHI's medical coverage then allows individuals with different values and desires to access any medical treatment they prefer in the NHI program. Therefore, even though the universal compulsory NHI regulates individuals' freedom to choose between different health care plans, they still have multiple choices for pursuing different medical treatments and are capable of fully exercising their moral powers. In other words, since individuals are still able to choose between different medical treatments under the NHI's broad medical coverage, their capacities to pursue incommensurable conceptions of the good are preserved.

However, this response focuses only on an individual's choice of medical treatments, but still ignores an individual's autonomy to decide what medical treatments should be included in the NHI's medical coverage. In other words, even though an individual is able to choose whatever medical treatment he or she prefers in the NHI, the individual still cannot freely purchase a health insurance which covers only certain medical treatments he or she prefers on the basis of the

²⁸⁸ BUREAU OF NAT'L HEALTH INS., *supra* note 14, at 25; COUNCIL FOR ECONOMIC PLANNING AND DEVELOPMENT, THE REPORT ON THE PLANNING OF NATIONAL HEALTH INSURANCE 103 (1990).

²⁸⁹ "Each traditional Chinese medicine clinic (TCM clinic), outpatient department of TCM hospitals and TCM outpatient department of hospitals may provide the following services: (1) Diagnosis; (2) Concentrated TCM preparations; (3) Therapeutic materials; (4) Common TCM treatment, acupuncture therapy as well as fracture and wound treatment." Regulations for NHI Medical Care art. 25.1, BUREAU OF NAT'L HEALTH INS., *available at* http://www.nhi.gov.tw/English/webdata/webdata.aspx?menu=11&menu_id=295&WD_ID=295&webdata_id=2430 (last updated Sept. 14, 2011).

²⁹⁰ National Health Insurance Act ch. IV, art. 39 (1994) (Taiwan), *available at* http://www.nhi.gov.tw/English/webdata/webdata.aspx?menu=11&menu_id=295&WD_ID=295&webdata_id=1865 (last visited Oct. 24, 2012). "Expenses arising from the following service items are not covered in this Insurance: (1) Medical service items on which the expenses shall be borne by the government according to other laws or regulations; (2) Immunization and other medical services on which the expenses shall be borne by the government; (3) Treatment of drug addiction, cosmetic surgery, non-post-traumatic orthodontic treatment, preventative surgery, artificial reproduction, and sex conversion surgery; (4) Over-the-counter drugs and non-prescription drugs which should be used under the guidance of a physician; (5) Services provided by specially designated doctors, specially registered nurses and senior registered nurses; (6) Blood, except for blood transfusion necessary for emergent injury or illness according to the diagnosis by the doctor; (7) Human-subject clinical trials; (8) Hospital day care, except for psychiatric care; (9) Food other than those which are to be tube feeding and balance billing for wards; (10) Transportation, registration fee, and certificate for the patient; (11) Dentures, artificial eyes, spectacles, hearing aids, wheelchairs, canes, and other treatment equipment not required for positive therapy; (12) Other treatments and drugs promulgated by the Competent Authority not to be covered." *Id.*

conceptions of the good. The medical coverage (or health care benefit package) is important because it also exemplifies an individual's diverse conception of the good regarding health care and shows the significance of voluntary health care decisions in health care rationing. For example, there are two medical treatments X_3 and Y_3 for disease D_3 , and an individual prefers health insurance that covers only medical treatment X_3 . However, under the compulsory NHI's single-payer system, he or she would be forced to purchase an all-inclusive medical coverage (including both medical treatments X_3 and Y_3), which is arbitrarily determined by the BNHI. The individual has no authority to exclude treatment Y_3 from that coverage. Therefore, even though the NHI's broad medical coverage allows the individual the option to choose medical treatment X_3 and to develop her own intrinsic value regarding medical treatments, her capacity for the conceptions of the good are still limited because she cannot pursue her rational choice of medical coverage, which also relates to intimate and important decisions about her health. Thus, requiring an individual to accept NHI's comprehensive, all-inclusive medical coverage of almost all medical treatments would deprive her capacities for the conceptions of the good. The central application range of the individual's freedom to purchase or decline health insurance then is unjustifiably restricted.

In conclusion, under the NHI's individual mandate clause, accompanied by the single-payer system's universal insurance package and the Finance Ministry's ban against "supplemental" private health insurance, individuals with incommensurable conceptions of the good are neither allowed to opt out the compulsory NHI nor allowed the chance to buy their preferred health care outside the NHI. They have no choice but to accept the NHI's universal benefits package, while their capacities to pursue their own conceptions of the good regarding health care through the purchase of private health insurance are significantly restricted.

2. Trade-off under the Compulsory NHI

Since the compulsory NHI with the single-payer system leaves individuals no option of other benefits policies and significantly restricts the central application range of the freedom to purchase or decline health insurance,²⁹¹ thus, the trade-off under the NHI's individual mandate should be assessed on the basis of the priority rule. In other words, the universal compulsory NHI's restriction on individual liberty is unjustified unless the Taiwanese government can prove that the policy is necessary to protect other liberties or to strengthen the total system of liberty, rather than to protect economic interests or social benefits.

Unfortunately, according to the discussions in Section VI, the policy purposes of the NHI are confined to maximizing the participation rate, increasing the financial revenues, preventing adverse selection, and protecting the disadvantaged citizen's right to health care. There is no motive to strengthen the total system of liberty shared by all. In other words, abandoning or adjusting the NHI's individual mandate would only cause potential economic losses, without disrupting other liberties of all citizens or the state's capacity to provide liberties for all. According to the priority rule, the burdens on the exercise of moral powers imposed by the compulsory NHI, which are directly related to individuals' capabilities to engage in mutually beneficial cooperation and honor fair terms, are much greater than pursued public orders, which are confined to economic interests only. Therefore, there is no proper

²⁹¹ See Hussey & Anderson, *supra* note 90.

trade-off between the restricted freedom to purchase or decline health insurance and the proposed public order. The human rights burden of the compulsory NHI with a single-payer system cannot be justified because it fails the priority rule.

D. Importance Test for Individual Mandate with Insurance Package Options

The second case is a compulsory health insurance scheme with a number of options in terms of insurance packages (President Obama's health care reform in the United States of America).²⁹² In that system, the central application range of the freedom to purchase or decline health insurance is deemed to be regulated rather than restricted. This freedom is deemed regulated even though all citizens are required to enroll in health insurance because the system still grants the freedom to negotiate with health insurers and to choose between different medical coverage.²⁹³ In other words, under a compulsory health insurance with additional options in terms of insurance packages, a rational individual still has room to choose particular medical interventions. This type of compulsory health insurance possesses the properties or promises to deliver the results an individual would likely want because they can choose different health insurance packages. Individuals with different ideas about what kinds of integrated bodily functions they prefer are still able to pursue their own and incommensurable conceptions of the good in health care. The individual's moral powers—especially the capacity for the conceptions of the good—are reserved in this case.

According to the importance test, a compulsory health insurance system with additional insurance package options does not restrict the central application range of the freedom to purchase or decline health insurance.²⁹⁴ Therefore, the evaluation of the trade-off between the restricted liberty and the pursued public order should be subject to the public interest rule. In other words, if the state proves that the compulsory health insurance scheme can achieve greater social benefits (e.g., preventing adverse selection and improving health care disparities, see Section VI), it is justified for the state to apply the compulsory health insurance scheme to “regulate” the freedom to purchase or decline health insurance.

²⁹² On the one hand, to avoid resistance from the currently insured, the Patient Protection and Affordable Care Act does not seek to supplant or supersede the private or public programs already in place. Tumulty et al., *supra* note 3. On the other hand, the Act also requires the government to develop uniform coverage documents so consumers (small businesses and individuals) can make apples-apples comparisons when shopping for health insurance and choosing from a selection of insurance policies. In other words, the new Act leaves a lot of room for variations. Tumulty et al., *supra* note 3. For example, according to Glenn Cohen, the U.S. health care reform's individual mandate somewhat restricts individual liberty, but it “continues to leave open as discretion as to plan choice (constrained by the mandates minimum benefit requirements).” Glenn Cohen, *Protecting Patients With Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467, 1550 (2010). Troy J. Oechsner & Magda Schaler-Haynes also argued that, the individual mandate merely requires individuals to maintain minimum essential coverage. Oechsner & Schaler-Haynes, *supra* note 57 at 280-81. As long as the minimum benefits requirements are met, consumers can compare competing health plan benefits and purchase their preferred plan. *Id.*

²⁹³ See Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010) Section 5000A(a).

²⁹⁴ See *supra* Part VIII(A).

Through epidemic statistics, there is also a greater social benefit for the compulsory health insurance with insurance package options to pursue in exchange for the limited individual liberty.²⁹⁵ For example, studies have shown that the NHI's individual mandate alone (regardless of the single payer system) can help to improve access to health care for vulnerable populations.²⁹⁶ In Taiwan, prior to the implementation of the NHI program in 1995, approximately 7.5 million individuals (40.1% of Taiwan's population, see *infra*, Figure 4) did not have any health insurance coverage.²⁹⁷ The uninsured were the most vulnerable population in society: 65.94% of the uninsured were children and adolescents, making up approximately 75% of the population of children and adolescents; and 8.00% of the uninsured were the elderly, making up approximately 26% of the elderly population.²⁹⁸ The uninsured vulnerable populations were significantly more likely to report a poor level of health and had significantly lower utilization rates for health care services, compared to those individuals who had similar health care needs.²⁹⁹ Since the NHI was implemented, more than 96% of Taiwan's population has been registered in this program – an economic scale large enough to prevent reverse selection.³⁰⁰ Individuals were more likely to report seeking health care when ill.³⁰¹ The newly insured consumed more than twice the amount of outpatient physician visits (0.21 vs. 0.48 physician visits in two weeks) and hospital admissions (0.04 vs. 0.11 hospital admissions in two weeks) than before the NHI was implemented. This brought the newly insured to the same amount of health care contacts as the previously insured groups in Labor Insurance, Government Employee Insurance, and Farmers Insurance.³⁰² In addition, studies also showed that the compulsory NHI maintained relatively low administrative costs.³⁰³ Since program implementation, the ratio of administrative costs to total health care expenditures has remained below the legally mandated cap of 3.5%.³⁰⁴

²⁹⁵ BUREAU OF NAT'L HEALTH INS., *supra* note 14, at 17.

²⁹⁶ LAURA MORLOCK ET AL., NATIONAL HEALTH INSURANCE IN TAIWAN: ANALYSIS OF INITIAL EFFECTS FROM AN INTERNATIONAL PERSPECTIVE 2 (1997).

²⁹⁷ DEPARTMENT OF HEALTH, OVERVIEW OF THE NATIONAL HEALTH INSURANCE REFORM 17-18 (2004).

²⁹⁸ *Id.*

²⁹⁹ *Id.*

³⁰⁰ *Id.*

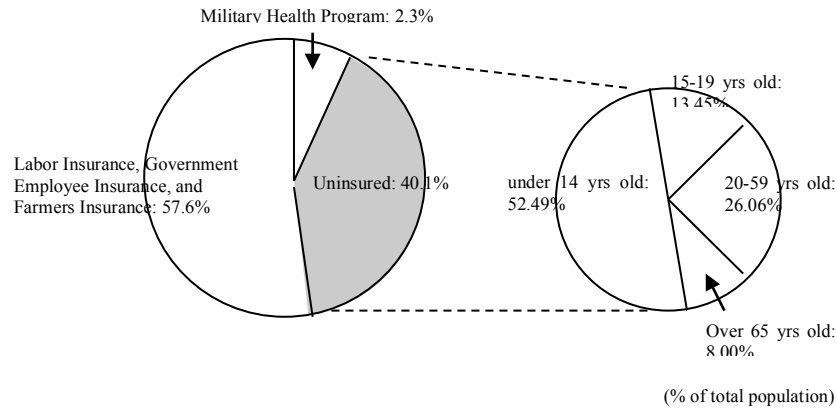
³⁰¹ *Id.*

³⁰² Shou-Hsia Cheng & Tung-Liang Chiang, *The Effect of Universal Health Insurance on Health Care Utilization in Taiwan*, 278(2) JAMA 89, 89 (1997).

³⁰³ BUREAU OF NAT'L HEALTH INS., *supra* note 14, at 27.

³⁰⁴ MORLOCK ET AL., *supra* note 296, at 4.

Figure 4. Socio-Economic Characteristics of the Uninsured before NHI (1995)



IX. CONCLUSION

This Article establishes a four-step human rights assessment to carefully explore how the compulsory NHI’s restrictions on the freedom to purchase or decline health insurance should be evaluated. After analysis, despite Taiwan’s universal compulsory NHI being adequate and effective (Step 2), such a coercive health care policy still unjustifiably restricts individuals’ freedom to purchase or decline health insurance because it is not the least intrusive alternative (Step 3) and provides no proper trade-off between restricted liberty and pursued public order (Step 4).³⁰⁵

Even though the NHI’s individual mandate might unconstitutionally and unjustifiably restrict individual liberty, neither the primary NHI nor the second-generation NHI (the health care reform enacted in 2011) address this problem squarely. Without adjusting the individual mandate clause, the new NHI Act of 2011 puts emphasis only on improving social benefits (such as the improvement of health care quality, and providing for mandatory disclosure for health care providers’ information) and reducing economic inefficiency – such as the balance between insurance revenues and medical disbursements, and the improvement of the efficiency of the administration system.³⁰⁶ The compulsory scheme, along with the single-payer system, has remained without careful and explicit assessment of the burdens this coercive health care policy imposes on human rights. Society’s continued disregard of the compulsory NHI’s restrictions on individual liberty not only fail to consider possible variations but also cause society to remain ignorant of the alternative policy which is least intrusive while achieving parallel policy

³⁰⁵ See *supra* Part IV.

³⁰⁶ Chih-Liang Yaung, *The Eight Myths of Second-Generation NHI*, DEPT. OF HEALTH, http://www.nhi.gov.tw/english/News_detail.asp?News_ID=56&menu_id=291 (last visited October 16, 2010). Chih-Liang Yaung, *Start the Count Down for Second-Generation NHI and Seize the Opportunity to Reform*, DEPT. OF HEALTH, http://www.nhi.gov.tw/english/News_detail.asp?News_ID=57&menu_id=291 (last visited October 16, 2010).

objectives.³⁰⁷ Furthermore, it would undervalue the significance of individual liberty in health care programs and disrespect individuals' incommensurable conceptions of the good regarding health care.³⁰⁸ Therefore, we must recognize that we are at a cross-roads: even though there seems to be a moral consensus that we should turn toward compulsory health insurance for greater social benefits, we have yet to discover a constitutionally clear path of doing so through careful consideration.³⁰⁹

³⁰⁷ The Republic of China Constitutional Court (Grand Justices Council) Reporter, J. Y. Interpretation No. 472 (January 29, 1999) (Taiwan), available at http://www.judicial.gov.tw/constitutionalcourt/EN/p03_01.asp?expno=472.

³⁰⁸ See *supra* Part VIII(A).

³⁰⁹ See Spece, *supra* note 287, at 89.