

DISTRIBUTIVE INJUSTICE(S) IN AMERICAN HEALTH CARE

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I

INTRODUCTION

Criticism of health care in the United States usually focuses first and foremost on the millions of Americans who lack health insurance of any kind. But the uninsured are not the only Americans whose welfare should concern policymakers. Because of the way private health services are financed on the one hand and dispensed on the other, the U.S. health care system burdens lower- and middle-income premium payers for the benefit of providers and high-income consumers. In this article, we seek to show the nature—and to suggest the cumulative magnitude—of the many regressive tendencies of the financing, regulatory, and legal regime governing the private side of U.S. health care.¹ Parts II and III chart some of the numerous pathways through which too

1. Although we focus on the private sector in this article, there are important distributive justice issues on the public side as well. To be sure, progressive redistribution appears in many programs of public subsidies and financing—the Medicaid program in particular. But many aspects of Medicare are not so progressive. Thus, less than a third of Medicare’s funding in 2004 came from general revenues raised through progressive taxation. *See* SOC. SECURITY & MEDICARE BD. OF TRS., STATUS OF THE SOCIAL SECURITY AND MEDICARE PROGRAMS: A SUMMARY OF THE 2005 ANNUAL REPORTS (2005) <http://www.socialsecurity.gov/OACT/TRSUM/trsummary.html> (showing breakdown of 2004 income of the Hospital Insurance and Supplementary Medical Insurance trust funds). A much larger share (fifty-four percent) was yielded by a 2.9% flat tax on the wages, salaries, and self-employment income of current workers—a tax that, because it applies only to earned income, is less equitable than a true flat tax. *See also infra* note 48. Moreover, if one views Medicare only as a pay-as-you-go program, this tax appears to be an enormous intergenerational transfer, taking large amounts from today’s workforce to provide health services for today’s retirees. If Medicare is viewed as social insurance, however, the unfairness is less clear because, up to now at least, each generation has gotten substantially more out of the program than it has put in. *See* Mark McClellan & Jonathan Skinner, *The Incidence of Medicare*, 90 J. PUB. ECON. 257 (2006). Nevertheless, it is unlikely that this pattern will continue. It depends, after all, not only on continuing upward trends in both health care costs and life expectancy but also on the willingness of the next generation of workers to pay the taxes needed to support the elderly population in the same generous way. There are good reasons, it would seem, to question the fairness of Medicare’s payroll tax to today’s workers.

Medicare’s intragenerational fairness can also be questioned—and is actively in dispute. It is at least an open question, it appears, whether, having made larger payments into the program, higher-income individuals may enjoy more than proportionately greater benefits from it. This could happen because higher-income individuals both live longer under the program and make more intensive use of its nominally equal entitlements. (We examine the latter matter at length *infra* notes 121–127 and

much money flows or appears to flow from the pockets of the less-than-affluent to the benefit of elite interests. Part IV observes how the legal and regulatory environment of U.S. health care has been structured according to the perceptions and preferences of these same elites, thus raising costs for everyone who seeks health coverage; because the marginal benefits of more and better health care are, of necessity, valued less by people with lower incomes and other unmet needs,² significant social-justice issues are raised by the American legal system's many ways of making families of modest means, if they want health coverage, pay for especially costly versions of it.

Our explicit concern in writing this article is that, for whatever reasons, the health care system's systematic exploitation of the many for the benefit of the privileged few has been either overlooked, underestimated, or conveniently ignored by analysts and policymakers. We will also suggest, however, that the regressive tendencies we observe are no accident, but result from a combination of ideology and the political economy of health care. Specifically, we see a seemingly well-meant but essentially destructive policy bias—assiduously cultivated by the health care industry and shared by many commentators and policy analysts—in favor of more and better health care for all with only nominal regard for how much it costs or who bears the burden.³ Because

accompanying text). For the latest (conflicting) findings on whether Medicare, taken as a whole, is a regressive or progressive program, compare McClellan & Skinner, *supra* (using average incomes within zip codes as proxies for beneficiaries' incomes and finding net wealth transfers from lower- to higher-income beneficiaries), with Jay Bhattacharya & Darius Lakdawalla, *Does Medicare Benefit the Poor?*, 90 J. PUB. ECON. 277 (2006) (using educational attainment as a proxy for income and finding net transfers from higher- to lower-income beneficiaries).

In view of this mixed record of distributive justice, one might wonder why Medicare is so rarely criticized by those concerned about the welfare of lower-income Americans. *But see* Jonathan Skinner & John E. Wennberg, *Exceptionalism or Extravagance: What's Different About Health Care in South Florida?*, 2003 HEALTH AFF. (WEB EXCLUSIVES) W3-372, W3-374 (“On equity grounds, we have problems with the idea of single working mothers in Nebraska (often themselves lacking health insurance) footing the bill for gold-plated health care provided to high-income Medicare enrollees in Miami.”).

2. For a fuller discussion of the income elasticity of demand for health services and its significance for our thesis, *see infra* note 101 and text accompanying note 209.

3. A good example of this pervasive bias can be found in the stated primary mission of the \$9 billion Robert Wood Johnson Foundation (RWJF): “To improve the health and health care of all Americans.” RWJF ANN. REP. 2004, at 1 (2004). The Foundation's ambivalent attitude toward cost as a relevant consideration in its grant making has recently been documented—notably, in a publication sponsored by the Foundation itself. Carolyn Newbergh, *The Robert Wood Johnson Foundation's Efforts to Contain Health Care Costs*, in TO IMPROVE HEALTH AND HEALTH CARE, VOLUME VII: THE ROBERT WOOD JOHNSON FOUNDATION ANTHOLOGY 57–80 (2004). Although the Foundation has not entirely ignored cost in its activities, it was only in 1998, twenty-six years after its founding, that it recognized cost considerations at all in its mission statement—as one of four subsidiary goals: “To assure that all Americans have access to basic health care at reasonable cost.” *Id.* at 64. In 2003, it substituted the word *quality* for *basic*, indicating that the objective of more and better health care still dominates. *See id.* at 80 n.2. Not only is the notion that costs must be subjectively “reasonable” little more than lip service to an obvious public concern, but, whenever the Foundation has acknowledged high costs as a problem, it has mostly seen them only as an obstacle to achieving its main mission, not as a possibly unwarranted burden on those who pay them. *See, e.g., Goals Update*, in RWJF ANN. REP. 1996, at 141 (1997) (“[C]ontrolling costs was clearly an essential prerequisite for our other goals . . .”). Newbergh describes how Steven Schroeder, M.D., RWJF's president from 1990 to 2002, downgraded interest in cost to a “half goal.” Newbergh, *supra*, at 63. Finally, it is significant that most of the

unwillingness to view health care as an economic good accords so well with illusions about health care in the public mind, it has been easy for industry and other interests to manipulate people's thinking about health care issues, both as consumers and as voters. In particular, we emphasize how policies effectively hiding the true cost of health coverage from the consumer-voters who ultimately bear them⁴ enable elite interests to have their way in the political process, thereby maintaining a system that is rigged against the true interests of the political majority.⁵ Contrary to the assumptions of many observers, ordinary Americans are not well served by health policies and practices founded on the premise that health care should be beyond price.

We hope, at least, that this article's demonstration of serious and systematic unfairness in the American way of financing, regulating, and dispensing health care will stimulate further research on distributional issues, including the scope, existence, and quantitative significance of the numerous specific injustices we have tried to identify.⁶ But we believe that, even without precisely quantifying

Foundation's activities relating to cost containment that Newbergh describes involved sponsoring community, governmental, or industry-wide cooperative initiatives (for example, an RWJF program focused on Medicaid managed care, its "Community Programs for Affordable Health Care," and its "Physician-Directed Program to Improve Medical Care Services and Control Costs") rather than promoting ways of making costs and quality negotiable in the marketplace. *See id.* at 62.

4. Crucial to our claim that premium payers are overburdened is the proposition, stoutly defended by most economists, that, even though employers purchase most health coverage, its cost is ultimately borne virtually in full by employees, principally in the form of reduced wages. Logically, employers are primarily concerned about a worker's total compensation and are largely indifferent about the forms in which that compensation is paid. Empirical studies support the economists' prediction. *See generally* Jonathan Gruber, *Health Insurance and the Labor Market* 55 (Nat'l Bureau of Econ. Research, Working Paper No. 6762, 1998) (reviewing the empirical literature and concluding that "the results that attempt to control for worker selection, firm selection, or (ideally) both, have produced a fairly uniform result: the costs of health insurance are fully shifted to wages"). Individual studies have found that real wages fall after government-mandated increases in the cost of insurance and when health costs rise, especially for high-consumption groups. *See* Jonathan Gruber & Alan B. Krueger, *The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers' Compensation Insurance* 1 (Princeton Univ. Indus. Relations Section, Working Paper No. 279, 1990) (finding that areas and industries with high workers-compensation costs led to a corresponding reduction in wages); Jonathan Gruber, *The Incidence of Mandated Maternity Benefits*, 84 AM. ECON. REV. 622 (1994) (finding that the mandated expansion of health insurance coverage in the Pregnancy Discrimination Act of 1978 led to reduced wages); Louise Sheiner, *Health Care Costs, Wages, and Aging* (Apr. 1999) (unpublished manuscript, on file with Fed. Reserve Bd. of Governors), *available at* <http://www.federalreserve.gov/pubs/feds/1999/199919/199919pap.pdf> (finding relatively lower wages for older workers and workers with family coverage in areas with high medical prices).

5. *See, e.g.,* Holman W. Jenkins, Jr., *Wanna Fix Health Care? Stop Hiding the Cost!*, WALL ST. J., Oct. 13, 2004, at A17.

6. The only extensive overall examination of distributional issues that we have found is a 1992 study, John Holahan & Sheila Zedlewski, *Who Pays for Health Care in the United States? Implications for Health System Reform*, 29 INQUIRY 231 (1992). Undertaken to inform efforts at major health reform, that study was mostly concerned with showing how the overall burden of paying for health care was then distributed among income classes in order to provide a baseline for evaluating any new plan or proposal. To be sure, that study found that "the distribution of the financing burden is regressive." *Id.* at 244. But, as Christopher Conover shows in this volume, this characterization is not helpful or accurate for present purposes because it depends upon an artificial and unrealistic definition of regressivity—in terms of the proportion of income that a given class spends on health care in general, including its own, rather than only the proportion that is diverted to essentially public purposes or to meeting regulatory requirements. Christopher J. Conover, *Distributional Considerations in the*

the cumulative extent of regressivity in U.S. medical care, we have shown enough actual and probable unfairness to the sub-affluent majority to suggest the desirability of shifting definitively to a health care system in which “you get what you pay for,” no less as well as no more, but also in which substantial public subsidies funded by progressive taxation ensure that inability or unwillingness to pay plays only a marginal role—a crucially important marginal role, to be sure—in allocating resources to health care. Of course, others might reasonably view the same injustices as pointing in the direction of less reliance on markets and more direct government intervention. In any event, in a time of justifiable concern about widening income disparities in American society,⁷ it is important to recognize that the health care sector offers a unique opportunity for society to mitigate a very large inequity—and, in so doing, to put the nation’s resources to more appropriate uses, thereby enhancing aggregate welfare, productivity, and competitiveness rather than diminishing them as other redistributive measures are often thought to do.

II

OVERSPENDING ON HEALTH CARE—WHO PAYS? WHO BENEFITS?

There are numerous reasons to believe that the United States spends too much of its considerable wealth on health care. A comparison with other developed nations, for example, suggests that excessive spending on health care in the United States amounts to several whole percentage points of gross domestic product (GDP)—possibly more than half a trillion dollars each year.⁸

Overregulation of Health Professionals, Health Facilities, and Health Plans, 69 LAW & CONTEMP. PROBS. 181, 183 (Autumn 2006). Moreover, the method employed by Holahan and Zedlewski in identifying cost burdens—estimating the average burden borne by individuals in each income decile—did not reveal the particular burden borne by lower- and middle-income premium payers to which we call attention in this article. Indeed, because each higher decile almost certainly included a greater number of persons having health coverage, the average cost calculated for each decile effectively obscured differences in the burdens borne by insured and uninsured individuals, both within each decile and across the board. Thus, whereas Holahan and Zedlewski’s data inadvertently made it appear that individuals in each higher income decile bore higher insurance costs than those with lower incomes, we hold it unlikely that insurance costs for those actually having insurance vary greatly according to income.

7. From the late 1980s to the late 1990s, the share of aggregate personal income received by the middle fifth of the population fell from 17.2% to 16.2%, while the income of the top fifth increased from 42.1% to 45.4%. JARED BERNSTEIN ET AL., PULLING APART: A STATE-BY-STATE ANALYSIS OF INCOME TRENDS xi (2000). The poorest quintile likewise fell further behind the high earners. Thus, incomes at the twentieth percentile were 16.8% of incomes at the ninetieth percentile in 1989 and 15.9% of such incomes (\$18,556 versus \$116,472) ten years later. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME IN THE UNITED STATES: 2002 26, available at <http://www.census.gov/prod/2003pubs/p60-221.pdf>.

8. See generally Organization for Economic Cooperation and Development (OECD) Health Data, chart 4-5 (June 5, 2005), <http://www.oecd.org/dataoecd/35/13/34966969.pdf>. In 2003, when health spending in the United States represented 15% of GDP, no other nation spent more than (Switzerland’s) 11.5% of its GDP on health care in that year, and the median level of expenditure among all thirty OECD nations was 8.6% of GDP. If Switzerland’s 11.5% of GDP devoted to health care is converted into “purchasing power parity international dollars” (PPP\$), the OECD data can be read to show that Switzerland in fact spent only 67% as much per capita on health care in 2003 as the United States (\$3,781 versus \$5,635). See Uwe E. Reinhardt et al., *U.S. Health Care Spending in an*

In this Part II we ask who benefits most, in their own terms, from this extraordinarily high level of spending and show that it is not just the economy in general that is overburdened but also, disproportionately, ordinary working Americans. Even if we have overstated the annual amount of misspent dollars by a hundred billion or so, it would still be a very heavy cost to impose unnecessarily on working families that are finding it increasingly difficult to pay energy bills, to raise and educate their children, and to save for an uncertain retirement. To be sure, excess spending yields some offsetting benefits in the form of improved health status, reassurance, and security. But paying for some of those benefits might be seen as an extravagance by those with pressing needs of other kinds. Moreover, only a fraction of the health care premiums paid by insured working Americans goes to defray the costs of their own health care. Instead, as we will show, much of the money they contribute as premiums is spent on services for persons other than themselves.⁹

Health care costs in the United States were projected to reach \$2.16 trillion in 2006 approximately \$7100 per capita and 16.5 percent of GDP.¹⁰ The annual premium for an average family's health coverage reached \$10,880 in 2005, equivalent to nearly 19 percent of the median household's income.¹¹ While burdensome to all but the most affluent families, this level of spending can be deemed excessive, in policy terms, only if either (1) the prices paid to providers and suppliers are too high—that is, significantly in excess of competitive prices—or (2) patients regularly receive services or products of such little benefit that the human and capital resources expended could have been better employed in providing other goods or services. In fact, U.S. health care appears to present both of these problems: both supracompetitive prices and inefficiently high levels of consumption, particularly in the intensity of care delivered.¹² Thus, there is reason for concern not only about the excessive cost

International Context, HEALTH AFF., May–June 2004, at 10 (using this methodology to derive similar estimates). Treating as “excessive” all U.S. health spending over this percentage provides a basis of sorts for the eye-catching number suggested in the text as a possible measure of the magnitude of U.S. overspending. The extreme outlier status of the United States also appears from a comparison of its 2003 health spending of 5,635 PPP\$ per capita with median per capita spending of 2,161 PPP\$ among all OECD nations. *See id.* To be sure, the income-elasticity of demand for health care is such that richer nations naturally spend higher percentages of their national income on it. *See infra* note 101. But this article shows not only that the level of spending in the U.S. results from a unique combination of dysfunctional markets and misguided public policies but also that it is working-class Americans, and not the affluent, whose money is being spent excessively on health care—without anything resembling their informed consent.

9. In addition, working Americans bear much of the cost of the largely pay-as-you-go Medicare program through a payroll tax of questionable fairness. *See supra* note 1.

10. Christine Borger et al., *Health Spending Projections Through 2015: Changes on the Horizon*, 2006 HEALTH AFF. (WEB EXCLUSIVES) W61, W62 exh. 1.

11. KAISER FAMILY FOUNDATION & HEALTH RESEARCH AND EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS: 2005 ANNUAL SURVEY 16 (2005) (estimating the average annual premium for family health insurance coverage in 2005 as \$10,880); U.S. DEP'T HOUS. & URBAN DEV., NOTICE PDR-2005-01 (2005) (estimating median family income in 2005 as \$58,000).

12. Wasteful spending might also take the form of excessive administrative costs, which many think they see in the U.S. private sector. *See, e.g.*, David U. Himmelstein, Steffie Woolhandler & Sidney M. Woolf, *Administrative Waste in the U.S. Health Care System in 2003: The Cost to the Nation, the States,*

burden itself but also about how both the burden and the benefits of excessive spending are distributed among different income classes. The two sections of this Part II call attention to the immense, regressive redistribution of wealth that results from public policies and industry practices that cause lower-income workers with health coverage both (1) to overpay for many health-related goods and services and (2) to consume more than they would freely choose to consume. Part III then observes how these same overcharged families may be regularly disadvantaged on the receiving end as well, getting both less and lower-quality health care than higher-income participants in the same health plans get for the same money.

A. Excessive Prices: Overpaying Providers and Suppliers

Prices paid for health care goods and services in the United States are quite high in comparison with similar prices in other developed nations.¹³ Likewise, prices paid to suppliers and providers by U.S. private payers significantly exceed comparable payments under the Medicare and Medicaid programs.¹⁴ In each case, the explanation may be simply that government-controlled health systems, here as well as abroad, exercise their buying (monopsony) power to set prices below fair, competitive levels.¹⁵ But the substantially higher prices observed in the U.S. private sector may also be a consequence of weak competition and unchecked monopoly or market power. To whatever extent prevailing prices exceed competitive levels and cannot be justified as appropriate rewards for inventive or entrepreneurial success, they can be deemed an unfortunate redistribution of income from consumers to various

and the District of Columbia, with State-Specific Estimates of Potential Savings, 34 INT'L J. HEALTH SERVICES 79 (2004). Although a decentralized, competitive industry will inevitably incur certain costs that could be avoided in a system run by government, those added costs are usually justified by a competitive market's better incentives for improved performance and greater ability to satisfy differing consumer needs and preferences. To the extent that the nominally decentralized U.S. health care system does not deliver these benefits (as we later suggest it largely fails to do), any higher costs it entails may be counted as unjustified burdens imposed on consumers for the benefit of the insurance industry and other interests. Rather than centralizing administration in government's hands, however, the better way to address inefficiency of this kind might be to enable, and encourage, health insurers to realize the usual benefits of competition. See Clark C. Havighurst, *Why Preserve Private Health Care Financing?*, in AMERICAN HEALTH POLICY: CRITICAL ISSUES FOR REFORM 87 (1993) (arguing that private health plans are hard to defend unless they are allowed to offer, and do offer, consumers a full range of health care options, including economizing opportunities).

13. Reinhardt et al., *supra* note 8; Gerard F. Anderson et al., *It's the Prices, Stupid: Why the United States Is So Different from Other Countries*, HEALTH AFF., May-June 2003, at 89. Comparisons of care in the United States with care in other OECD nations suggest that American health care consumers do not receive generally better quality but are simply paying more for comparable goods and services. See, e.g., Peter S. Hussey et al., *How Does the Quality of Care Compare in Five Countries?*, 23 HEALTH AFF. 89 (2004).

14. The Medicare Payment Advisory Commission (MedPAC) reports that although hospital payment-to-cost ratios for private payers declined fairly steadily through the 1990s, dropping from approximately 130% to 115%, comparable ratios for Medicare and Medicaid were substantially lower. MEDPAC, MEDICARE PAYMENT POLICY 62 fig.2B-1 (2002). For physician services, Medicare payments were only eighty-three percent of private payments in 2004. MEDPAC, MEDICARE PAYMENT POLICY 81 (2006).

15. See *infra* note 34.

elements of the health care industry. Of course, merely redistributing income does not affect aggregate wealth. In this case, however, the unjustified gains enjoyed by the winners appear large enough that it is important to know just who the losers are and whether there are ways to reduce their losses.

1. How Health Insurance Exacerbates the Redistributive Effects of Monopoly

Even though rewarding providers handsomely does not itself lessen total wealth, aggregate welfare does suffer when the economy's capital, labor, and other resources are not used to their maximum advantage. In economic theory, high monopoly prices can result in "deadweight loss" (from "allocative" inefficiency) because they discourage consumption of the monopolized good, thus diverting productive resources to other sectors and away from their best use.¹⁶ Strikingly, this misallocative tendency of monopoly is not a significant problem in health care because of health insurance, which enables consumers to *pay* inflated prices rather than being discouraged by them from consuming the overpriced item.¹⁷

But at the same time that health insurance reduces the danger that any monopolized good or service it covers will be underproduced, it exacerbates the other objectionable consequence of monopoly pricing: its regressive redistribution of income from consumers to producers.¹⁸ It does this by enabling monopolists to set substantially higher prices than they could set if consumers were exposed to actual prices.¹⁹ Because insureds face only deductibles, co-

16. See generally JEAN TIROLE, *THE THEORY OF INDUSTRIAL ORGANIZATION* 65–78 (1988) (outlining the distortions and inefficiencies associated with monopoly in economic theory). For reasons why economists are chary of basing policy prescriptions on claims that their adoption will increase allocative efficiency, see note 212 *infra*.

17. Thus, health insurance eliminates most of the "deadweight loss triangle" that appears under the demand curve in textbook illustrations of monopoly's misallocative effect. See Arti K. Rai, *The Information Revolution Reaches Pharmaceuticals: Balancing Innovation Incentives, Cost, and Access in the Post-Genomics Era*, 2001 U. ILL. L. REV. 173, 202–09 (2001) (observing that "providing access to insurance is a low-cost mechanism for reducing deadweight loss"); Martin Gaynor, et al., *Are Invisible Hands Good Hands? Moral Hazard, Competition, and the Second-Best in Health Care Markets*, 108 J. POL. ECON. 992 (2000) (considering offsetting allocative effects of insurance-induced moral hazard and supracompetitive prices for health services). For a graphic presentation of deadweight loss, see TIROLE, *supra* note 16, at 67.

18. Most economists take no professional position regarding the distribution or redistribution of income because it has no effect on aggregate welfare (that is, efficiency) unless one makes certain assumptions about the marginal utility of income to different individuals. See generally Daniel A. Farber, *What (If Anything) Can Economics Say About Equity?*, 101 MICH. L. REV. 1791 (2003) (reviewing LOUIS KAPLOW & STEVEN SHAVELL, *FAIRNESS VERSUS WELFARE* (2002), extensively examining arguments in law and economics). But monopoly's redistributive effects can be a potent political issue—as we suggest they should be in the current state of U.S. health care.

19. In the normal monopoly case, there is a trade-off between allocative inefficiency and redistribution. Thus, while more elastic demand makes high prices more likely to discourage desirable consumption, it also means that there is less consumer surplus (see *infra* note 54) available for a monopolist to capture; likewise, to whatever extent a monopolist is able to practice price discrimination, consumption is facilitated and deadweight loss is reduced—but the monopolist earns greater profits at consumers' expense. Strikingly, this reciprocal relationship between monopoly's misallocative and redistributive effects does not generally hold in the U.S. health care market. As the

insurance, or co-payments, the pricing decisions of monopolists selling insured products or services are only slightly constrained by the limits of consumers' willingness or ability to pay.²⁰ By effectively steepening the demand curve a monopolist faces, health insurance enhances the monopolist's pricing freedom and ability to exploit consumers, enabling it to charge even more than the theoretical "monopoly price."²¹

Because health insurance so greatly dilutes the individual consumer's price-consciousness as a check on provider pricing freedom, price competition in health care depends heavily on private insurers' acting as knowledgeable, aggressive purchasing agents for their insureds. Indeed, large private insurers and health plans are often thought to exercise substantial buying power vis-à-vis providers.²² But even though health plans certainly make competition more effective in potentially competitive markets (because of their superior skill in searching the market and their ability to reward low-price providers by steering substantial business their way), they are largely helpless in confronting true

text in this and the next section explains, once U.S.-style health insurance and a few other factors (specifically, the peculiar incentives and conduct of nonprofit firms) are added to the mix, monopoly may generate excessive rather than suboptimal consumption. And this misallocation of resources (if it occurs as we hypothesize), instead of being offset in some sense by a reduction in monopoly's redistributive effect, is simply an additional burden on the economy.

20. The differences among different forms of cost sharing are important in this context. In health plans with so-called tiered benefits, payment of a fixed co-payment usually entitles the insured to full coverage of the remaining cost of "medically necessary" care and medications. In other plans, stop-loss provisions entirely eliminate co-insurance at some point. In both cases, once the initial deductible or other cost-sharing requirement is met, the sky may be almost literally the only limit on the monopolist's pricing freedom. To be sure, the amount of pricing freedom enjoyed by sellers of patented, therapeutically unique prescription drugs has not been quite so great because, until fairly recently, a large proportion of the population lacked extensive coverage for these products, and Medicare generally did not cover them (even though its beneficiaries were particularly heavy users). But, according to one survey, seventy-three percent of non-institutionalized Medicare beneficiaries aged sixty-five or older had some form of public or private (Medigap or retiree) coverage of prescription drugs in 2003. Dana G. Safran et al., *Prescription Drug Coverage and Seniors: Findings from a 2003 National Survey*, 2005 HEALTH AFF. (WEB EXCLUSIVES) W5-152. Also, coverage for the rest of the population expanded rapidly from the late 1980s. See Patricia M. Danzon & Mark V. Pauly, *Health Insurance and the Growth in Pharmaceutical Expenditures*, 45 J. LAW & ECON. 587 (2002). The finding by Danzon and Pauly that the rapidly rising share of the national health dollar claimed by prescription drugs during the period in question reflected improved insurance coverage is consistent with the hypothesis that monopolistic sellers found it increasingly profitable to price their products in the range where demand was especially inelastic due to health insurance. In any event, our observations about how monopoly and health insurance interact appear to have important (though as yet unrecognized) implications for the implementation of the new Medicare prescription drug benefit. See generally Jennifer Bowman et al., *Access to Cancer Drugs in Medicare Part D: Formulary Placement and Beneficiary Cost Sharing in 2006*, 25 HEALTH AFF. 1240 (2006).

21. A typical monopolist seeking maximum profit sets its unit price so that "marginal cost" (the cost of producing one additional unit) does not exceed the additional ("marginal") revenue generated by that price across all units. Because higher prices generally reduce the number of units that can be sold, there is normally a finite point beyond which a higher price per unit will net the monopolist a lower total profit, not a higher one. With health insurance helping consumers pay the monopolist's price, however, marginal cost and marginal revenue will equate at a higher level. In other words, with insurance in the picture, the monopolist's profit-maximizing price will be significantly higher, and the redistribution of income it causes will be significantly greater.

22. See generally Roger D. Blair & Jill Boylston Herndon, *Physician Cooperative Bargaining Ventures: An Economic Analysis*, 71 ANTITRUST L.J. 989 (2004).

monopolists. It is highly unlikely, for example, that an afflicted enrollee would easily accept a plan decision to forgo purchasing a monopolized service or product on his behalf simply because its price was too high. By hypothesis, there would be no close substitute for the monopolized service or product as a treatment for certain health problems, and enrollees facing those problems could be expected to protest, even sue, if the plan refused to purchase it for them.²³ Although it is possible to imagine health plans whose enrollees agree in advance to let the plan make benefit-cost trade-offs in designing coverage and purchasing for the group, insurance of that kind has not been accepted in the U.S. market.²⁴ In the absence of insurer competition focused on giving subsets of consumers optimal value for their health care dollars (rather than merely easy access to all “medically necessary” services and products), private health insurance enables providers and suppliers possessing advantageous market positions to parlay them into unusually large profits earned at premium payers’ expense.

23. For truly stunning examples of the price-increasing and profit-generating effects of combining U.S.-style health insurance and monopoly, see Geeta Anand, *The Most Expensive Drugs* (pts. 1–4), WALL ST. J., Nov. 15, 2005, at A1 (quoting one drug company executive as saying, “I never dreamed we could charge that much”); WALL ST. J., Nov. 16, 2005, at A1; WALL ST. J., DEC. 1, 2005, at A1; WALL ST. J., Dec. 28, 2005 at A1. This series of articles reports that insurers are paying amounts up to, and even in excess of, \$600,000 per patient per year for drugs needed to treat a relatively small number of individuals with rare chronic conditions. Purveyors of these drugs, which generally cost relatively little to produce, enjoy exceptionally strong protection against competition for their drugs and biologics under the Orphan Drug Act of 1983, Pub. L. No. 97-414, 96 Stat. 2049 (1983). Although other health-sector monopolists, even patent monopolists, may not possess the same market dominance as firms protected by the Orphan Drug Act, the insurers with which they deal have few tools with which to resist paying quite high prices for often small or debatable incremental benefits. *See infra* notes 24 & 27.

24. *See* Rai, *supra* note 17, at 208 (“The extent to which plans can engage in price/quality competition based on true cost-benefit tradeoffs . . . is still limited by the structure of contract and tort law. Limitations on quality that emerge from limitations on beneficial coverage will be difficult to implement in our current system.”). One of the instant authors has consumed much ink in trying to make the world safe for such economizing contracts. *See, e.g.*, CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM (1995) [hereinafter HAVIGHURST, HEALTH CARE CHOICES]. The legal system and the market have been largely unwilling to embrace them, however. *See generally* Mark V. Pauly, *Competition and New Technology*, 24 HEALTH AFF. 1523 (2005) (recognizing lack of contractual freedom as a reason why costs of new technology are uncontrolled); Clark C. Havighurst, *How the Health Care Revolution Fell Short*, 65 LAW & CONTEMP. PROBS. 55, 67–74 (Autumn 2002) [hereinafter Havighurst, *How the Revolution Fell Short*]. Indeed, managed health care ran into a political firestorm in the 1990s when it began to appear that health plans might invoke their contracts to ration arguably beneficial care. *See generally id.* at 64–100; Mark A. Hall, *The Death of Managed Care: A Regulatory Autopsy*, 30 J. HEALTH POL. POL’Y & L. 427 (2005) (reviewing and explaining the dramatic decline in health plans’ efforts to actively manage health care costs); *see also* Michael E. Chernew et al., *Barriers to Constraining Health Care Cost Growth*, HEALTH AFF., Nov.-Dec. 2004, at 122 (reporting post-backlash interviews with health plan administrators and finding unwillingness to constrain technology-driven cost increases). Evidence of insurers’ lack of either the will or the means to limit their insureds’ access to costly treatments on the basis of well-calibrated benefit-cost comparisons appears in their difficulty in resisting paying even the staggering prices demanded by firms with monopolies under the Orphan Drug Act. *See* Anand, *supra* note 23, pt. 1 at A1 (reporting, however, that, in the face of Orphan Drug Act monopolies, “employers and insurers are now pushing back” but only by “excluding coverage of certain orphan drugs [or] requiring employees to pay as much as half the cost of the pricey medicines”).

While many health care markets feature reasonably effective price competition for health insurers' business, there are many others in which health insurance appears to facilitate price gouging by monopoly sellers. Antitrust enforcement, although actively pursued since the 1970s, has been relatively unsuccessful in preventing hospital mergers and consolidations that increase already high levels of market concentration.²⁵ Also, despite some success in preventing providers from nakedly combining for the purpose of bargaining collectively with payers, antitrust agencies have not been able to stop the formation of integrated single-specialty medical groups with substantial pricing freedom in their local markets.²⁶ In fact, in many health-care markets and

25. "[S]ince 1981, the Commission and DOJ have challenged relatively few hospital mergers, in some instances seeking relief only for part of the transaction. . . . From 1994 through 2000[,] . . . when there were approximately 900 hospital mergers, the Agencies and state antitrust enforcers lost all seven cases they litigated." FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION ch. 4, at 1 (July 2004). See generally *id.* at 1–33; Cory S. Capps et al., *Antitrust Policy and Hospital Mergers: Recommendations for a New Approach*, 47 ANTITRUST BULL. 677 (2002). On the price-increasing effects of mergers and consolidations, see David Dranove, THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE 122 (2000) ("I have asked many providers why they wanted to merge. Although publicly they all invoked the synergies mantra, virtually everyone stated privately that the main reason for merging was to avoid competition and/or obtain market power."); Jack Zwanziger & Cathleen Mooney, *Has Price Competition Changed Hospital Revenues and Expenses in New York?*, 42 INQUIRY 183 (2005) (finding that mergers undermined price- and cost-reducing effects of hospital competition following deregulation); Cory Capps & David Dranove, *Hospital Consolidation and Negotiated PPO Prices*, HEALTH AFF., Mar.-Apr. 2004, at 175; Martin Gaynor & William B. Vogt, *Competition Among Hospitals*, 34 RAND J. ECON. 764, 764 (2003) ("During the second half of the 1990s, a dramatic wave of hospital consolidation occurred in the United States. . . . [M]any local markets, including quite a few large cities such as Boston, Minneapolis, and San Francisco, have come to be dominated by two or three large hospital systems. Not surprisingly, many health plans have complained about rising prices as a result of this consolidation."). On the courts' special tolerance for anticompetitive mergers of nonprofit hospitals, see *infra* note 41.

26. On enforcement policy toward the formation of large medical groups and physician networks, see Fed. Trade Comm'n & U.S. Dep't of Justice, Statements of Enforcement Policy in Health Care 61–105 (1996), available at <http://www.ftc.gov/reports/hlth3s.pdf>. See also FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *supra* note 25, ch. 2, at 34–41. The agencies' enforcement policy guidelines take the view that physician joint ventures must involve a substantial degree of "integration"—either financial risk-sharing or close cooperation in clinical matters—before the agencies will deem them anything other than naked price-fixing if they facilitate collective bargaining with payers over prices. See, e.g., letter from Jeffrey W. Brennan, Bureau of Competition, Fed. Trade Comm'n, to John J. Miles (Feb. 19, 2002) (MedSouth advisory opinion), available at <http://www.ftc.gov/bc/adops/medsouth.htm> (giving tentative approval, subject to re-examination in light of actual experience, to a potentially large physician joint venture in Denver that promised some clinical efficiencies in coordinating care provided by independent medical practices). In the *MedSouth* matter, the FTC staff neglected to consider that the venture, if truly procompetitive, should not need price-fixing to succeed because the promised efficiencies and improvements, if realized, should make participating physicians especially attractive to payers and thus, presumably, able to command higher compensation in individual, rather than collective, negotiations; also, the FTC has reported no follow-up examination of the MedSouth joint venture to verify that its consequences were not anticompetitive. More generally, one commentator has observed that

the federal enforcement agencies have been slow to challenge physician or other provider networks Generally, they have targeted only near-monopolies and outright cartels. Further, the agencies' advisory opinions in many cases have generously extended the safe-harbor limits contained in their own policy statements. Consequently, many private attorneys advise clients that it is a relatively low risk proposition to form networks that encompass large segments of a market. In sum, agencies' failure to back up their advisory opinions with enforcement actions may have undermined the prophylactic potential of their advisories.

submarkets (or niches) significant monopoly or market power exists and is uncontestable under the antitrust laws because it arises solely from market circumstances, technological causes, or regulation. For example, natural-monopoly conditions, entry barriers, network effects, exclusionary licensure or certificate-of-need requirements, significant product differentiation, tacit coordination among oligopolists, valid patents, trade secrets, or first-mover advantages all can bestow de facto market power.²⁷ In addition, providers and suppliers may have undue pricing freedom simply because insurers lack strong incentives to drive hard price bargains with providers even when there are opportunities to do so. For example, if purchasers of health insurance are themselves less than fully cost-conscious (as we later argue is the case²⁸) and therefore tend to overvalue such things as unrestricted access to providers or small increments of arguable quality, provider prices will be supracompetitive.

Where lawful or uncontested power over price exists, private health insurance—at least the kind currently found in the United States—not only provides inadequate countervailing bargaining power but positively facilitates the translation of market power into a major redistribution of income from consumers to providers or suppliers. Indeed, the recent renewal of health care cost escalation after several years of relative stability appears directly attributable in part both to increasing supply-side market power as a result of hospital consolidations and the growth of provider organizations and to reduced purchasing discretion of health insurers following the backlash against managed health care in the 1990s.²⁹ It is also no accident that prescription drugs and

Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, HEALTH AFF., Mar.-Apr. 2002, at 185, 190. Even when enforcement occurs, the sanctions are generally prospective cease-and-desist orders, the threat of which creates little deterrent to future violations by other physician groups.

27. Monopoly and market power, defined as the ability to charge prices higher than marginal cost, are always matters of degree, of course. Thus, many pharmaceutical products, including those with patent protection, have reasonably close substitutes, limiting their sellers' pricing freedom. Yet price competition in markets for prescription drugs is often less than robust even after generic substitutes enter the market. See Atanu Saha et al., *Generic Competition in the U.S. Pharmaceutical Industry* (May 2005) (unpublished manuscript), available at <http://www.analysisgroup.com/AnalysisGroup/uploadedFiles/Publishing/Articles/Generic%20Competition%20in%20the%20U.S.%20Pharmaceutical%20Industry.pdf> (finding that "each additional [generic] entrant on average is associated with a 0.2% decline in brand price. Nevertheless, unless the number of generic competitors is large, brand prices continue to rise in absolute terms."); see also Alex Berenson, *A Cancer Drug's Big Price Rise Disturbs Doctors and Patients*, N.Y. TIMES, Mar. 12, 2006, at A1 (reporting large price increases of unpatented, single-source drugs for small market segments and pressure on insurers to cover such drugs). For present purposes, it suffices to understand that the pricing freedom of firms with market power is frequently greatly enhanced by health insurance even though in some circumstances insurers strengthen price competition.

28. See *infra* text accompanying notes 90–92.

29. See *supra* notes 25 & 26; see also MEDPAC, MEDICARE PAYMENT POLICY 57 (2005) (noting that insurers' use of selective contracting "has been limited by both hospital consolidation and consumers' reluctance to accept limitations on their choice of providers"); Hall, *supra* note 24 (describing how the backlash against managed care weakened health plans' discretion in dealing with powerful providers). As a practical matter, hospitals' monopoly power does not appear to be exercised so much by raising the price of individual services for which there is no close substitute (geographically or otherwise) as by resisting insurer demands for steeper discounts from arbitrarily set list prices for its

medical devices (both areas in which patents and trade names can confer valuable market power) have been important contributors to recent cost increases.³⁰ Because premium payers appear to bear a particularly heavy burden due to supracompetitive prices in health care markets, there is reason to examine the fairness of the resulting redistribution of income.

Its exceptional redistributive effects aside, the combination of monopoly and U.S.-style health insurance also contributes in a different way to allocative inefficiency. Although health insurance diminishes the usual tendency of monopoly to discourage consumption, the prospect of extraordinary profits that health-sector monopolists can hope to earn by virtue of health insurers' inability to negotiate prices can be expected to influence firms to pursue such profits aggressively, often in ways that are not socially productive. Richard Posner has hypothesized that, even in the general economy, monopoly's most important misallocative effects flow not from discouraging marginal consumption but from inducing firms to make excessive investments in seeking to gain, hold onto, or increase market power.³¹ Indeed, Posner observes that there is no certainty that a successful monopolist will not dissipate most of its monopoly profits, earned at consumers' expense, in such endeavors. To be sure, some efforts to gain and retain market power, especially by technological and other innovation, are socially beneficial. But the prospect of monopoly profits also induces conduct that is purely rent-seeking, such as lobbying for and exploitation of protectionist regulation, spurious product differentiation, uninformative advertising and other promotional activities, erecting entry barriers, and other monopolistic conduct. Precisely because U.S.-style health insurance makes health-sector monopolies more profitable than monopolies of other kinds, Posner's recognition of the social waste potentially generated by the prospect of

full range of services; thus, for example, a hospital may be able to charge an insurer \$5 for an aspirin tablet because it has a powerful position in the market for open-heart surgery. For insights on how hospitals usually negotiate their prices, not service-by-service but by agreeing to across-the-board discounts for a bundle of services, see Christopher P. Tompkins, Stuart H. Altman & Efrat Eilat, *The Precarious Pricing System for Hospital Services*, 25 HEALTH AFF. 45 (2006). Unfortunately, it is difficult to quantify hospitals' market power except by noting that hospitals' revenues from private sources tend to exceed allocations of fully distributed costs (not necessarily the true costs of treating patients insured by such private sources) by substantially greater margins than their revenues from public sources. See *id.* at 47. Although hard data on hospitals' monopoly profits are lacking, we see no reason to doubt our conceptual hypothesis that, although insurers keep prices well down for many things, they still enable true monopolists to charge exorbitant prices that premium payers ultimately pay.

30. See Bradley C. Strunk, Paul B. Ginsburg & John P. Cookson, *Tracking Health Care Costs: Declining Growth Trend Pauses in 2004*, 2005 HEALTH AFF. (WEB EXCLUSIVES) W5-286 (finding a 7.2% increase in prescription drugs spending from 2003 to 2004, accounting for 21% of the overall increase in health care costs in 2004); see also Katharine Levit et al., *Health Spending Rebound Continues in 2002*, HEALTH AFF., Jan.-Feb. 2004, at 147 (noting that spending on prescription drugs increased to 11% of total health care expenditures in 2002 from 7% in 1997 and that drugs accounted for 16% of the total increase in health expenditures in 2002); Danzon & Pauly, *supra* note 20. A study by PriceWaterhouseCoopers found that drugs and medical devices together accounted for 22% of premium increases from 2001 to 2002. PriceWaterhouseCoopers, *The Factors Fueling Rising Healthcare Costs*, at tbl.1 (April 2002).

31. RICHARD A. POSNER, ANTITRUST LAW 13-18 (2d ed. 2001).

monopoly profits is especially significant for health policy. There are, unfortunately, few guarantees that the extraordinary profits earned by health-sector monopolists will induce only investments beneficial to the economy as a whole, let alone to the premium payers who bear the ultimate cost.³²

2. Cross-subsidies: One Consequence of Providers' Insurance-Enhanced Market Power

Even though U.S.-style health insurance exacerbates the income-redistributive effects of monopoly, not all of the extraordinary monopoly profits earned by health care monopolists end up, as such, in private pockets. Many health care institutions, especially nonprofit hospitals, plow excess earnings back into the health care enterprise, using them to cross-subsidize activities that the market would not otherwise support.³³ Therefore, much of the high cost of health care in the United States appears not in monopoly profits accruing to providers and suppliers, but as the cost of activities in which certain industry members are financially able to engage only because of the way health insurance and monopoly interact.

Among the costs that are frequently covered out of surpluses earned on providers'—especially hospitals'—other business are those that result when prices paid by government for services rendered under Medicare or a state Medicaid program add up to less than the costs the provider incurs in caring for that program's beneficiaries.³⁴ In addition, legal and regulatory requirements

32. See *infra* notes 45 & 59.

33. Besides hospitals, private payers and providers of other kinds sometimes cross-subsidize services for which individuals pay either nothing at all or less than the cost of the services or coverage they receive. See, e.g., *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) (describing, and upholding against a claim of federal preemption, a complex New York statutory scheme, since repealed, designed to preserve the ability of Blue Cross, as well as some private hospitals, to finance care for individuals who would otherwise be uninsured or uninsurable); see also *IHC Health Plans, Inc. v. Comm'r*, 325 F.3d 1188 (10th Cir. 2003) (denying federal tax exemption to health maintenance organization in part because it failed, unlike some other HMOs, to cross-subsidize indigent care, education, or research); see also *In re Health Care Admin. Bd.*, 415 A.2d 1147 (N.J. 1980) (upholding a regulation requiring nursing homes to reserve a reasonable number of their beds for indigent persons as a condition of licensure).

34. To be sure, a responsible government monopsonist would pay suppliers and providers enough to ensure continuing supplies of needed goods and services of appropriate quality—which would be in jeopardy if potential new entrants could not expect investment returns at least comparable to what they could earn elsewhere. Nevertheless, it appears that government does in fact sometimes fail to compensate providers, particularly hospitals, generously enough for them to break even in caring for their government-financed patients. See Stuart H. Altman, David Schactman & Efrat Eilat, *Could U.S. Hospitals Go the Way of U.S. Airlines?*, 25 HEALTH AFF. 11, 14 (2006) (“[I]n 2003[,] Medicaid reimbursed hospitals at 92 percent of costs, and Medicare, at 95 percent.”). Medicaid appears to be the worst offender in this regard, since state Medicaid budgets are generally tight and legislatures often find it easier to resist provider lobbies and welfare advocates than to raise taxes. See generally Jason S. Lee et al., *Medicare Payment Policy: Does Cost Shifting Matter?*, 2003 HEALTH AFF. (WEB EXCLUSIVES) W3-480, W3-485 (quoting view of long-time observer that “the big cost shifter is Medicaid” and presenting graphic evidence of significant cost shifting by both Medicare and Medicaid from 1987-1992). Since 1992, hospitals have, on average, had positive margins on their Medicare inpatients but have lost money on outpatients. MEDPAC, MEDICARE PAYMENT POLICY 78–79, fig.3A-7 and tbl.3A-2 (2004) (showing that inpatient margins followed a bell-shaped trajectory from 1% in 1993, to a peak

frequently force providers to incur costs (for example, in their emergency departments) for which government makes no restitution and that cannot be charged directly to some private payer.³⁵ Moreover, most major medical centers voluntarily engage in extensive research and educational activities only partly paid for by grants, contracts, tuition payments, or government subsidies for professional education.³⁶ Finally, hospitals render a great deal of uncompensated health care, estimated at \$30–\$35 billion in 2003, to the millions who have no or incomplete health coverage.³⁷ Although much of the cost of maintaining this safety net for those who cannot pay is paid ultimately by taxpayers at different levels,³⁸ hospitals themselves are stuck with a significant

of approximately 16% in 1997, to 4.7% in 2002, while outpatient margins from 2000 to 2002 were consistently below zero, fluctuating between -12% and -6%).

35. The prime example of such an “unfunded mandate” is the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2003) [hereinafter EMTALA], which requires that any hospital that both maintains an emergency department and takes Medicare money must screen every patient (not just Medicare patients) coming to the emergency room and must stabilize any emergency medical condition found, all without regard to the patient’s ability to pay. Although a hospital is free to close its emergency room and escape this costly obligation (and a significant number have done so), most hospitals believe that their mission requires them to maintain money-losing services of this and other kinds. See *infra* note 40. Other examples of care that is mandated but not paid for by government include laws prohibiting “discrimination” against the disabled and handicapped. See, e.g., *In re Baby “K”*, 832 F. Supp. 1022 (E.D. Va. 1993), *aff’d on other grounds*, 16 F.3d 590 (4th Cir. 1994) (finding several statutory duties of hospital to treat hopeless case); see also E. Haavi Morreim, *Futilitarianism, Exoticare, and Coerced Altruism: The ADA Meets Its Limits*, 25 SETON HALL L. REV. 883 (1995). Another example is the “free-care” obligation imposed at one time on hospitals pursuant to the Hill-Burton Act. See *Am. Hosp. Ass’n v. Schweiker*, 721 F.2d 170 (7th Cir. 1983). See also *Methodist Med. Ctr. v. Ingram*, 413 N.E.2d 402 (Ill. 1980) (holding the state’s police power “sufficient to justify, in proper circumstances, uncompensated deprivation of . . . property”).

36. For an estimate that health-profession education costs hospitals \$20–25 billion annually, see Bruce C. Vladeck, *Paying for Hospitals’ Community Service*, 25 HEALTH AFF. 34, 38 (2006). Medicare allowances to hospitals frequently contain upward adjustments for “indirect medical education” and “direct medical education” (totaling \$3.7 billion and \$2.2 billion, respectively, in 1999). Lee et al., *supra* note 34 at 485. See also SEAN NICHOLSON, *MEDICARE HOSPITAL SUBSIDIES: MONEY IN SEARCH OF A PURPOSE* 7–24, 55 *tbl.3* (2002). In considering the issue of distributive justice in U.S. health care, it is appropriate to question the practice of forcing taxpayers or premium payers, or both, to subsidize the training of individuals for lucrative careers as physicians or other health professionals.

37. Vladeck, *supra* note 36, at 37, exh. 1. Although hospitals are not generally compelled to create money-losing services, a hospital that chooses to maintain an unprofitable service, such as a burn, shock-trauma, or neonatal intensive care unit, or to become a regional referral center, is legally obligated to serve all comers without regard to ability to pay. EMTALA, 42 U.S.C. § 1395dd(g) (2000).

38. State and local governments directly support public and community hospitals and community health centers both by direct subventions and by exempting them from various taxes. The Medicare and Medicaid programs also provide extra payments to hospitals with a “disproportionate share” of nonpaying patients. See *The Tax-Exempt Hospital Sector: Hearing before the Comm. on Ways and Means*, 109th Cong. (2005) (Statement of Mark McClellan, Administrator, Centers of Medicare and Medicaid Services), available at <http://www.cms.gov/media/press/testimony.asp?Counter=1476> (“Preliminary data show that during 2004, Medicare DSH payments amounted to about \$8.5 billion, while Federal and State Medicaid DSH payments totaled nearly \$17.2 billion.”); see also NICHOLSON, *supra* note 36, at 25–35. Medicare is also especially generous to certain kinds of rural hospitals, and allowances paid to teaching hospitals in recognition of their educational functions, see *supra* note 36, are also viewed as supporting the safety net, as well as the training of health professionals. It is relevant for present purposes that Medicare payments to hospitals are financed almost entirely by a flat tax on wages and salaries, not from general revenues. See *infra* text accompanying notes 47 & 48.

portion of the bill in the form of bad debts and uncompensated care.³⁹ This burden comes on top of hospitals' burdens from Medicare and Medicaid underpayments, unfunded governmental mandates, and activities they elect to cross-subsidize, all of which add up to a very large cost burden⁴⁰ with the misallocative and distributional consequences noted immediately below.

Most observers of the health care industry find it entirely appropriate that most of the monopoly profits earned in providing health services are used to defray other health-related costs.⁴¹ But in the absence of either market discipline or effective political oversight, there is no assurance that easily gained revenues will not be squandered in low-priority activities, in overpaying for

39. For an estimate that that for 2001 the net cost to hospitals for uncompensated care was \$1.5–3 billion, see Jack Hadley & John Holohan, *How Much Medical Care Do the Uninsured Use, and Who Pays for It?*, 2003 HEALTH AFF. (WEB EXCLUSIVES) W3-66, W3-76. This relatively low estimate of hospital uncompensated-care costs, derived by upwardly adjusting reports from uninsured patients themselves, was seemingly provided to suggest that the new public cost of covering the uninsured would be small. The hospital industry understandably reports a much higher burden from bad debt and uncompensated care. See *First Hearing in a Series on Tax Exemption: Pricing Practices of Hospitals, Before the Subcommittee on Oversight of the House Committee on Ways and Means*, 108th Cong. (2004) (statement of David Bernd, Chairman of the Board of the American Hospital Association) (reporting that hospitals incurred \$22 billion in uncompensated care costs in 2002). See also Altman et al., *supra* note 34, at 14 (“[G]eneral hospitals provide a sizable amount of uncompensated care—an average of 5.5 percent of total general hospital costs, or about \$25 billion, in 2003.”). The rapid increase in the number of the uninsured is putting increased pressure on hospital budgets.

40. See Vladeck, *supra* note 36, at 37 (estimating hospitals' total community service costs at \$80-95 billion in 2003). This is not to say there is an actual “cost-shift,” at least in the strict sense that, say, a cutback in government payments or an increase in the hospital's uncompensated-care burden translates directly into a compensating increase in prices charged to private payers. Indeed, economists are quick to point out that a firm possessing market power in any market would normally exercise that power to the fullest, whatever its other costs or obligations in other markets might be. See Michael A. Morrissey, *Cost Shifting: New Myths, Old Confusion, and Enduring Reality*, 2003 HEALTH AFF. (WEB EXCLUSIVES) W3-489. In the real world, however, there are influences that appear to keep some hospitals, particularly nonprofit ones, from maximizing profits. See generally Allen Dobson, Joan DaVanzo & Namrata Sen, *The Cost-Shift Payment “Hydraulic”: Foundation, History, and Implications*, 25 HEALTH AFF. 22 (2006); Paul B. Ginsburg, *Can Hospitals and Physicians Shift the Effects of Cuts in Medicare Reimbursement to Private Payers?*, 2003 HEALTH AFF. (WEB EXCLUSIVES) W3-472 (suggesting that some hospital boards might deem their mission to include some obligation to charge fair prices). On the other hand, managers of nonprofits have a strong interest in expanding the firm's size and maximizing its output as a way of enhancing their own authority, prestige, job satisfaction, and perquisites. The principal way they can do this is by earning excess profits whenever possible and either reinvesting them in bricks and mortar or using them to cross-subsidize activities that the market will not support. Price discrimination (that is, charging different prices to different buyers based on differences in ability or willingness to pay) is therefore common in nonprofit firms, even to the extent of charging below-cost (even zero) prices for some activities—a practice that would normally be irrational for a for-profit monopolist. Strictly speaking, such price discrimination is not cost shifting, because the hospital is rationally pursuing its own objectives, rather than being forced into involuntary spending. See Morrissey, *supra*. However, the burden on premium payers is the same.

41. The belief that nonprofit monopolies are largely benign appears to account for the antitrust agencies' lack of success in challenging mergers bestowing market power on nonprofit hospitals. See Barak D. Richman, *The Corrosive Combination of Nonprofit Monopolies and U.S.-Style Health Insurance: Implications for Antitrust and Merger Policy*, 69 LAW & CONTEMP. PROBS. 139, 142–43 (Autumn 2006) (observing the significance for antitrust policy of this article's emphasis on the extraordinary pricing freedom enjoyed by monopolists, nonprofit as well as for-profit, selling services covered by U.S.-style health insurance).

inputs, or simply through managerial slack.⁴² Indeed, tax-exempt monopolists in health care markets are committed by their corporate charters and the tax code to pursuing only “charitable” purposes,⁴³ with the result that any surpluses they generate are essentially trapped in the health sector and unavailable for use elsewhere in the economy—even if they would yield greater welfare gains in alternative uses. Thus, hospital and other nonprofit monopolies suck large amounts of cash out of the economy either to support ongoing health-related activities or to create new health facilities or new health-sector monopolies. Over time, this one-way flow of capital into the health sector has built enormous enterprises that can legally use their untaxed income and assets only for health-related activities, whatever the economy’s or the public sector’s or premium-paying individuals’ other needs. Too little attention has been given, we submit, to the involuntary flow of substantial funds from premium payers into the coffers of powerful private institutions that are largely unsupervised and unconstrained with respect to their use of those resources.⁴⁴ It is ironic that, while health insurance eliminates monopoly’s usual threat to allocative efficiency—the danger that monopolized goods or services will be

42. See also *infra* note 45. It is well established that nonprofit hospitals are more likely than for-profits to offer unprofitable services. See Jill R. Horwitz, *Does Corporate Ownership Matter? Service Provision in the Hospital Industry 2* (Nat’l Bureau of Econ. Research, Working Paper No. 11376, 2005) (also observing that nonprofits are more likely than government hospitals to offer highly profitable services). But, even though many believe that this fact alone establishes that nonprofits are in all respects socially beneficial, there remains the possibility that nonprofits frequently exercise market power and invest the resulting profits in activities to which the public would ascribe relatively little value.

43. Nonprofit corporations can be exempt from various federal, state, and local taxes if (1) their earnings accrue only to the firm and not to any private interest (which might reinvest them outside the health sector) and (2) their resources, surpluses, and other assets are used exclusively for charitable purposes, variously defined. Nonprofit hospitals, which generate supracompetitive returns in many lines of business even when the whole institution seems to struggle, have been treated with special favor under federal law, which accepts “the promotion of health” in a community as a purpose charitable enough for tax exemption without regard to the amount of indigent care provided. Rev. Rul. 69-545, 1969-2 C.B. 117.

44. Such attention as these firms receive nearly always focuses only on similarities and differences in the behavior of nonprofit and for-profit firms and on the appropriateness of tax exemptions for the former. See, e.g., Mark Schlesinger & Bradford Gray, *How Nonprofits Matter in American Medicine, and What to Do About It*, 2006 HEALTH AFF. (WEB EXCLUSIVES) W6-287 (reviewing empirical literature comparing the behavior of nonprofits and for-profits in the health sector); David A. Hyman & William M. Sage, *Subsidizing Health Care Providers Through the Tax Code: Status or Conduct?*, 2006 HEALTH AFF. (WEB EXCLUSIVES) W6-312 (suggesting that nonprofits’ tax subsidies be tied to quantifiable measures of performance). This article emphasizes significantly larger issues, particularly the unfairness of systematically financing costly public services by undue impositions on premium payers rather than out of public funds. See Clark C. Havighurst, *The Debate over Health Care Cost-Containment Regulation: The Issues and the Interests*, in INCENTIVES VS. CONTROLS IN HEALTH POLICY: BROADENING THE DEBATE 9 (Jack A. Meyer ed., 1985) (opining that, at least in the mid-1980s, “cross-subsidies in the health care industry . . . may constitute the most entrenched, most extravagant, and least closely-supervised government-tolerated use of private monopoly to generate revenues for public purposes anywhere in the U.S. economy”). Many hospitals enjoy much of their market power solely because of regulatory protection (under so-called certificate-of-need laws) against competition that would undermine their ability to generate revenues needed for seemingly worthy purposes. Regulation that confers monopoly power on private interests as a quid pro quo for providing publicly approved services has been characterized as “taxation by regulation.” Richard A. Posner, *Taxation by Regulation*, 2 BELL J. ECON. & MGMT. SCI. 22 (1971).

underproduced—it conduces, in combination with other incentives and circumstances in the American system, to allocative inefficiency of precisely the opposite kind: too *much* of a good thing.⁴⁵

Even if hospitals and other entities in the health care sector cross-subsidized only activities of indisputable value to the general public, it would be no less objectionable to see those activities financed by means of extraordinary monopoly overcharges to private payers. The buck obviously does not stop with the payer. Instead, the heavy costs of activities unrelated to the care of the payer's own patients are inevitably passed on to working Americans more or less in proportion to the health insurance premiums that employers largely pay on their behalf. The result is a well-entrenched method of financing important health-related activities, many of uncertain value, through what amounts to a hidden "head tax." True to the nature of such a tax, the burden is distributed more or less equally across all premium payers rather than in proportion to their wealth or income.⁴⁶ In view of the magnitude of the burden thus imposed on lower- and middle-income premium payers, the regressivity resulting from the corrosive combination of nonprofit monopolies and U.S.-style health insurance should be a matter of specific public concern.

A telling final point is that, to the substantial extent that hospitals are compensated by the Medicare program for their various unremunerative undertakings (and thus do not have to finance them out of monopoly profits earned at premium payers' expense),⁴⁷ the burden still falls unfairly—though less unfairly than a head tax—on working Americans. Such Medicare subventions to hospitals are financed almost entirely by a 2.9 percent payroll tax on all current workers, including those without health coverage of their own. Because this tax applies to all earned, and no unearned, income, it is regressive in a way that even a true flat tax is not.⁴⁸

45. *But see infra* note 212. To be sure, monopoly's extraordinary profitability in the health sector can also induce allocative inefficiency in the form of less-good things, including wasteful spending in pursuit and defense of market dominance. *See supra* text accompanying notes 31 & 32. Examples of such rent-seeking behavior in the hospital industry include advertising, *see* Robert J. Town & Imran Currim, *Hospital Advertising in California, 1991-1997*, 39 *INQUIRY* 298 (2002); advocacy and exploitation of protectionist certificate-of-need regulation, *see infra* notes 156 & 157 and accompanying text; anticompetitive mergers; and restrictive agreements with actual or potential competitors.

46. Although cross-subsidization is sometimes analogized to a system of taxation, its unfair regressivity as a kind of head tax is generally not observed. *E.g.*, Dobson et al., *supra* note 40, at 30–31 (likening the cost shift to a premium tax without observing its regressivity); Holahan & Zedlewski, *supra* note 6, at 236 (treating uncompensated care "as a kind of premium surtax for families with private insurance that is transferred to those who receive uncompensated care").

47. Such subsidies represent roughly twelve percent of total Medicare payments for hospital inpatient care. NICHOLSON, *supra* note 36.

48. *See supra* note 1. An additional inequity results to the extent that higher-income employees contribute higher percentages of their earnings to tax-favored retirement plans, thereby escaping payroll taxes that, unlike deferred income taxes, are not recaptured when plan accumulations are distributed.

Recently, attention has been directed to hospitals' attempts to recoup otherwise unrecovered costs by overcharging—of all people—the uninsured.⁴⁹ Contrary to a widespread impression, many uninsured are not impecunious, and hospitals have not been shy—at least until the practice was recently spotlighted—about charging their full list prices to patients for whom no insurer has negotiated a discount from those prices.⁵⁰ Because list prices are set arbitrarily (mostly to establish a favorable baseline for negotiating with insurers), hospital bills rendered to patients without insurance can be literally outrageous. Nevertheless, it does not seem likely that very much of hospitals' community service burden is borne by the relatively small number of uninsured individuals unlucky enough to be hit with both a catastrophic health need and a staggering bill for treating it. As demonstrated by the large number of personal bankruptcies caused by health-care-related liabilities,⁵¹ many such charges go unpaid. In any event, because those who actually pay the big bills are demonstrably wealthier than those who do not, hospitals' discriminatory pricing practices do not have regressive distributional implications of the kind focused upon in this article.⁵² It is nonetheless striking to see firms claiming to operate for charitable purposes using their market power and extreme price discrimination to punish those who, whether voluntarily or otherwise, have no insurance coverage.⁵³

3. Innovation Incentives: Technological Progress at Whose Expense?

In the special case of monopolies (including patent monopolies) resulting from valuable innovation, it is arguable that the greater profits that health insurance enables monopolists to earn are justifiable as rewards for past innovations and inducements for future ones. Indeed, Darius Lakdawalla and Neeraj Sood have cogently observed that whereas incentives for innovation are systematically suboptimal in most markets (because even patent-protected innovators cannot hope to capture the full potential value of their inventions to consumers⁵⁴), health insurance can, in theory at least, create near-optimal

49. See Tompkins et al., *supra* note 29; Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57 (2006).

50. For a review of legal and other issues raised by such discriminatory pricing by hospitals, see Mark A. Hall, *Paying for What You Get and Getting What You Pay for: Legal Responses to Consumer-Driven Health Care*, 69 LAW & CONTEMP. PROBS. 159, 161–65 (Autumn 2006).

51. See Melissa B. Jacoby, Teresa Sullivan & Elizabeth Warren, *Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375 (2001); David U. Himmelstein et al., *Illness and Injury As Contributors to Bankruptcy*, 2005 HEALTH AFF. (WEB EXCLUSIVES) W5-63. *But see* David Dranove & Michael L. Millenson, *Medical Bankruptcy: Myth versus Fact*, 2006 HEALTH AFF. (WEB EXCLUSIVES) W74 (finding earlier estimates of frequency of bankruptcies caused by health costs to be exaggerated).

52. See also Hall, *supra* note 50, at 163 (reporting that hospitals are rapidly reducing their efforts to “tax” at least the lower-income uninsured).

53. On class-action litigation challenging such discriminatory pricing and other alleged neglect of nonprofit hospitals' charitable mission, see *id.* at 162–63.

54. In economic theory, the usual monopolist's potential rewards are limited to the “consumer surplus” (measured by the maximum prices that individual consumers would pay, as reflected in the demand curve) that consumers would enjoy if they could purchase the service or product at a

incentives for developing valuable medical technologies.⁵⁵ According to their argument, a health insurer can set its co-payment requirement so that anyone able to pay the marginal cost of a new product or service can purchase it, thus avoiding the deadweight loss usually associated with monopoly pricing. At the same time (the theory goes), the insurer, by paying the remainder of the monopolist's price, can reward the monopolist with the full value of the innovation to the insured group. The result, if one could assume universal health insurance with such characteristics, would be near-optimal incentives for innovation.⁵⁶

A possible implication from the work of Lakdawalla and Sood is that, because health insurance is substantially less than universal (and incentives for innovation therefore substantially suboptimal), the extraordinary rewards that innovators can hope to gain from insured consumers in the U.S. market should be valued as socially beneficial inducements to potential innovators.⁵⁷ Nevertheless, the practical difficulties that U.S. health plans would face in attempting to curb their members' demand for a monopolized product or service (in order to bargain more effectively with the monopolist) leave us still

competitive price. In reality, given the difficulty of price discrimination (that is, charging different prices to different buyers, depending on where they appear on the demand curve), ordinary monopolists cannot hope to capture all consumer surplus, let alone the value of any positive externalities the product may yield. Incentives to pursue valuable innovations are therefore suboptimal in the absence of insurance. The innovation literature leaves no doubt that suboptimal investments are made in basic scientific research, *e.g.*, Richard R. Nelson, *The Simple Economics of Basic Scientific Research*, 67 J. POL. ECON. 297 (1959), although there is some disagreement over whether investments in applied research and development of specific goods and services are also suboptimal. *See generally* ANTITRUST, INNOVATION, AND COMPETITIVENESS (Thomas M. Jorde & David J. Teece eds., 1992).

55. Darius Lakdawalla & Neeraj Sood, *Insurance and Innovation in Health Care Markets* (Nat'l Bureau of Econ. Research, Working Paper No. 11602, 2005).

56. For a theoretical demonstration, using different assumptions about pricing than those used by Lakdawalla and Sood, that universal health insurance, even with optimal copayments, may yield *excessive* incentives for innovation, see Alan M. Garber, Charles I. Jones & Paul M. Romer, *Insurance and Incentives for Medical Innovation* (Nat'l Bureau of Econ. Research, Working Paper 12080, 2006).

57. A series of studies by such researchers as David Cutler and Frank Lichtenberg show large social gains from investing in new medical and pharmaceutical technology. *See infra* note 68. Such studies appear to justify all spending on technology development because the consumer surplus generated by life-saving and health-improving technologies is so large, easily exceeding the social costs incurred. Indeed, the authors' seeming lack of concern about marginal trade-offs in the adoption of new technologies, *see infra* note 68, appears to be attributable to their sense that, in general, innovation incentives are seriously suboptimal. Certainly, the case for valuing R&D very highly is strong, particularly if one takes an international perspective. *See, e.g.*, Frank R. Lichtenberg, *The Impact of New Drug Launches on Longevity: Evidence from Longitudinal Disease-Level Data from 52 Countries: 1982-2001* (Nat'l Bureau of Econ. Research, Working Paper No. 9754, 2003) (attributing forty percent of world-wide decline in mortality in the period studied to the introduction of innovative drugs). (Many health problems in third-world nations would yield to new technologies, yet those nations are too poor to offer innovators much incentive to produce them, and strict price controls on many health-related technologies in other developed nations would seem to unduly diminish incentives for R&D, making the U.S. market the principal source of such incentives.) The potentially large social benefits of health-related R&D notwithstanding, however, it is far from clear to us that those benefits should be given full weight in assessing U.S. health policy and used to justify imposing their heavy costs on lower- and middle-income premium payers in U.S. health plans. *See infra* note 154 (discussing and questioning so-called Kaldor-Hicks efficiency, which permits gains to winners to justify imposing costs on others without regard to distributional consequences).

concerned about unjustified wealth transfers. The imperfections in U.S.-style health insurance put patentees and other innovating monopolists in a position to capture, systematically, more from insured consumers than their innovations may be worth to those consumers,⁵⁸ with the result that too much of the cost of inducing socially beneficial innovation is borne—once again as a kind of “head tax”—by lower- and middle-income payers of health insurance premiums.⁵⁹ Just as the burden of hospitals’ cross-subsidies of activities that are arguably socially beneficial should not fall equally across the premium-paying population, it is unfair to finance or induce technological progress by “taxing” insured Americans in proportion not to their wealth or income, but to the insurance premiums they pay.

We have offered here the perception that, as a class, lower-income payers of health insurance premiums are probably net losers, not net gainers, from whatever valuable technological innovations they indirectly finance. Our concern is warranted not only by the argument that U.S.-style health insurers generally cannot resist paying true monopolists virtually any price they ask, but also by our later argument that lower- and middle-income premium payers are unable, under current legal, regulatory, and market conditions, to opt for low-cost coverage that limits their potential access to new or other high-cost technologies.⁶⁰ However, even if evidence can be found to refute our contention

58. See Garber et al., *supra* note 56, at 14 (illustrating how, even with well-designed insurance, “profits earned by [a] pharmaceutical company can exceed the consumer surplus associated with the drug treatment”).

59. As in the analogous case of hospital cross-subsidies, we are reluctant to accept the argument that large social benefits justify maintaining innovation incentives, without regard to who bears the cost burden, in large part because of Richard Posner’s observation that the prospect of large monopoly profits can induce wasteful as well as productive behavior. See *supra* text accompanying notes 31 & 32. For example, there is a significant literature on the wasteful expenditures that the patent system can induce—even without the prospect of extraordinary monopoly profits of the kind that U.S.-style health insurance makes possible. See, e.g., Mark F. Grady & Jay I. Alexander, *Patent Law and Rent Dissipation*, 78 VA. L. REV. 305, 308 (1992) (“The defect of the system is that if multiple inventors expend resources in competition for the patent monopoly, the benefit to society of having the invention will be dissipated by the cost of numerous, redundant, development efforts.”). See also Yoram Barzel, *Optimal Timing of Innovations*, 50 REV. ECON. STATISTICS 348, 349 (1968) (“[C]ompetition among potential innovators may deprive innovations of all their special economic value.”). In addition to the wastefulness of so-called “patent races,” the social value of innovations may be further dissipated in promoting, attacking, defending, and inventing around valuable patents. In the health care sector, for example, one sees extensive efforts to create and heavily promote relatively modest product improvements and to differentiate brand-name products from nearly equivalent generics by heavy investment in direct-to-consumer advertising. In particular, there is evidence that the decreased price elasticity of demand for brand-name drugs following the expansion of insurance coverage for prescription drugs in the 1990s increased manufacturers’ expected returns from promotional efforts, many of which are socially unproductive. Danzon & Pauly, *supra* note 20.

60. See *infra* Part IV.C. The importance of the practical inability of consumers to purchase health insurance providing only selective coverage of costly technology has recently been recognized by economist Mark Pauly. Pauly, *supra* note 24. See also Donald W. Moran, *Whence and Whither Health Insurance? A Revisionist History*, 24 HEALTH AFF. 1415, 1423 (2005) (predicting that, with the advent of so-called consumer-directed health care, see *infra* text accompanying notes 93–98, consumer cost-consciousness and competitive pressure on health plans to control big-ticket items “will push back strongly against manufacturers’ pricing flexibility. Increasingly, the question of whether a high-cost

that health insurers are unable as a practical matter to limit their payments to monopolists to the true consumer surplus that their insureds enjoy from unique innovations, it would not invalidate our larger claim that U.S.-style health insurance generally enables health-sector firms with dominant market positions—most of which are not gained or retained principally by “superior skill, foresight, and industry”⁶¹—to exploit consumers unduly.

4. Financing the Health Sector by Means of a Regressive “Head Tax”

Foregoing discussion has characterized in two ways the extraordinary profits that health-sector firms with market power are able to earn because of dysfunctional aspects of U.S.-style health insurance. First, such profits may be seen, as monopoly profits often are, simply as a redistribution of income from consumers to producers; although such redistributions are not troublesome as a matter of economic efficiency, the manner in which health insurance enhances the profitability of monopoly should be a matter of concern from the standpoint of equity. Second, because health-sector profits may either subsidize or induce activities having some, perhaps substantial, social value, they may be viewed and evaluated as a kind of tax levied in support of these activities. Both in the case of cross-subsidization by nonprofit firms and in the case of profits serving as incentives for socially desirable innovation, we have analogized the burden borne by premium payers to a “head tax,” which falls on individuals without appreciable correlation to wealth, income, or ability to pay. In neither case does the manner in which the proceeds are used appear to rectify the apparent regressivity.

Likening to a kind of tax the extra charges, in excess of their costs, that health care monopolists can impose on payers of private health insurance premiums is quite helpful for the purposes of this article. In addition to inviting attention to the burden’s incidence and fairness (our particular concerns), the analogy provides a warrant for comparing monopoly overcharges with explicit taxes in terms of the political accountability of those imposing the burden and spending the resulting revenue. Not only are health industry monopolists relatively free to set their own prices, but they are subject to very little political accountability in choosing how to use the surpluses they generate.⁶² Thus, many of the activities that nonprofit providers cross-subsidize from monopoly profits would not, we submit, be found worthy of public financing if they were subject to the usual public processes for levying explicit taxes, appropriating funds, and

technology is covered at all by an insurance plan will become the most important determinant of product economics.”).

61. *United States v. Aluminum Co.*, 148 F.2d 416, 430 (2d Cir. 1945) (famous antitrust opinion by Learned Hand, J., acknowledging that even a powerful monopoly might be lawful if gained and maintained by “superior skill, foresight, and industry” and not by unlawful “monopolizing” behavior). See *supra* text accompanying notes 25–27 on the wide variety of factors, many of them fortuitous, that may explain why a seller is free to set unduly profitable prices in health care markets.

62. See *supra* text accompanying notes 42–45.

authorizing their expenditure.⁶³ Moreover, any projects that public lawmakers *would* be willing to support would almost certainly be financed in less regressive ways.

Similarly, given clear choices in the marketplace, a substantial majority of consumers might rationally elect to pay substantially less for their health protection even if it meant somewhat reducing both their access to costly new products of health care R&D and the likelihood that more such products or services would eventually be produced. To be sure, consumers economizing on their own health coverage may, as free riders, be counting on others to support R&D from which they hope eventually to benefit, leading to even greater underinvestment in R&D. But this is the nature of all so-called public goods. That public or philanthropic investment would otherwise be needed to achieve appropriate levels of spending on new technology is not a persuasive argument for forcing a subset of consumers to support R&D through an unfair tax, or against giving health care consumers a wider range of choice. In fact, most consumers would probably choose coverage that, while being somewhat selective about covering technologies at any price, would provide ample incentives for valuable future R&D.

Finally, having noted how the heavy burdens of health-sector cross-subsidies and R&D spending fall regressively on lower-income premium payers, we also observe how the benefits of these same expenditures accrue disproportionately not only to well-off suppliers and providers of medical goods and services but also, less directly and less obviously, to high-income consumers of health care. The latter are benefited, in the first instance, by having the needs of the uninsured, the production costs of a wide variety of quasi-public goods (including R&D), and other arguable public responsibilities met by means other than equitable taxes. Moreover, high-income users of the health system also appear to benefit from having their own health insurance premiums, which they pay to obtain access to the costly new technologies they particularly covet, substantially reduced by the involuntary contributions of other, less privileged premium payers.⁶⁴ To be sure, it is easy to assume that more and better health care services and products are equally good for everyone. But the convenient assumption of industry and economic elites that the spending and other

63. Cf. Posner, *supra* note 44. One justification often given for exempting certain private entities from public taxation is that they assume burdens that the public would otherwise have to bear in educating children or caring for the uninsured sick. See, e.g., *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265, 278 (Utah 1985) (denying state tax exemption to hospitals in the absence of “the essential element of gift to the community, either through nonreciprocal provision of services or through the alleviation of a government burden”). This “burden theory” is usually invoked, however, without any determination that, but for the private entity’s efforts, the public sector would *in fact* incur costs equivalent to the tax relief granted. In other words, a judge or public official inclined to favor government generosity in general or public support for the particular activity in question (e.g., health care) might confer a tax exemption under the burden theory even if, had it come to a vote, the legislature would not have been so generous. Reasonable minds differ over whether, in an ostensible democracy, such spending choices should be made exclusively by elected officials.

64. This apparent (though unproven) inequity is discussed at length in Part III.

priorities of ordinary Americans with respect to health care coincide with their own preferences has never been put to a fair test in either the marketplace or the political process.

5. In Sum

In the foregoing discussion we have made four important and somewhat original observations: First, U.S.-style private health insurance, by greatly weakening price elasticity of demand as a constraint on monopoly pricing by health care providers and suppliers, facilitates the latter's exercise of market power, producing profits substantially exceeding the usual returns to lawful monopoly.⁶⁵ Second, such monopoly profits fuel a great deal of otherwise unremunerative health-sector spending, mostly by tax-exempt nonprofit firms, that society has in no economically or politically reliable way validated as appropriate uses of its scarce resources. Third, it is questionable whether inducing even highly valuable technological innovations in the diagnosis and treatment of disease justifies forcing lower- and middle-income premium payers to pay the extraordinarily high monopoly prices that insurance enables true monopolists to charge. And, fourth, the burden of overpaying providers and suppliers is imposed more or less equally, as if by a head tax, on all Americans having private health coverage, thus regressively impacting all premium payers below the high end of the income spectrum.

It has not escaped our notice that these observations about the consequences for the United States of combining monopoly and health insurance could be cited to support either a shift to a single-payer health system or extensive administrative regulation of prices, especially for hospital services

65. We have not found in economics literature anyone expressly hypothesizing, as we do, that U.S.-style health insurance, by substantially increasing actual and anticipated returns to both nonprofit and for-profit monopolies in the health sector, not only adds to monopoly's redistributive effects but also induces allocative inefficiencies both different from and more troublesome than those usually associated with monopoly. *But see* Garber et al., *supra* note 56 (2006 working paper demonstrating that health insurance "creates incentives for a monopoly provider of a pharmaceutical to charge far more for its product than it otherwise would"). Reasons why economists may be less concerned than we are about monopoly's effects in the health care sector include their sense that deadweight loss is not a serious problem, *see supra* note 212, and their professional agnosticism about the welfare implications of redistributing income, *supra* note 18. In addition, they may assume that unlawful monopoly is both rare and a matter for antitrust enforcement when it does occur and that lawful monopoly is either a natural phenomenon or a transient reward for entrepreneurial endeavor. In any event, our concern is not about monopoly as such but about how it and health insurance interact. Here the problem is that economists do not always appreciate the significance (*see* Part IV.C.) of *de facto* and *de jure* limits on insurers' willingness and ability to optimally counteract moral hazard. *See, e.g.,* Gaynor, et al., *supra* note 17 (considering whether, in theory, imperfect competition in medical markets might, by raising prices, offset the misallocative tendencies of moral hazard, but answering the question only on the assumption that, contrary to our observation, the insurance industry "is competitive [and] chooses insurance policies . . . that maximize consumer welfare"). *But see* Pauly, *supra* note 24. The articles we have found that are at all close to our theme include Danzon and Pauly's demonstration of how broader insurance coverage and new technologies reciprocally induce each other. Danzon & Pauly, *supra* note 20 (observing that insurance increases inelasticity of demand and may thus "may affect . . . the launch price of new drugs"). *See also* Garber et al., *supra* note 56 (demonstrating that health insurance facilitates pricing of pharmaceuticals in ways that, in theory, may create excessive incentives for innovation).

and prescription drugs. But private health insurance does not *inevitably* produce the consequences described here and might be reconfigured to allow consumers to make real economizing choices, thereby restoring price elasticity as a constraint on monopolists' pricing. As discussion in Part IV of the article will show, the problems we have identified in U.S.-style health coverage have roots in public policies and private practices that could be easily adjusted to enable lower-income consumers to escape many burdens the current system imposes.

B. Excessive Costs: Undercompensating for Moral Hazard

The most commonly noted market distortion caused by private or public health insurance, more familiar than its facilitation of the exercise of providers' and suppliers' market power, is the inefficiency that flows from so-called moral hazard—that is, the tendency of insurance to induce consumption that would not otherwise occur.⁶⁶ Indeed, the fundamental lesson of health economics is that insulating patients and providers from the direct cost of health services at the time they are consumed guarantees that, without countermeasures, health services will be consumed in excessive quantities, generating costs that, at the margin, are greater (in theory, at least) than the extra services' contribution to well-being. This potential for excessive spending worsens over time, moreover, as incentives for innovation tend to invite cost-increasing improvements more than cost-saving ones.⁶⁷ Achieving efficient resource allocation in the face of such powerful distortions is obviously a daunting task. Even conducting a

66. See, e.g., 2004 ECONOMIC REPORT OF THE PRESIDENT, H.R. DOC. 108-145 (2004), 24, 189 (“Over-reliance on health insurance as a payment mechanism leads to an inefficient use of resources in providing and utilizing health care.”). See generally CHARLES E. PHELPS, HEALTH ECONOMICS 325 (2003) (describing moral hazard as the “induced demand due to the health insurance coverage”).

67. Recent work by Amy Finkelstein estimates that the spread of health insurance from 1950 to 1990 (including the implementation of Medicare and Medicaid) accounted for at least forty percent of the dramatic increase in per capita health spending during that period. Amy Finkelstein, *The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare* (Nat'l Bureau of Econ. Research, Working Paper No. 11619, 2005). Although public and private insurance provided both valuable financial security and subsidized access to essential health services, the moral-hazard effect detected by Finkelstein is substantially greater than economists had previously detected in studies of individual behavior under various insurance arrangements (for example, the RAND Health Insurance Experiment). In contrast to the earlier studies, Finkelstein's long time horizon enables her to detect long-term market-wide effects induced by the substantially steeper demand curves that sellers increasingly faced as health insurance spread. These effects include greatly altered styles of medical practice and strong incentives to create and use technologies that would not pass most people's benefit-cost test. Finkelstein and others have also shown that Medicare, which provided only very limited coverage for prescription drugs, did not appreciably stimulate pharmaceutical innovation. Daron Acemoglu et al., *Did Medicare Induce Pharmaceutical Innovation?* 2 (Nat'l Bureau of Econ. Research, Working Paper No. 11949, 2006).

For looks at the other side of the same coin, observing that markets with large HMO market shares featured slower diffusion of new technologies and correspondingly lower health care expenditures, see Laurence C. Baker, *Managed Care and Technology Adoption in Health Care: Evidence from Magnetic Resonance Imaging*, 20 J. HEALTH ECON. 395 (2001); see also Laurence C. Baker et al., *The Relationship Between Technology Availability and Health Care Spending*, 2003 HEALTH AFF. (WEB EXCLUSIVES) W3-537, W3-547-48 (acknowledging slowing the rate of availability of technology may slow the spending growth rate).

constructive debate over health policy is practically impossible because of the difficulty of focusing on health care's marginal, rather than its aggregate, contributions to welfare.⁶⁸

To be sure, the cost-increasing effects of moral hazard are arguably only an abstract, theoretical problem at the "macro" level, where allocative efficiency is the principal concern.⁶⁹ But excessive consumption also has substantial consequences at the "micro" level of household budgets. Although the cost of

68. Precisely because health care generates such large amounts of consumer surplus compared to other industries (because the value of its benefits to individuals—when it yields benefits—can be so great, perhaps the difference between life and death), it is difficult to think about health care at the margin, where costs are apt to be large and benefits small, especially in probabilistic terms. Occasional studies seek to justify large and increasing expenditures on health care by noting the huge benefits obtained in recent years from improving life expectancy for, say, victims of heart disease or afflicted neonates. *E.g.*, DAVID M. CUTLER, *YOUR MONEY OR YOUR LIFE: STRONG MEDICINE FOR AMERICA'S HEALTH CARE SYSTEM* 63 (2004) ("On the basis of low-birth-weight-infant- and cardiovascular-disease-care alone, therefore, the benefits of medical care are about equal to its costs."); David M. Cutler & Mark McClellan, *Is Technological Change in Medicine Worth It?*, *HEALTH AFF.*, Sept.-Oct. 2001, at 11 (examining five new technologies and concluding from these examples that "medical spending as a whole is clearly worth the cost" (emphasis added)); Lichtenberg, *supra* note 57; Frank R. Lichtenberg, *Are the Benefits of Newer Drugs Worth Their Cost? Evidence from the 1996 MEPS*, *HEALTH AFF.*, Sept.-Oct. 2001, at 241; Frank R. Lichtenberg, *Pharmaceutical Innovation, Mortality Reduction, and Economic Growth* (Nat'l Bureau of Econ. Research, Working Paper No. 6569, 1998) (concluding that "a one-time R&D expenditure of about \$15 billion subsequently saves 1.6 million life-years per year, whose annual value is about \$27 billion"). Such studies divert attention from the all-important margin, however. *See* Jonathan S. Skinner, Douglas O. Staiger & Elliott S. Fisher, *Is Technological Change In Medicine Always Worth It? The Case of Acute Myocardial Infarction*, 25 *HEALTH AFF.* 34 (2006) (questioning Cutler and McClellan, *supra*, on cost-justifications for increased spending on cardiovascular disease after 1996; also noting, from regional data, lack of correlation between spending increases and improvements in survival rates); *see also* Havighurst, *How the Revolution Fell Short*, *supra* note 24, at 80 n.89 (criticizing Cutler & McClellan, *supra*). Many investments in R&D produce little, if any, useful knowledge, and many new technologies represent only marginal improvements, at best, over earlier, cheaper treatments. The crucial fact remains that the system lacks accepted mechanisms for comparing marginal benefits and costs, especially in cases in which a patient hoping for relief naturally demands heavy spending on his own behalf. *See supra* note 24. Indeed, because the public resists any recognition of tradeoffs, it is politically dangerous even to suggest in a public forum that people might be better off with less rather than more health care. Moreover, any policymaker concerned that health care may be claiming too large a piece of the economic pie must also reckon with the political strength of the health care industry. And, finally, it is hard to argue with the industry's consistent ability to attract capital and create jobs in an otherwise up-and-down economy or with its seemingly miraculous technical accomplishments. Largely for these reasons, it is only *rising* health care costs that ever trigger political concern. Whatever its magnitude, inefficiency that is already embedded in the economy is simply never going to be viewed as a problem by the political class. *See* HAVIGHURST, *HEALTH CARE CHOICES*, *supra* note 24, at 89–92 (putting high and rising health care costs in political and economic perspective).

69. To the extent that health insurance reduces the apparent price of the insured service below its marginal cost, it introduces a welfare-loss triangle comparable to the deadweight-loss triangle it helps to eliminate in the case of monopoly. *See supra* note 17. This triangle lies *above* the service's demand curve, however, and represents not underconsumption, but arguable overconsumption, of services—specifically, services that consumers would not have found worth purchasing at marginal cost (the competitive price). *But see infra* note 212 (expressing caveat about relying too mindlessly on demand curves as indicators of welfare). The case of patented pharmaceuticals is anomalous because their marginal cost of production is usually very low. Even a co-insurance payment of twenty percent might therefore exceed it, creating at least a modest deadweight loss of the usual kind. As a substitute for insured (and therefore underpriced) hospital and other medical care, it seems likely that drugs are used less in therapy than they would be under an efficient pricing system—that is, if everything were priced at marginal cost.

such overutilization is distributed more or less equally across premium payers at all levels of income, consumers with lower incomes are likely to attach less value than their upper-income counterparts (at least, in the sense of their willingness to pay) to insurance giving them easy access to all arguably beneficial health care.⁷⁰ Forcing working families who want health coverage to bear, unnecessarily, the cost of rampant moral hazard could seriously diminish their welfare. This second section of Part II focuses on health care costs and utilization rather than on prices alone and shows how insurers' suboptimal attention to the moral-hazard problem not only misallocates resources but also severely overburdens ordinary premium payers for the benefit of the health care industry and elite consumers of health services.⁷¹

1. Conceding the Benefit-Cost No Man's Land

Although insuring health care inevitably increases spending on it, not all of the added spending thus induced is necessarily inefficient. After all, consumers choose to buy health coverage specifically to enable themselves to purchase services they might otherwise not be able to afford; added spending resulting from consumer choices of this kind is efficient to the extent that it is an unavoidable cost of valuable financial protection. Likewise, although health coverage can be administered to curb the effects of moral hazard, it is often more cost-effective to tolerate those effects than to incur the administrative costs necessary to avoid them; once again, to the extent that moral-hazard costs are incurred as a necessary cost of desired protection against risk, there is no inefficiency from either an individual or a social point of view.⁷²

Despite the acceptability of some higher costs as a necessary price of avoiding financial risks, third-party-financed spending on health care could be seriously inefficient for either of two reasons: (1) because payers are artificially inhibited, by law or otherwise, from taking cost-effective steps to counter moral hazard; or (2) because health coverage is not designed in the first instance with a view to striking a suitable balance between financial protection and moral hazard's potentially huge costs. Unfortunately, U.S.-style health insurance generates inefficiency on both scores, as health plans have not had, or even sought, all the *de facto* and *de jure* authority they would need to efficiently counteract the cost-increasing effects of moral hazard.⁷³ Indeed, the U.S. system appears to be rigged to give moral hazard nearly full sway. Thus, custom, practice, law, and regulation all appear to be premised on the not-quite-explicit

70. See *infra* text accompanying note 209.

71. The article we have found that comes closest to expressing insights on the latter issue that are similar to our own is Daniel Shapiro, *Why Even Egalitarians Should Favor Market Health Insurance*, 15 SOC. PHIL. & POL'Y 84 (1998).

72. By the same token, it is inefficient, strictly speaking, for health insurance to cover a service that easily passes a benefit-cost test in a particular case if covering it generally would generate moral-hazard or administrative costs reversing the benefit-cost calculation. See *infra* note 75.

73. Part IV of this Article focuses more directly on the legal system's responsibility for the regrettable state of U.S. health care, including its effects in raising the costs of resisting moral hazard.

notion that, subject only to modest cost-sharing requirements,⁷⁴ unlimited access to all arguably efficacious health services that a physician is willing to prescribe is an inalienable right of all Americans having health coverage of any kind. To be sure, this entitlement is not universal because many millions have no coverage at all.⁷⁵ The principal focus of this article, however, is on the many millions more who pay excessive premiums to support a style of medical care that serves the interests of the health care industry and elite consumers far better than their own.

Even in the heyday of managed health care, health plans were not truly in the business of legitimately administering coverage with a view to giving premium payers optimal value in purchasing health services—by establishing, mediating, and enforcing mutually agreed-upon limits on the right of individual insureds to draw upon the premium pool. Instead, virtually all health plans have long undertaken to pay for all “medically necessary” care, thereby making efficacy and cost-effectiveness (in comparison with other measures of equal efficacy) the only issues in most coverage disputes.⁷⁶ In effect, U.S. health insurers concede to the moral-hazard enemy virtually the entire no man’s land of benefit-cost tradeoffs, where the battle against inefficient spending must be fought if it is ever to be won.⁷⁷ Since managed health care abruptly fell out of

74. On the regressive consequences of cost sharing as a method of counteracting moral hazard, see *infra* notes 105–108 and accompanying text.

75. The nation’s failure to provide health coverage for the uninsured is in large measure a consequence of the high and (currently) uncontrollable moral-hazard costs that such coverage would certainly entail. Even so, it would be hard (in both senses of the word) to argue that present policy toward the uninsured is, on this basis, actually “efficient.” See *supra* note 72. Our point instead is that the insurance gap exists and widens over time largely because U.S. health insurers are unduly limited by custom, law, and regulation in what they may or can do to contain moral hazard. Indeed, our main argument is that these de facto and de jure restraints on health insurers’ ability to administer their premium pools are part of a larger pattern of health policies that, whether intentionally or not, burden middle- and lower-income Americans in order to serve other interests. That they also contribute heavily to the plight of the uninsured, while in some respects a separate matter, should certainly be of equivalent concern. For a study showing the various ways in which rising health insurance premiums are adversely affecting lower-wage workers, see Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums* (Nat’l Bureau of Econ. Research, Working Paper No. 11160, 2005) (estimating that a 10% increase in health insurance premiums results in a 1.6% reduction in the aggregate probability of being employed, an increase of 1.9% in the likelihood that a worker will be employed only part-time, and 2.3% decrease in wages for those who remain employed with employer-sponsored health insurance; for hourly workers, such a premium increase will reduce hours worked by 1% and reduce the probability of being offered health insurance by 3.8%; also finding it likely that workers covered by employer insurance will “bear the full incidence of increases in health insurance premiums”). See also Michael Chernew et al., *Increasing Health Insurance Costs and the Decline in Insurance Coverage*, 40 HEALTH SERVS. RES. 1021, 1034 (2005) (finding that rising health insurance premiums accounted for over half of the decline in health insurance coverage during the 1990s).

76. See generally Timothy P. Blanchard, “Medical Necessity” Determinations—A Continuing Healthcare Policy Problem, 37 J. HEALTH L. 599 (2003); William Sage, *Managed Care’s Crime: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597 (2003); Einer Elhauge, *The Limited Regulatory Potential of Medical Technology Assessment*, 82 VA. L. REV. 1525 (1996).

77. The no-man’s-land metaphor is explained graphically in Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 NW. U.L. REV. 6, 15–20 (1975). See also HAVIGHURST, HEALTH CARE CHOICES, *supra* note 24, at 93–96.

political and consumer favor in the late 1990s, U.S. health insurers have had even less room to counteract moral hazard by administratively discouraging consumption that fails any kind of benefit-cost test. The limits of health plans' ability to refuse payment for particular prescribed services on benefit-cost grounds help to explain not only the overutilization of health services of all kinds but also the extraordinary profits (noted previously) that private monopolists can generate in health care markets.⁷⁸

The magnitude of overspending on health care occasioned by moral hazard in the United States is ultimately an empirical question, of course, and it has been suggested that the United States does not in fact greatly overuse resources because its utilization rates for many services are comparable to those in other nations.⁷⁹ Such a comparison is largely pointless, however, because the moral-hazard problem is universal and foreign systems may handle it almost as badly as we do; also, it would be more informative to compare foreign consumption patterns to the rates at which services are used by *insured* Americans—especially (for our purposes) by Americans with private coverage.⁸⁰ In any event, there is evidence that even much heavier spending on health care in some parts of the United States correlates poorly, and sometimes inversely, with improvement in health outcomes.⁸¹ In addition, many studies have revealed heavy spending that is wasteful even by professional standards of medical necessity, let alone by comparison with consumer preferences about how their personal resources should be deployed.⁸² To be sure, such studies,

78. Although not labeled as such in earlier text, the extra pricing freedom that health insurance confers on monopolists is itself a manifestation of moral hazard, flowing as it does from the removal of consumers' price-consciousness in purchasing insured services.

79. Anderson et al., *supra* note 13; Reinhardt et al., *supra* note 8.

80. *See infra* note 197.

81. *See* Jonathan Skinner, Elliott Fisher & John Wennberg, *The Efficiency of Medicare*, in ANALYSES IN THE ECONOMICS OF AGING (D. Wise, ed., 2005); Elliot S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care*, 138 ANNALS OF INTERNAL MED. 273 (2003); Elliot S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care*, 138 ANNALS OF INTERNAL MED. 288 (2003); Katherine Baicker & Amitabh Chandra, *Medicare Spending, the Physician Workforce, and the Beneficiaries' Quality of Care*, 2004 HEALTH AFF. (WEB EXCLUSIVES) W4-184.

82. Studies to show inappropriate utilization were common in the 1980s and early 1990s, many of them conducted under the auspices of the RAND Corporation. *See, e.g.*, MARK R. CHASSIN ET AL., INDICATIONS FOR SELECTED MEDICAL AND SURGICAL PROCEDURES: A LITERATURE REVIEW AND RATINGS OF APPROPRIATENESS: CORONARY ARTERY BYPASS GRAFT SURGERY (1986); Robert H. Brook et al., *Predicting the Appropriate Use of Carotid Endarterectomy, Upper Gastrointestinal Endoscopy, and Coronary Angiography*, 323 NEW ENG. J. MED. 1173 (1990); Lucian L. Leape et al., *The Appropriateness of Use of Coronary Artery Bypass Graft Surgery in New York State*, 269 J. AM. MED. ASS'N 753 (1993); Lee H. Hilborne et al., *The Appropriateness of Use of Percutaneous Transluminal Coronary Angioplasty in New York State*, 269 J. AM. MED. ASS'N 761 (1993); Steven J. Bernstein et al., *The Appropriateness of Use of Coronary Angiography in New York State*, 269 J. AM. MED. ASS'N 766 (1993). In order to ensure acceptance by the medical profession, the earlier RAND studies relied heavily on professional opinion without asking physicians to compare benefits and costs, yet still found numerous surgical and other procedures to be significantly overused. *See, e.g.*, ROLLA EDWARD PARK ET AL., PHYSICIAN RATINGS OF APPROPRIATE INDICATIONS FOR SIX MEDICAL AND SURGICAL PROCEDURES 6 (1986). In later studies, in order to identify spending of truly marginal benefit, the researchers asked physicians to focus, not just on medical necessity or appropriateness, but

while certainly suggestive of a systematic failure to compare benefits and costs, are really little more than anecdotal evidence of inefficiency since they take no account of costs that would have to be incurred to achieve a more efficient result. But there is, in any event, one feature of the American system that clinches the argument that the current U.S. spending level is highly inefficient—namely, the unlimited tax subsidy for employer-purchased health coverage, the pernicious effects of which are described immediately below.⁸³

2. How the Tax Subsidy Aids the Moral-Hazard Enemy

The ultimate reason why sellers and purchasers of health coverage have not designed it in the first instance to balance the value of financial protection to consumers against the costs of moral hazard is the substantial tax subsidy that government has long provided to encourage employers to purchase private health insurance. This subsidy takes the form of an exclusion of employer-sponsored health plan premiums from employee income subject to federal and state income and payroll taxes.⁸⁴ Its principal effect over time has been to induce employers to be casual about efficiency in the health coverage they procure on their employees' behalf. Thus, instead of seeking optimal insurance for various subsets of their workers, they bought generous, comprehensive coverage with minimal cost sharing for everyone in order that as many health care bills as possible could be paid with untaxed dollars.⁸⁵ Amplified by uncontrolled moral hazard, such overinsurance causes an apparently severe misallocation of the economy's resources.

Many observers think they detect regressivity in the tax subsidy simply because of its greater apparent value to higher-bracket taxpayers and those with the costliest coverage—frequently one and the same.⁸⁶ Yet the unfairness here

on “cruciality,” producing an even more troublesome picture. *See, e.g.*, PAUL P. LEE ET AL., CATARACT SURGERY: A LITERATURE REVIEW AND RATINGS OF APPROPRIATENESS AND CRUCIALITY 48–50, 163–274 (1993). These studies and their findings are discussed in some detail in HAVIGHURST, HEALTH CARE CHOICES, *supra* note 24, at 254–62.

83. PHELPS, *supra* note 66, at 356–57 (1997) (estimating, based on empirical estimates of demand for insurance, that “employer-group health insurance premiums would be only about 55 percent as large today if the tax subsidy were not in effect”; “it seems possible that the health sector would be at least 10 to 20 percent smaller without the tax subsidy for health insurance”).

84. *See generally* Mark V. Pauly, *Taxation, Health Insurance, and Market Failure in the Medical Economy*, 24 J. ECON. LIT. 629 (1986). A complementary subsidy allows deductions for health insurance premiums paid by self-employed individuals. The total 2004 cost, in revenue forgone, of the various federal and state “tax expenditures” subsidizing privately purchased health insurance has been estimated at \$209.9 billion. John Sheils & Randall Haught, *The Cost of Tax-Exempt Health Benefits in 2004*, 2004 HEALTH AFF. (WEB EXCLUSIVES) W4-106. Other tax subsidies with possible implications for fairness include the deduction allowed (for itemizers) for out-of-pocket health expenses above 7.5% of adjusted gross income and the favorable tax treatment of health spending through flexible spending accounts. On new tax breaks for health savings accounts, *see infra* notes 93–98 and accompanying text.

85. For employees in the highest federal and state tax brackets, the saving achievable may exceed fifty percent.

86. *E.g.*, MADISON POWERS & RUTH FADEN, SOCIAL JUSTICE: THE MORAL FOUNDATIONS OF PUBLIC HEALTH AND HEALTH POLICY 132–33 (2006). It is estimated that 26.7% of the economic benefit they confer accrues to the 14% of taxpayers with annual incomes of at least \$100,000; likewise, “only 28.4 percent of all [these] tax expenditures will go to families with incomes below \$50,000, even

may be more apparent than real. Indeed, the regressive tax consequences would be entirely offset if, as is arguably the case, the government replaces the revenue it loses through such tax expenditures by taxing other income at higher progressive rates.⁸⁷ Thus, the tax subsidy may do no more for high-bracket taxpayers, directly, than give them with one hand what the government simultaneously takes away with another. But, even though this aspect of the tax subsidy provides, at best, only weak evidence of the pervasive injustice we observe in U.S. health care, there are other, more indirect ways in which the subsidy disproportionately benefits economic elites at the expense of the less affluent.

A particularly important effect of the tax subsidy for employer-purchased health coverage has been to make employers—rather than consumers, acting individually or in other, more homogeneous groups—responsible for designing or selecting most of the private health coverage that Americans enjoy. Although seemingly serving as purchasing agents for their employees, employers have agendas of their own and will inevitably make choices that benefit some (usually higher-income) employees more than others.⁸⁸ It is at this point that the greater value of the tax subsidy to higher-income workers has distributional consequences, by biasing employers in the direction of buying costlier coverage than even a median-income employee would choose for himself under a more equitable subsidy.⁸⁹

Perhaps the most important and pervasive effect of the tax subsidy and employer purchasing induced thereby is a subtle one. By making health coverage a largely undisclosed part of employees' overall compensation, employer purchasing effectively hides the true cost of coverage from those who

though this group contains 57.5 percent of all U.S. families.” Sheils & Haught, *supra* note 84, at 110. But for this substantial regressivity, characterizing the exclusion from taxable income as a “subsidy” might not be appropriate at all, since a taxing authority might simply find it fairer to tax individuals' income only after certain basic necessities were provided for. But the subsidy here is decidedly not limited to encouraging the purchase of only *basic* coverage. See Lawrence Zelenak, *Of Head Taxes, Income Taxes, and Distributive Justice in American Health Care*, 69 LAW & CONTEMP. PROBS. 103, 113 (Autumn 2006).

87. For a study showing awareness of this point, see Holahan & Zedlewski, *supra* note 6, at 235, 240 tbl.6 (in estimating total health care cost burdens borne by various deciles of consumer-taxpayers, “we calculate income and payroll taxes that are required to finance the employer-paid health benefit tax exclusion”). Many believe that tax expenditures—exclusions and deductions designed to achieve substantive policy objectives—are generally unwise as a matter of tax policy because they shrink the tax base, thus requiring higher marginal tax rates on other income to produce the same amount of revenue. These higher rates, it is believed, adversely affect overall productivity. In any event, it is unclear that higher-income Americans need any subsidy at all to encourage their purchase of essential health coverage.

88. See Havighurst, *How the Revolution Fell Short*, *supra* note 24, at 70 (“[Because] only a generous plan sends workers the message most employers want to convey about their concern for worker welfare . . . and also because health benefits are useful in attracting and keeping workers with the best chances of being hired by someone else, employee health plans are likely to be costlier than even the average worker would demand (even with tax subsidies enhancing his purchasing power).”).

89. See *infra* text accompanying note 100.

ultimately bear most of that cost in the form of reduced take-home pay.⁹⁰ Precisely because their costs are hidden from them, employees are more likely to demand and expect expensive health care even when their true interest would be served by economizing.⁹¹ The entitlement mentality induced by consumers' inability to see the connection between their pocketbooks and the many macro health-care choices that others make on their behalf plays out not only in employment groups but also in explicitly political arenas where legislative and regulatory policies with large consequences for the cost of care are made.⁹² Discussion in Part IV of this article will show that hiding health care costs from those who pay them is a key element in the systematic exploitation of ordinary consumers in U.S. health care law and policy.

The impact of the tax subsidy for employer-purchased health coverage may change somewhat in the near future as a result of recent legislation extending favorable tax treatment to the funding of health savings accounts (HSAs). Under the Medicare Prescription Drug, Improvement and Modernization Act of 2003,⁹³ consumers (or employers on their behalf) are permitted, within limits, to fund HSAs with untaxed dollars if the HSA is coupled with a high-deductible health plan (HDHP) meeting certain requirements.⁹⁴ This legislation is widely heralded as the centerpiece of a movement toward "consumer-directed" health care (CDHC), which aims to correct the tax-induced tendency toward overinsurance and thereby to restore a degree of cost-consciousness to individuals' consumption and purchasing decisions. Arguably, the new tax break for funds that consumers set aside to pay future health care bills offsets the previous tax-induced bias in favor of comprehensive insurance coverage and against the use of substantial cost sharing to counter moral hazard. Although a better way to achieve this objective would have been to cap the tax subsidy or

90. See *supra* note 4. Employers only rarely offer their workers more than one health care option with the employee required to pay the full additional cost above the cost of the lowest-price plan. See Alain C. Enthoven, *The Fortune 500 Model for Health Care: Is Now the Time to Change?*, 27 J. HEALTH POL. POL'Y & L. 37 (2002); see also *infra* note 119.

91. The only time that consumers may actually see the true cost of health coverage is in choosing between jobs that do and do not carry health benefits. See MARK V. PAULY, HEALTH BENEFITS AT WORK: AN ECONOMIC AND POLITICAL ANALYSIS OF EMPLOYMENT-BASED HEALTH INSURANCE (1997); see also *supra* note 4. Although wage differentials between otherwise similar jobs have been noted, such all-or-nothing choices, with health care as only one of many considerations being weighed, are not clearly reliable expressions of consumer preferences with respect to marginally beneficial care.

92. The political consequences of the tax subsidy are rarely recognized, even by scholars. *But see* Havighurst, *How the Revolution Fell Short*, *supra* note 24, at 78–86.

93. Pub. L. No. 108-173, § 101, 117 Stat. 2066 (2003).

94. The HDHP must have an annual deductible anywhere from \$1000 to \$5000 for single coverage or from \$2000 to \$10,000 for families, in which event untaxed dollars may be contributed to the individual's HSA each year in amounts up to the lesser of \$2250 for an individual (\$4500 for a family) or the HDHP's deductible. (Because the stated amounts are indexed for inflation, they are understated here). HSAs, which may be maintained with either a financial institution or an insurer, can then accumulate investment earnings tax-free. Account owners may draw on these funds at any time, without tax on the distribution, to pay a broad range of "qualified medical expenses," broadly defined. See *infra* note 96. For arguments for expanding the scope of HSAs even further, see Michael F. Cannon, *Health Savings Accounts: Do the Critics Have a Point?*, POL'Y ANALYSIS (CATO INST., Washington, D.C.) May 30, 2006, at 1, available at http://www.cato.org/pub_display.php?pub_id=6395.

to replace it with government-issued vouchers of a limited, perhaps means-tested value, such reform ideas have not been well received in the political world.⁹⁵ The CDHC agenda has therefore been implemented, not by cutting back the tax benefits of buying health services through an insurance plan, but by creating an equivalent tax break for out-of-pocket (or, more accurately, out-of-HSA) spending.⁹⁶

The CDHC reforms' leveling of the playing field of health insurance choices should in due course cause a shift toward health coverage that is less significantly bedeviled by moral hazard. Indeed, under the reforms, moral hazard's costs, though they can never be eliminated, should eventually become merely an inherent cost of insuring against undue financial risks, no longer inflated by over-broad coverage designed primarily to exploit a tax loophole. Moreover, the availability of funds in HSAs that can be used to pay amounts that an individual's health plan is not obligated to pay should make it more tolerable for health plans both to require more than nominal cost sharing and to deny coverage for services that fail contractual tests requiring comparisons of benefits and costs.⁹⁷ To be sure, the tax subsidy will continue to affect substantially the margin at which employers and consumers face trade-offs, ensuring high levels of consumption. But the CDHC reforms may in time change many employer calculations that have heretofore allowed moral hazard far too much room in which to operate.⁹⁸

95. See Pauly, *supra* note 84; see also *infra* note 217 (suggesting limited, refundable tax credits as a more practical and equitable way to subsidize and universalize basic coverage).

96. It is relevant to our thesis in this article that the strategy chosen creates, whether by accident or design, an important new tax shelter for the well-to-do. Lower-bracket taxpayers will not, it seems certain, be in a position to take equivalent advantage of this new tax break because, in addition to deriving smaller tax savings than those with higher incomes, they will find it harder to deposit the full amounts allowed. Wealthier taxpayers, on the other hand, not only can afford to deposit more untaxed money in their HSAs but also can elect to spend after-tax dollars on their medical care, leaving their HSA funds to accumulate tax-free, as in a tax-favored retirement plan. (After an HSA owner attains age sixty-five, any funds remaining in the HSA may be either withdrawn as taxable income or rolled over into a tax-favored retirement account for further tax deferral.) The effect is to give higher-bracket taxpayers yet another means of deferring taxes on present income and of escaping payroll taxes altogether. See Eric Dash, *Wall Street Senses Opportunities in Health Care Savings Accounts*, N.Y. TIMES, Jan. 27, 2006, at A1, A16 ("Not since the creation of the individual retirement account in the mid-1970's has such a potentially huge mountain of money landed in the lap of the financial services industry."). A very strong tax-equity argument can be made for making earnings on HSAs taxable with individuals' other income.

97. The need to manage health benefits and moral hazard will be essentially unaffected by the CDHC reforms because the great majority of health care spending occurs in cases that would quickly consume the contemplated deductibles. See generally Mark A. Hall & Clark C. Havighurst, *Reviving Managed Health Care with Health Savings Accounts*, 24 HEALTH AFF. 1490, 1490-91 (2005) (arguing that "combining managed care with HSAs can help to re-legitimize managed care in the public eye by clarifying the respective decision-making responsibilities of health plans and patients. . . . Specifically, the availability of HSAs should make it clearer to most people that plans' denials of coverage are not meant to ration health care itself but only to limit the availability of third-party financing.").

98. See also *infra* notes 148-50 and accompanying text.

3. Who Benefits (Most) from Uncontrolled Moral Hazard?

The high costs that Americans incur in overconsuming health care yield greater benefits for some people than for others. Obviously, the economic well-being of the health care industry and the some twelve million individuals it employs has come to depend on the excess resources that flow into the health care enterprise because of uncontrolled moral hazard and the unchecked market power exercised by many of the industry's components.⁹⁹ Of course, not all elements of the industry are excessively rewarded for their efforts, and, as noted earlier, much of the excess profit that some providers and suppliers are able to earn because of entry barriers, weak competition, and so forth is used to support a variety of seemingly (though far from clearly) worthwhile activities. Nevertheless, many industry participants are enriched unduly, often for performing services that the public has in no reliable way decided are worth paying for. Moreover, although the beneficiaries of the various cross-subsidies and investments in innovation are difficult to trace, it is unlikely that they are all equally needy or deserving. In general, the health care system's inefficiencies support a huge, politically powerful industry whose claims on the nation's wealth and premium payers' incomes have not been validated either through a well-functioning, well-informed political process or by consumers' informed choices in unrigged markets.

Less obvious beneficiaries of public policies abetting moral hazard are those consumers who especially prefer, even at high cost, health coverage that puts few obstacles in their way in consuming health services and few limits on their access to costly technology. In particular, affluent Americans, because they are less daunted by extravagant price tags and more heavily subsidized by the tax system, especially want their employers to select a health plan that will pay for virtually everything their physicians prescribe. Moreover, they are in a strong position to have this preference honored because the tax subsidy's dilution of cost-consciousness inclines lower-income employees in the employment group also to favor health coverage of this expensive kind.¹⁰⁰ High-income Americans are thus well served by a system that, by effectively hiding the cost of coverage,

99. See Uwe E. Reinhardt, *Resource Allocation in Health Care: The Allocation of Lifestyles to Providers*, 65 MILBANK Q. 153 (1987) (emphasizing the extent to which consumer savings from enhanced price competition would come at the direct expense of industry insiders). Although many people admire the health care industry for providing numerous secure, well-paying jobs and for being relatively recession-proof, these features are a direct consequence of a financing system that denies consumers easy opportunities to economize when family budgets are squeezed. Moreover, the reciprocal effect of the health sector's relative stability is greater instability in the rest of the economy, including lessened job security for those who work outside the health sector but pay tribute to it through their health insurance premiums. This is simply one more unrecognized way in which U.S. health policy hurts working Americans while benefiting stakeholders in the health sector.

100. To be sure, generous health benefits are also found in plans that some employers maintain only for lower- and middle-income, usually unionized, workers. Labor unions' persistent demands for especially generous benefits do not disprove, however, our contention that rich health plans are contrary to the true interests of middle-income workers. Instead, they prove only that, like politicians, union leaders (another elite) know how to exploit, in their own interest, workers' mistaken belief that the employer alone bears the cost of their health benefits.

induces employees of all incomes to favor the costliest variety. “Other Ranks” often pay more so that the elite classes can be assured of health care suiting their elevated tastes.

III

ARE LOWER-INCOME PREMIUM PAYERS SHORTCHANGED ON THE RECEIVING END AS WELL?

Affluent Americans may benefit at the expense of their lower-income coworkers in another, more direct way. To be sure, it would not necessarily be unfair if higher-income employees generally enjoyed somewhat more and better health care than those with lower incomes;¹⁰¹ they also drive safer cars, eat

101. For recent journalism implying both surprise and concern that health services often vary according to the patient’s income, see Janny Scott, *Life at the Top in America Isn’t Just Better, It’s Longer*, N.Y. TIMES, May 16, 2005, at A1. But demand for much health care is income-elastic, meaning that people naturally spend more on it as their incomes increase. See also Renee Mentnech et al., *An Analysis of Utilization and Access from the NHIS: 1984-92*, HEALTH CARE FIN. REV. Winter 1995, at 51, 55–56 (concluding from National Health Interview Survey data that among patients in relatively good health, higher income increases the probability of a physician visit); see generally PHELPS, *supra* note 66, at 148–49. Studies of individuals under full insurance indicate that income elasticity is positive but rather small. See EMMETT B. KEELER ET AL., THE DEMAND FOR EPISODES OF MEDICAL TREATMENT IN THE HEALTH INSURANCE EXPERIMENT (1988) (data from RAND experiment showing relatively small income effects, elasticities of about 0.2). Income elasticities estimated from time series data, which capture the effects of new medical technologies, are higher and approach unity. See Martin Feldstein, *Hospital Cost Inflation: A Study of Nonprofit Price Dynamics*, 60 AM. ECON. REV. 853–72 (1971); Catherine McLaughlin, *HMO Growth and Hospital Expenses and Use: A Simultaneous-Equations Approach*, 22 HEALTH SERVICES RES. 183–202 (1987) (finding an income elasticity of 0.7 using data from 1972 to 1982). Although proper measurement of income elasticity would focus on permanent income, most correlation studies use data reflecting transitory income, thus diluting the apparent effect of income on health expenditures if households encountering sudden sickness both earn below their normal income and increase their consumption of health care. In any event, studies show that, for many health services, income elasticity exceeds unity, which means percentage increases in income translate into even greater percentage increases in spending on those services. See, e.g., Ronald Andersen & Lee Benham, *Factors Affecting the Relationship Between Family Income and Medical Care Consumption*, in H.E. KLARMAN, EMPIRICAL STUDIES IN HEALTH ECONOMICS (1970) (finding income elasticity greater than unity for dental care); Fred Goldman & Michael Grossman, *The Demand for Pediatric Care: An Hedonic Approach*, 86 J. POL. ECON. 259 (1978); Marian E. Gornick, *Disparities in Medicare Services: Potential Causes, Plausible Explanations, and Recommendations*, HEALTH CARE FIN. REV. Summer 2000, at 23 (citing data on physician visits and medical procedures); Carol L. Jenkins, *Resource Effects on Access to Long-Term Care for Frail Older People*, 13 J. AGING & SOC. POL’Y 35 (2001) (presenting data on nursing home care).

In our view, the income elasticity of demand for health care makes much of the recent concern over disparities in the care received by different racial, ethnic, and income groups, see *infra* note 111, unrealistic, reflecting a too-casual assumption that consumption of health care should be equal for all groups and classes. Such equality, in addition to being unrealistic as a practical matter—which is not to say that it should not be actively promoted in specific contexts—would be achievable at reasonable cost only by leveling down, thus radically denying people the freedom to spend more on health care than others choose or are able to spend. Cf. *Chaoulli v. Quebec*, 2005 S.C.C. 35, 29272, [2005] S.C.J. No. 33 QUICKLAW (June 9, 2005) (Canadian Supreme Court’s invalidation of Quebec law prohibiting purchase of private health insurance for services covered by Canada’s national health program, on the ground that adverse health consequences resulting from national program’s waiting lists made prohibition unconstitutional). Moreover, while equality has great symbolic value for many, maintaining it as a goal hampers efforts to ameliorate the specific inequities we identify in this article.

healthier food, and live in safer, less-polluted neighborhoods.¹⁰² But it should certainly be a cause for concern if consumption patterns vary greatly and positively with income—rather than with health needs alone—in situations where everyone pays the same premium for the same health coverage. This appears to be the case in many U.S. health plans, since higher-income employees seem to make greater use of their coverage, demanding and receiving more and costlier services at plan expense than their lower-income coworkers.¹⁰³ Although appearances may be deceiving, in many employment groups it certainly looks as if health insurance premiums paid on behalf of lower-income members go to subsidize the costly consumption habits of those with higher incomes. If this perception of systematic inequity in the purchase and distribution of benefits within individual health plans is accurate, it would represent yet another unfairness to working Americans—on top of the other regressive features of the U.S. system observed in previous discussion. Once again, the tax subsidy is the ultimate source of the problem. By causing health coverage to be purchased in heterogeneous employment groups (including individuals with disparate, income-correlated preferences and consumption patterns), it creates conditions in which lower-income premium payers may be paying—unwittingly—costs incurred by their more demanding, affluent, and influential coworkers. The unfairness would only be compounded by the circumstance that lower-income persons often are in generally poorer health and have greater health care needs.¹⁰⁴

The most obvious factor that could be expected to cause income-correlated differences in the consumption of health services by individuals in the same health plan is cost sharing. Most studies of cost sharing focus only on whether it unduly discourages consumption of health services by less-affluent patients.¹⁰⁵

102. In general, society treats health care as a merit good, not to be rationed solely by ability and willingness to pay. At the margin, however, spending on health care provides only limited value for money spent—perhaps only hope or a slightly reduced probability or imminence of a bad outcome—making it (presumably) socially acceptable for persons with higher incomes to receive services that others cannot afford. Such persons are in a position to put a higher valuation on their well-being, ascribing higher costs to sick days and higher value to healthy ones, and to substitute away from time-intensive investments in health, such as bed rest, in favor of paying for medical interventions.

103. This tendency was dramatized for one of the authors when, in the 1970s, his employer, in a seemingly progressive move, combined two similar health plans it maintained for hourly-paid and higher-paid salaried workers, respectively, with the result that the former's premium contributions rose while the latter's declined.

104. See generally James P. Smith, *Healthy Bodies and Thick Wallets: The Dual Relation Between Health and Economic Status*, 13 J. ECON. PERSP. 145 (1999) (illustrating that socioeconomic status tends to positively correlate with health status). Even if it should appear that a health plan's expenditures were the same per capita for both high- and lower-income members, it could be argued that the poorer health status of the latter group should entitle them to additional, not just equal, spending; in any event, a finding of such equality would belie the usual assumption that, in employee health plans, the healthy wealthy substantially subsidize the low-wage sick. Although we suspect that it may be the other way around, the picture is more complicated to the extent the health status of lower-income workers is worse. For a fuller exposition of the possibility that the predominant redistribution is as generally assumed, see Hall, *supra* note 50, at 165–68. See also *infra* note 116.

105. The classic study was the RAND Health Insurance Experiment. See JOSEPH NEWHOUSE ET AL., *FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT* (1993). See also

Our concern, however, is not that health care is rationed or distributed unequally but the likelihood that conditioning eligibility for insurer payments on patients' willingness to make certain out-of-pocket payments causes lower-income participants in employee health plans to get disproportionately fewer benefits than their more affluent coworkers receive in return for equivalent premiums; similar effects might also occur in health plans offering such point-of-service choices as the option of spending more to see a non-network physician or to use a brand-name drug.¹⁰⁶ Likewise, as employers pursue the increasingly popular strategy of funding health savings accounts and enrolling their workers in high-deductible health plans, it is possible that greater emphasis on cost sharing to contain moral hazard will cause insurers' premium pools to be allocated even more disproportionately to the care of the affluent.¹⁰⁷ Although these matters do not appear to have been specifically studied by others, we hypothesize that many common forms of employee health coverage allow those who are better able to pay various up-front fees to enjoy disproportionately large insurance benefits at the expense of others.¹⁰⁸

Still another possible cause of income-correlated disparities in the volume and quality of health services received by participants in the same health plan may be physicians' and health plans' different approaches and attitudes in treating different patients. According to one observer, "[w]ell-off and influential patients tend to link up with elite academic and private physicians, to

JULIE HUDMAN & MOLLY O'MALLEY, KAISER COMMISSION ON MEDICAID AND THE UNINSURED, HEALTH INSURANCE PREMIUMS AND COST SHARING: FINDINGS FROM THE RESEARCH OF LOW INCOME POPULATIONS (2003); Mitchell D. Wong et al., *Effects of Cost Sharing on Care Seeking and Health Status: Results from the Medical Outcomes Study*, 91 AM. J. PUB. HEALTH 1889 (2001); Avi Dor & William Encinosa, *Does Cost Sharing Affect Compliance? The Case of Prescription Drugs* (Nat'l Bureau of Econ. Research, Working Paper No. 10738, 2004).

106. The apprehended unfairness would not occur if, as we believe is only rarely the case, the plan charged patients who choose the more expensive option its full incremental cost. *Cf. infra* notes 119 & 120. It is also notable—although our point here is somewhat different—that using more or costlier services, out-of-network providers, or non-formulary drugs may frequently produce better health outcomes. Thus, those who are most discouraged by additional charges may get poorer service while still seemingly subsidizing higher-quality care for those whose consumption choices are less affected. *See, e.g.*, Dor & Encinosa, *supra* note 105 (showing that co-insurance and, to a lesser extent, fixed co-payments unduly discourage patients from taking efficacious preventive medicine).

107. This would occur if, as seems likely, lower-income individuals are more reluctant than higher-income participants in the same HDHPs to spend their HSA funds to satisfy deductibles and other cost-sharing prerequisites for tapping insurance funds. Indeed, the *raison d'être* of the CDHC reform strategy is to encourage use of heavier cost sharing to counteract moral hazard, displacing the arguably more even-handed rationing methods employed by managed-care organizations. *See* Hall & Havighurst, *supra* note 97, at 1492 (“[T]he strategy of causing consumers to set aside assets for spending on their own health care should inspire at least some economizing behavior of the sort that has been systematically missing with comprehensive first-dollar coverage.”). The empirical issue, not yet studied (as far as we are aware), is whether and how much HSAs will affect the income-elasticity of demand for health services. *See supra* note 101.

108. Intuition suggests that such effects will occur under any insurance plan providing ostensibly equal benefits for both high- and low-income enrollees. Although we have found no studies attempting to detect actual regressive effects in individual employment groups, data from the RAND Health Insurance Experiment clearly showed that, in a controlled setting, cost sharing had noticeably greater effects on middle-income consumers than on higher-income ones. NEWHOUSE, *supra* note 105, at 46. This is just the effect we believe causes systematically regressive effects in employee health plans.

sustain their relationships with these physicians, and to benefit from these physicians' sponsorship and advocacy in hospital and other institutional settings. Middle-class patients tend to access a lower level of sponsorship and advocacy"¹⁰⁹ It would also be natural for physicians and other decisionmakers, perceiving that more educated patients have especially high expectations concerning their health care, to strive to accommodate those expectations, whatever the patient's nominal entitlement. Moreover, insured individuals who are more Internet-savvy, articulate, assertive, or demanding can frequently get their physicians or health plans to prescribe more or better services for them than other patients normally receive.¹¹⁰ Thus, in addition to the economic incentives associated with cost sharing, a number of other factors generally correlated with income also suggest that affluent patients may systematically get more out of their health plans than they pay for while others get less.¹¹¹

Some economists may be hard to persuade that lower-income members of a health plan actually subsidize their higher-income coworkers even though the latter, as a class, take greater advantage of collectively purchased health benefits. To be sure, economists are generally comfortable with the idea that employees, not employers, ultimately bear the cost of their health coverage.¹¹² But they could plausibly argue that it is artificial to treat an employee's pro rata share of the employer's total premium as the actual cost that the individual

109. M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL'Y L. & ETHICS 95, 108 (2001).

110. A suggestive example of how some patients can "work the system" appears in a notable recent case: *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) (finding no obstacle in federal law to enforcing Illinois statute requiring so-called external review of HMO denials of coverage). The plaintiff, having been clever enough to find an out-of-state surgeon offering an especially aggressive treatment for her neurological condition, was able to persuade her HMO doctor (though he disclaimed any expertise) to opine that the surgery was medically necessary—contrary to several other medical opinions supporting the HMO's more conservative approach. She was also able to travel out of state twice, pay nearly \$100,000 to have the procedure done, and hire a lawyer to take her case through several courts to obtain reimbursement of that amount. It is virtually certain that other members of the HMO, though paying the same premiums as Ms. Moran, would not have received similarly costly treatment for a similar problem.

111. Researchers are currently paying a great deal of attention to disparities that correlate with patients' racial and ethnic characteristics. See, e.g., INSTITUTE OF MEDICINE, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE* (2003); Symposium, *Racial & Ethnic Disparities*, 24 HEALTH AFF. 316 (2005). Some of these disparities may be attributable in whole or in part to considerations of the kind mentioned in the text. Although most studies of the matter have focused only on inequality as such, several can be cited in support of our hypothesis that physicians resonate to income-correlated patient expectations. E.g., Michelle van Ryn & Jane Burke, *The Effect of Patient Race and Socio-Economic Status on Physicians' Perceptions of Patients*, 50 SOC. SCI. & MED. 813 (2000) (examining physicians' attitudes toward patients and revealing that lower-SES patients are viewed as less independent, less rational, less responsible, and less intelligent than their wealthier counterparts); S. Willems et al., *Socio-Economic Status of the Patient and Doctor-Patient Communication: Does It Make a Difference?*, 56 PATIENT EDUC. & COUNSELING 139 (2005) (reviewing literature finding that patients from lower social classes receive less-effective communication and exert less control over their consultations with their physician). Evidence from countries in which health insurance status is equal for all patients also suggests that low-SES patients tend to receive fewer services at health-plan expense. See *infra* note 121 & 122.

112. See *supra* note 4.

bears. Indeed, strictly speaking, the true cost of health coverage to an employee is the opportunity cost of forgoing alternative employment that pays more but lacks equivalent health coverage. In light of this fact, an economist might suggest that employers unconsciously adjust the amount of wages they are willing to pay to different classes of worker to reflect the class's propensity to utilize employer-financed health benefits—in which case it might be incorrect to hypothesize that lower-income workers actually bear costs incurred by higher-income, higher-utilizing participants in the same plan.¹¹³

Despite the plausibility of these alternative hypotheses, the question is ultimately an empirical one on which little evidence has been collected. Moreover, the notion that there is no regressivity depends on heroic assumptions about employee and employer perceptions, rationality, and the smoothness of the market's operation. Thus, workers' decisions about which jobs to take turn on many factors besides the implicit value of particular health coverage. Furthermore, employers probably think only rarely in terms of total compensation packages, perhaps even administering employee benefits and cash compensation in separate cost centers.¹¹⁴ In any event, although we cannot be certain that labor market forces do not ameliorate the situation we apprehend, it would be ironic if defenders of the health care system, most of whom customarily reject all economic theorizing as unrealistic, were to cite such market forces in arguing that, despite appearances in many health plans, lower-income insureds do not in fact subsidize the health care of the rich.

Our concern about possible regressive redistribution in employer-sponsored health plans would be obviated if employers generally offered their employees separate plans, each designed for a different income group.¹¹⁵ In each such plan,

113. Under this hypothesis, the employer referred to in *supra* note 103 would be expected to adjust wages (upward) and salaries (downward) in subsequent years to eliminate the seeming inequity. But proving that such adjustments actually occurred would be difficult if, rather than being made explicitly, they took the form of unconscious responses to labor market conditions.

114. One apparent exception—that nevertheless may only help to prove the general rule—is the lower wages paid by employers to obese workers, which have been convincingly attributed in part to such employees' greater demands on the employer's health insurance. Jay Bhattacharya & M. Kate Bundorf, *The Incidence of the Healthcare Costs of Obesity* (Nat'l Bureau of Econ. Research, Working Paper No. 11303, 2005). As to employees in general, however, unless an employer is self-insured, it is unlikely to have good information on how heavily various employee subgroups use their health benefits; indeed, because the researchers in the cited study did not distinguish between self-insured and other employers or show that employers knew what wage adjustments to make, they could not rule out the possibility that the reduced wages of obese workers reflected only assumptions or general prejudice. In any event, it does not follow from the treatment of obese employees that the salaries of high-utilizing, high-income employees would be similarly reduced. On the other hand, if the market does adjust wages downward for high utilizers, it should also, presumably, adjust them favorably for employees using fewer services. But few would expect to find that employees on the wrong side of widely noted racial disparities are receiving compensatorily higher wages.

115. This suggestion that insurance pools should be subdivided flies in the face of the conventional view that large, heterogeneous pools are socially desirable because they seem to cause healthier, wealthier insureds to subsidize the care of less healthy, lower-paid enrollees. *See supra* note 104. Although not finally proven, the hypothesis we offer in the text suggests not only that such progressive redistribution is not necessarily the rule but also that most employment groups provide, not social insurance, but what might be called “anti-social” insurance, with subsidies actually running in regressive

members would be similarly, rather than dissimilarly, affected by cost sharing and other factors affecting consumption, thus minimizing income-correlated differences in access to the premium pool. Moreover, benefits in each plan could be designed with particular regard to the group members' financial circumstances. For example, lower-wage workers, with fewer discretionary funds available in a health crisis, would presumably prefer lower cost sharing for essential services; on the other hand, for higher-paid personnel, optimal protection against moral hazard would require higher out-of-pocket payments.¹¹⁶ Of course, a plan with lower cost sharing—if it were meant to optimally serve lower-income workers—would have to economize in other ways, perhaps by not undertaking to cover everything deemed “medically necessary” and instead by obtaining contractual authority to compare benefits and costs in resolving coverage issues. Plans for higher-income workers, on the other hand, could be more generous. In any event, if employers did provide such explicitly different coverage to different income groups, there would be little basis for concern about regressive redistribution because take-home pay for members of each group could then be reasonably presumed to reflect their respective health benefits. More economical coverage would also materially enhance the welfare of the lower-income group.¹¹⁷

Our impression is that today's employers, rather than creating different health plans for different folks, regularly include all workers in the same insurance pool.¹¹⁸ To be sure, many employers offer their employees a menu of health plan choices. But many such arrangements appear to exacerbate, rather than eliminate, the potential for regressive results. Thus, in the great majority of instances, the employer pays more for those who choose costlier options—rather than, as Alain Enthoven has convincingly advocated, making them pay

directions. It is probable, to be sure, that large insurance groups organized in employment settings do benefit incidentally those whose recurrent health problems and serious chronic conditions might make them uninsurable, or insurable only at prohibitive cost, in an insurance market in which individuals seek to pool their health risks only with others facing similar risks. In any event, analyzing these matters is obviously complicated by the possibility, discussed in the text, that the labor market ultimately causes wages and salaries to reflect the actual burdens that various income classes impose on the employer's health plan.

116. In theory, optimal cost sharing is a function of several factors, including the insured's ability to bear financial risk and the slope of the group's demand curve for the service in question (which reveals whether it is viewed as a discretionary service or a vital one in most cases). Indeed, but for the high cost of administering finely tuned coverage, coinsurance rates would be set separately for each discrete service rather than, as is the general practice, applied across the board to all services (a notable exception being the generally higher coinsurance rates charged for outpatient psychiatric services, imposed in the belief that such services are especially discretionary). The problem might be addressed in part, of course, by offering different plans with different cost sharing so that lower-income persons could purchase coverage more suitable for their situations.

117. See Shapiro, *supra* note 71.

118. On the case of employers dealing with labor unions, see *supra* note 100. The usual explanations given for large risk pools are that they can command lower premiums for actuarial reasons and can drive harder bargains with providers. Although such considerations introduce tradeoffs that might tilt the balance in some cases, the alternative explanation we offer suggests that some such benefits, even if real, may come at the expense of distributional fairness.

the full additional cost.¹¹⁹ In these cases, there is reason to fear that those choosing the cheaper package are indirectly bearing some of the costs incurred by those who choose (and get) more costly care.¹²⁰ Once again, of course, the question is an empirical one, but we will not be easily persuaded that regressivity all comes out in the wash—that is, that salaries and wages are lower or higher for particular subgroups depending upon the coverage members of the group tend to select. As usual, the unlimited tax subsidy, both by empowering employers to make the crucial choices and by hiding the true (or marginal) cost of coverage from the rank-and-file, is the main culprit—the reason why both rank-and-file and higher-income employees tend to be included in the same insured groups, creating environments in which cost-sharing requirements and other factors can naturally cause the regressive effects that concern us.

Although we have found little empirical research confirming (or rejecting) our hypothesis that employer-sponsored health plans in the United States are rife with regressive redistributions of wealth, significant inequities in the distribution of benefits in other countries' national health systems are suggestive of similar effects in U.S. health plans. Thus, a study in Canada found that “patients with higher incomes and education levels were significantly more likely to have been referred for coronary angiography . . . , cardiac rehabilitation . . . , and to a cardiologist . . . following discharge from . . . hospitalization [for acute myocardial infarction].”¹²¹ Similarly, data from the British National Health Service indicate that “[m]ore deprived individuals (in terms of income, education and employment) have lower than expected use of

119. KAISER FAMILY FOUNDATION & HEALTH RESEARCH AND EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS: 2004 ANNUAL SURVEY 63, exh. 4.7 (2004) (reporting that only nineteen percent of employers offering employees a choice of plan—and the same percentage of the largest employers as well—make the same dollar contribution regardless of plan chosen); see Enthoven, *supra* note 90. Regressivity would not be a significant problem under Enthoven's prescription—assuming that incremental costs are calculated actuarially, with appropriate awareness of different groups' propensity to use their coverage.

120. Indeed, we speculate that employers pool all their nonunionized employees for purposes of health coverage in part because the unwitting contributions of lower-income workers make it cheaper for them to provide the benefits that high-income employees particularly desire. See *supra* text accompanying notes 88 & 89. Under the hypothesis that employers prefer arrangements under which the rank-and-file subsidize the coverage of more affluent employees, one would expect most employers to resist—as they have—Enthoven's proposal to equalize contributions for each employee. Also, employers could be expected to be slow—as they have been—to adopt the CDHC approach, under which HSAs must be funded equally for all employees. Gary Claxton et al., *What High-Deductible Plans Look Like: Findings from a National Survey of Employers*, 2005 HEALTH AFF. (WEB EXCLUSIVES) W5-434 (finding less than four percent of employers offered HSA/HDHP coverage in 2005).

121. David A. Alter et al., *Socioeconomic Status, Service Patterns, and Perceptions of Care Among Survivors of Acute Myocardial Infarction in Canada*, 291 J.A.M.A. 1100, 1103–04 (2004); see also Norman Frohlich et al., *Health Service Use in the Winnipeg Regional Health Authority: Variations Across Areas in Relation to Health and Socioeconomic Status*, HEALTH MGT. FORUM, Supplement (Winter 2002) 9–14 (presenting additional Canadian data).

health services.”¹²² These regressive distributional results presumably flow from factors similar to those we believe cause disproportionate allocations of insurance funds to higher-income participants in health plans sponsored by U.S. employers.

Experience under the Medicare program is also consistent with our impression that, even when a health plan creates equal entitlements for a large population, wealthier participants will prove more equal than others.¹²³ To be sure, the principal reason why wealthier beneficiaries consume more than an equal share of Medicare-financed services is the shorter life spans of lower-income beneficiaries, who, despite having paid Medicare taxes throughout their working lives, do not live long enough, on average, to derive as much value from the program as wealthier beneficiaries. But wealthier beneficiaries also consume Medicare services at higher rates during their years in the program—even though beneficiaries lower on the income scale tend to have poorer health. Thus, several studies by Jonathan Skinner and co-authors have found Medicare spending on beneficiaries residing in zip codes where incomes are highest to be substantially greater than spending in other areas—except where incomes are lowest but beneficiaries have not only the poorest health but also special assistance from Medicaid in paying out-of-pocket costs.¹²⁴ Another study found

122. M. Sutton et al., *Allocation of Resources to English Areas: Individual and Small Area Determinants of Morbidity and Use of Health Care Resources, Report to the Department of Health* (Edinburgh: Information and Services Division, 2002); see also Max Exworthy et al., *Evidence into Policy and Practice? Measuring the Progress of U.S. and U.K. Policies to Tackle Disparities and Inequalities in U.S. and U.K. Health and Health Care*, 84 MILBANK Q. 75, 79 tbl.1 (2006). For data from Australia, see Anthony Scott et al., *Is General Practitioner Decision Making Associated with Patient Socio-economic Status?*, 42 SOC. SCI. MED. 35 (1996) (finding patients of high socioeconomic status more likely to be tested for illnesses and less likely to receive a prescription, suggesting the visit was unnecessary).

123. See Karen Davis & Roger Reynolds, *Medicare and the Utilization of Health Care Services by the Elderly*, 10 J. HUM. RESOURCES 36 (1975) (finding significant income effects on the number of physician visits by Medicare beneficiaries with a similar health status); Marian E. Gornick et al., *Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries*, 335 NEW ENG. J. MED. 791 (1996) (showing a positive correlation between Medicare beneficiaries' income and their utilization of certain physician services, including screenings); Charles R. Link et al., *Equity and the Utilization of Health Care Services by the Medicare Elderly*, 17 J. HUM. RESOURCES 195 (1982) (concluding that income affects the number of physician visits by those on Medicare when controlling for health status); Gornick, *supra* note 101. On the regressivity of Medicare's financing—that is, the question of who pays as opposed to who benefits (the subject of discussion here)—see *supra* notes 1 & 48. On the larger question of Medicare's net distributional effects, see *supra* note 1.

124. Their more recent data suggests that lower-income households began to account for higher levels of spending in the mid-1990s. See McClellan & Skinner, *supra* note 1; Julie Lee, Mark McClellan & Jonathan Skinner, *The Distributional Effects of Medicare Expenditures* (Nat'l Bureau of Econ. Research, Working Paper No. 6910, 1999); Jonathan Skinner & Weiping Zhou, *The Measurement and Evolution of Health Inequality: Evidence from the U.S. Medicare Population* (Nat'l Bureau of Econ. Research Working Paper No. 10842, 2004). But see Bhattacharya & Lakdawalla, *supra* note 1.

Query whether similar distributional effects may occur under the new Medicare prescription-drug benefit once it is finally implemented. See *supra* note 20. This benefit, enacted in 2003, includes a so-called “doughnut hole”—that is, a lack of coverage for any annual expenditures between \$2250 and \$3600 that applies only after an initial government outlay of seventy-five percent of all expenditures up to \$2250 (after a \$250 deductible) and that a beneficiary must cover himself before new catastrophic drug coverage kicks in. The up-front benefit, covering easily budgetable expenditures, was obviously adopted so that the (Republican) proponents could represent to voters that the bill, while generally

that in the second and third years prior to death, average Medicare spending was greater for beneficiaries living in areas with the highest median income.¹²⁵ Mark McClellan and Skinner, considering such evidence in 1999, concluded that “lower-income beneficiaries who are not eligible for Medicaid [are] the income group that fares least well in terms of net benefits in traditional Medicare,” and that Medicare’s intragenerational transfers are largely from lower-income to higher-income households.¹²⁶

Unfortunately, Medicare data provides only weak support for our thesis that, all else being equal, higher-income beneficiaries of a single health plan will get significantly more out of it. Because higher-income Medicare beneficiaries are more likely to have Medigap coverage, they face lower financial barriers to using Medicare benefits.¹²⁷ Their higher utilization rates therefore do not finally establish that nominally equal entitlements alone do not guarantee income-neutral distribution of benefits. Even in the absence of definitive U.S. evidence, however, our hypothesis is supported by appearances, intuition, and experience in analogous settings. On this basis, we are prepared, pending further investigation, to make our allegation of regressivity an additional count in our indictment of U.S. health care as, in several important respects, a fraud on the working class. Together with the many other unfairnesses we detect in American health care, the regressive tendencies we adumbrate here invite attention to reforms that would enable people to purchase, collectively or individually, only the health care they want and are willing, with the help of public subsidies (up to a point), to pay for.

confusing, would immediately benefit all beneficiaries, not just the minority with very high drug costs. But this representation hid the doughnut hole, which could present a problem for many lower-income beneficiaries, with the result that higher-income users of the system are likely to claim a disproportionate share of total benefits.

125. Lisa R. Shugarman et al., *Differences in Medicare Expenditures During the Last 3 Years of Life*, 19 J. GEN. INTERNAL MED. 127 (2004). Note that focusing on consumption in years prior to death, rather than on consumption by age cohorts, may be a good way to ensure comparisons of consumption by individuals with a similar health status.

126. Mark McClellan & Jonathan Skinner, *Medicare Reform: Who Pays and Who Benefits?*, HEALTH AFF., Jan.–Feb. 1999, at 48, 59. The authors observe, however, that Medicare’s overall unfairness was mitigated by legislation in 1994 removing the earlier ceiling on the amount of salaries and wages subject to the Medicare tax. Another study, adding some irony to consumption disparities, finds that much of the higher utilization is explained by the more inpatient-based and specialist-oriented patterns of care that are typical of high-spending regions and that this additional consumption does not appear to improve quality of care, access to care, satisfaction with care, or health outcomes. Fisher et al., *supra* note 81.

127. See Rezaul K. Khandker & Lauren A. McCormack, *Medicare Spending by Beneficiaries with Various Types of Supplemental Insurance*, 56 MED. CARE RES. REV. 137 (1999) (finding that Medicare beneficiaries who enjoy Medigap or employer-sponsored supplemental coverage consume more Medicare dollars than beneficiaries covered by Medicare alone); Renee Mentnech et al., *An Analysis of Utilization and Access from the NHIS: 1984–92*, HEALTH CARE FIN. REV., Winter 1995, at 51 (similar finding with respect to a Medicare beneficiary’s likelihood of visiting a physician); Nadereh Pourat et al., *Socioeconomic Differences in Medicare Supplemental Coverage*, HEALTH AFF., Sept.–Oct. 2000, at 186 (finding that lower-income individuals are less likely to enjoy supplemental coverage).

IV

OVERREGULATION OF HEALTH CARE: IN WHOSE INTEREST?

The previous discussion describes the surprising number of ways in which those working Americans who have health coverage bear, or appear to bear, excessive costs in supporting a health care system that serves the interests of the health care industry and its higher-income customers better than it serves themselves. This Part IV shows how industry practice, public policy, health care law, and government regulation are all structured at the most fundamental levels to ensure that this regressive allocation of benefits and costs remains the pattern in U.S. health care. The story told here is largely about how the political process and the legal system operate in tandem to limit, *de facto* and *de jure*, consumers' opportunities to economize, thus ensuring that their money will continue to flow, without their consent (if they want health coverage at all), to the benefit of elite interests.

A. Prescription Versus Consumer Choice

A crucial question is why Americans do not treat health care as an ordinary consumer good in the sense that they buy more or less of it (both in quantity and quality) as their personal preferences and financial situations dictate.¹²⁸ To be sure, health insurance and the tax subsidy make consumers less cost-conscious than they normally would be, thus shifting outward the margins at which most choices are made. But these influences do not explain why, at these new margins, consumers' choices are still not free, but are instead narrowly cabined by industry convention and practice on the one hand and by law and regulation on the other. Nor are the limits on freedom of contract adequately explained—as so many seem to think—by health care's special significance. Although health care can often make the difference between a healthy life and death or disability, it is not itself risk-free, nor is it all equally important to well-being. Moreover, when the special character and importance of health care *are* clear, government and the legal system have long supplied specific protections for patients—for example, the legal duty of hospitals to provide emergency care without regard to ability to pay.¹²⁹ With the special importance of health care

128. On the macroeconomic consequences, indirectly adverse to Americans working outside the health sector, of limiting consumers' opportunities to economize on health care, see *supra* note 99.

129. Both federal and state laws require hospitals with emergency departments to stabilize emergent conditions without regard to commercial considerations. See, e.g., *supra* note 35 and accompanying text; *Thompson v. Sun City Cmty. Hosp.*, 688 P.2d 605, 610–11 (Ariz. 1984) (enforcing the statutory duty to treat an indigent's emergency at county expense). Although these laws stop short of imposing a duty to provide free extended care or other services, federal, state, and local governments also provide subventions, public hospitals, and public clinics as additional safety nets for those with serious health needs and no health insurance. See *supra* note 38. Also, in the same spirit as laws requiring emergency care, common-law courts do not permit a health care provider having an established relationship with a patient to terminate it at will if doing so would place the patient in peril. E.g., *Surgical Consultants, P.C. v. Ball*, 447 N.W.2d 676, 682 (Iowa Ct. App. 1989) (holding that although her doctor's office had told the plaintiff she was no longer a patient because of an unpaid bill, a valid claim for "abandonment" could be proved by "evidence that the physician has terminated the relationship at a critical stage of the

recognized in these specific respects, it might seem acceptable for freedom of contract to prevail with respect to less crucial, though still consequential, matters. Our question here is why health care is mostly provided under very costly prescriptions of a regulatory and professional nature, not under conditions reflecting consumer preferences freely revealed in the marketplace.

To be sure, health care is a paradigmatic example of a so-called merit good, something that society does not wish to see distributed solely on the basis of individuals' ability and willingness to pay. But characterizing health care in general as a merit good does not preclude its being treated as a consumer good at the margin.¹³⁰ The two characterizations are not mutually exclusive. Thus, it is possible to visualize a health policy under which public subsidies would enable each consumer to purchase a contractual entitlement to at least essential services of decent quality and no one would receive more or better health care than he or she prospectively purchased with that assistance. Yet the nation has never treated health care this way, nor has it ever seriously considered doing so.¹³¹ Moreover, because the health care marketplace does not make low-cost options available, millions of Americans go without any coverage at all despite the financial subsidies available to them, and many millions more pay substantially more for health care than they would rationally choose to pay if they had good information and a full range of choices. Parts II and III of this article showed how the bargains offered consumers in the current marketplace are, for the great majority of them, bad ones. Not only are lower-income consumers denied the chance to take marginal risks (which might be their best bets in spending limited resources), but the premiums they pay for coverage defray many costs unrelated to their own care.

The most obvious reason why low-cost health care—provided, for example, by less highly trained professionals or with only restricted access to expensive technology—is unavailable to American consumers is government intervention and the U.S. legal system. Many such options are simply excluded from the

patient's treatment, that the termination was done without reason or sufficient notice to enable the patient to procure another physician, and that the patient [was] injured as a result thereof."). In addition, insurance law provides special protections against such dangerous insurer practices as bad-faith denials of claims for benefits. *See generally* WILLIAM M. SHERNOFF ET AL., *INSURANCE BAD FAITH LITIGATION* (1984 & Supp. 2006); Alan O. Sykes, "Bad Faith" Breach of Contract by First-Party Insurers, 25 J. LEGAL STUD. 405 (1996).

130. *See supra* note 102.

131. The Clinton administration's proposed Health Security Act of 1994 was first presented to the public with the claim that it "empowers consumers to make more cost-conscious choices by choosing among health plans on the basis of price and quality. Consumers reap the savings from enrolling in a health plan that delivers the guaranteed benefits for a lower premium." Press Release, The White House, Health Security Preliminary Plan Summary (Sept. 22, 1993), *available at* <http://www.clintonfoundation.org/legacy/092293-press-release-on-health-care-security-plan.htm>. But although this and other rhetoric implied that competition and consumer choice would primarily drive the projected system, the plan's details, by specifying seemingly generous "guaranteed benefits," greatly limited consumers' options and the role of private contracts in particularizing rights and obligations. In fact, the proposal's egalitarianism quotient (and thus its probable cost) was quite high. See HAVIGHURST, *HEALTH CARE CHOICES*, *supra* note 24, at 29–89, for a thorough review of the Clinton proposal in this light.

market by legal doctrines, rules, and regulations ostensibly designed to uphold the quality of the health services people receive or the health coverage they enjoy. Other options, although not explicitly precluded by law, would present the first innovator with enough legal risk and uncertainty to make the cost of introducing them prohibitive.¹³² However well-intended and protective the legal regime may seem to be, any marginal benefits it yields are, of necessity, of greater value to some people than to others. Without questioning the need for basic legal protection against bad quality, misrepresentation, and overreaching, we first observe here the general propensity of our legal and political institutions to lay down and maintain rules that serve elite interests at the expense of everyone else and, then, show some ways in which the legal environment of U.S. health care manifests this regressive propensity. Although the legal regime does not directly redistribute income from the have-lesses to the have-mores, its biases and influences add significantly to our picture of a system rigged for the latter's benefit. Our interest here is the political economy and legal environment of health care and how they effectively deny consumers opportunities to economize when it would be in their interest to do so. Although the discussion below covers some familiar ground, it also identifies some special, under-recognized reasons why, under current circumstances, popular government cannot be trusted to treat lower- and middle-income consumer-voters fairly in making health policy.

B. Legislating for Health Care

Political theorists and realists alike have long appreciated that legislation on economic matters is hardly ever the product solely of objective reasoning about what the overall public interest requires. Instead, it emerges from a complex political struggle in which special interests and factions compete, often behind the scenes, to induce government to employ its taxing, spending, prescriptive, and coercive powers in ways advantageous to themselves. Even in theory, the democratic process of majority voting provides little basis for confidence that legislation will improve aggregate welfare. Indeed, with so few constitutional limits on what a majority can do, majority rule is pregnant with the possibility that significant minority interests will be sacrificed for small majority gains. Although some minorities (the affluent, for example) are well positioned to protect their interests in the political arena, others are highly vulnerable to legislation that worsens their position, whatever its net effect on society as a

132. As a thought experiment, it is instructive to ask why Americans cannot buy Canadian-style or U.K.-style health care, both substantially cheaper than the U.S. variety though in some respects (waiting time, for example) probably less good. *Cf. Chaoulli v. Quebec*, 2005 S.C.C. 35, 29272, [2005] S.C.J. No. 33 QUICKLAW (June 9, 2005). It is our sense that such innovative offerings, even if not actually barred by law, would face enough legal uncertainty to make them untenable despite their potential attractiveness to many consumers. No single firm could afford to defend its innovation against the inevitable legal challenges if its competitors could follow at no cost any trails it succeeded in blazing. It would be hard to argue, though, that what is good enough to satisfy a political majority of Canadians or Britons is not good enough for many Americans.

whole. More ominously (and as next explained), the political process provides few guarantees that even *majority* interests will not frequently be sacrificed for the benefit of especially powerful minorities. In the health care field, the net effect of such failures of the political market is a systematic overburdening of those at the lower end of the income scale.

1. The Political Power of Influential Minorities

Social (or public) choice theory and research have shown that majority rule, despite its logic, does not prevent powerful minorities from frequently using the legislative process to their own advantage, even at the expense of the electoral majority. The paradigm case is one in which a small number of participants in the political process have large individual stakes in a legislative measure about which members of the majority care little, either because each individual's interest is very small or because they have not taken the trouble to inform themselves about it. The small, more homogeneous group has a comparative advantage in solving the collective-action problem—that is, the tendency of some members of an affected group to hang back (as free-riders) in the hope that others will take the actions needed to identify, protect, and advance their collective interest.¹³³ Even if a voting member of the majority recognizes his potential stake in a particular matter, he must also realize that neither his vote nor any other action he might take has much chance of affecting the legislative outcome—a circumstance that lessens his incentive to inform himself fully in the first place or to act on whatever information he may have.¹³⁴ Thus, whenever a legislative struggle pits a smaller group with large interests against the mass of consumers or taxpayers, the minority is likely to win. Moreover, the rent-seeking minority's gains, while substantial, may easily be less than the net costs imposed on the majority, thus diminishing aggregate welfare.

133. As an interest group becomes larger and more diverse, the practical problems of organizing for political or other collective action become greater. *See generally* MANCUR OLSON, *THE LOGIC OF COLLECTIVE ACTION* (rev. ed. 1971); Mark A. Peterson, *From Trust to Political Power: Interest Groups, Public Choice, and Health Care*, 26 *J. HEALTH POL. POL'Y & L.* 1145, 1154–57 (2001) (describing the declining political effectiveness of the American Medical Association and the rise of competing interest groups in the health care field).

134. A perennial problem in policy analysis is the quickness with which some analysts endorse a larger role for government than for markets on the ground that consumers, on whose choices markets depend, are ignorant, powerless, and easily manipulated. *See, e.g.*, Russell Korobkin, *The Efficiency of Managed Care “Patient Protection” Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 *CORNELL L. REV.* 1 (1999). Yet those same consumers, precisely because they have so little hope of protecting themselves successfully in the political process, are apt to be even more ignorant, individually powerless, and manipulable in their capacity as voters—to whom democratic government is supposed to be accountable. Moreover, some consumer-voters are better equipped to participate in and influence the political process than others, compounding the potential for harm to the most ignorant and least politically effective. On the other hand, an attractively democratic feature of free markets is the absence of majority dictation to the minority and the incentives they therefore create for participants to cater specifically to minority tastes and needs. Whatever need there may be for law and regulation to protect against real abuses, it too often serves as an excuse for disenfranchising consumers and for empowering government and those whom it serves best.

Political scientists and some others will rightly say that things are not as simple as social-choice or interest-group theory suggests.¹³⁵ But even when the legislative struggle is complex and features a large number of competing interests and factions interacting over time, the likelihood of coalitions against poorly organized consumers and taxpayers remains high. Thus, even conceding that legislators and public servants sometimes rise above opportunism and act in the interest of higher values, political outcomes, if scrutinized with care (including due skepticism about the values politicians profess to serve), are very often consistent with the theory. Indeed, even proposals that seem unarguably progressive on their face are regularly tailored for special interests before they emerge from the legislative process. Such failures of the political market appear to be especially common in the health care field, manifesting themselves both in explicit regulation and in other measures that tilt sharply in the direction of elite interests.¹³⁶

2. The Political Consequences of Hiding Costs from Those Who Pay

Although public choice theory alone can explain much of the cost-increasing, rent-generating regulation found in the health care sector, such regulation has been much easier to enact and maintain because the cost of health care is so well hidden from consumers as a direct and indirect consequence of the tax subsidy.¹³⁷ Because health coverage is paid for mostly through employers' undisclosed reductions of employees' taxable income, consumers have seen little reason, as voters, to question legal restrictions that purport to uphold the quality of care.¹³⁸ Certainly employers have some interest in health care costs as well as significant political influence that they might use to contest regulatory excesses. But employers' attitudes toward health care regulation are heavily influenced by the perceptions and expectations of their workers and by their own awareness that, in the last analysis, their employees,

135. See, e.g., Symposium, *Getting Beyond Cynicism: New Theories of the Regulatory State*, 87 CORNELL L. REV. 267 (2002).

136. For an example of special-interest influence over seemingly benign legislation in the health care field, see Sallyanne Payton & Rhoda Powsner, *Regulation Through the Looking Glass: Hospitals, Blue Cross, and Certificate-of-Need*, 79 MICH. L. REV. 203 (1980), which shows how hospital and insurance interests supported early certificate-of-need laws that were promoted as cost-containment measures but in fact served to curb competition and to legitimize, rather than prevent, cost increases. Although our overview cannot do full justice to all the specific regulatory programs and legal rules touched upon, our survey adds weight to our claim that U.S. health care is systematically arranged and governed to take unfair advantage of the lower- and middle-income majority. We have already suggested in Part II the breathtaking magnitude of the injustice that concerns us.

137. See *supra* text accompanying notes 84–92.

138. Many of the most questionable regulatory policies, moreover, are maintained well out of public view and are even more rarely seen as controversial. Although federal regulators are now required to provide benefit-cost comparisons when adopting new regulations, similar requirements rarely govern health-sector regulation at the state level. See generally Richard H. Pildes & Cass R. Sunstein, *Reinventing the Regulatory State*, 62 U. CHI. L. REV. 1 (1995) (discussing use of regulatory impact analyses by federal agencies). For a discussion and comparison of regulatory impact statements by state agencies, see Robert W. Hahn, *State and Federal Regulatory Reform: A Comparative Analysis*, 29 J. LEGAL STUD. 873 (2000).

not themselves, will pay any higher costs. Consumer-voter complacency about their own health care costs thus removes a vital counterweight to the political advantages usually enjoyed by regulated interests, creating a political economy in which legal and regulatory standards are set with little regard for the costs they cause consumers to bear.

The conventional justification for many kinds of government regulation is consumers' inability to distinguish in the marketplace between good and bad quality. Additionally, it is generally thought self-evident that the extra complexity of health care, together with its extra potential for causing serious harm, justifies heavy regulation of the health sector. But when consumers for the most part are not—or think they are not—spending their own money, the situation is fraught with new hazards. Such consumers, fully cognizant of the special riskiness of purchasing health services in ignorance, will want both health coverage that virtually eliminates temptations to economize and rigorous regulatory measures to exclude risky options from the market.¹³⁹ Because the insured population represents such a large voting bloc, their weak cost-consciousness combined with their nervousness about economizing virtually ensures political choices that err on the side of overspending. Only the interest of the federal and state governments in the costs of their own health programs provides a countervailing interest in keeping costs in hand.¹⁴⁰ The irony, of course, is that most consumer-voters tend—in their ignorance—to support policies contrary to their true self-interest.

The inability of consumers to see what they are spending on their health coverage is no accident but has long been a keystone of U.S. health policy. Although fortuity may explain the original decision in the 1940s to subsidize health coverage through the tax system, for two generations powerful interests resisted making costs visible in ways that might cause consumers to consider how much, given their other needs, they wished to spend on marginal health

139. In a classic 1963 article on medical economics, economist Kenneth Arrow speculated that consumers' fears about purchasing in ignorance alone were a sufficient explanation for health-sector regulation:

The general uncertainty about the prospects of medical treatment is socially handled by rigid entry [i.e., physician licensing] requirements. These are designed to reduce the uncertainty in the mind of the consumer as to the quality of product insofar as this is possible. I think this explanation, which is perhaps the naive one, is much more tenable than any idea of a [medical] monopoly seeking to increase incomes. No doubt restriction on entry is desirable from the point of view of the existing physicians, but the public pressure needed to achieve the restriction must come from deeper causes.

Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 966 (1963). Writing before Medicare and Medicaid and at a time when the public was both less insulated from and less concerned about the cost of health services, Arrow had no reason to be concerned about the possibility of overregulation.

140. Even here, state governments, which are responsible for some of the most restrictive regulatory controls, see none of the costs of Medicare and only a fraction of their own Medicaid costs, which are paid in substantial measure with matching federal funds. See James F. Blumstein & Frank A. Sloan, *Health Care Reform Through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and a Paradigm*, 53 VAND. L. REV. 125, 136–49 (2000).

care.¹⁴¹ The most obvious beneficiary of the cost-hiding policy was the health care industry itself, which wanted as little resistance as possible when indulging its propensity for higher spending. In addition, however, high-income consumers of health care have also benefited from policies and practices that consumer-voters supported only because they did not appreciate the effects on their own finances. The tax subsidy also gave union leaders an opportunity to earn credit with the rank and file by negotiating expensive health benefits seemingly provided at employers' expense; more important to the powers that be, it also reduced the labor movement's interest in promoting national health insurance, as trade unions had successfully done in other western countries.¹⁴² As the specific needs of the less well-off were neglected, the health care industry and its affluent allies enjoyed many happy returns.

For a variety of reasons, therefore, the tax subsidy remained untouchable in the political system for many years even though no one could defend it on its policy merits. To be sure, one might argue (1) that the public really wanted (a) as much health care as doctors advised patients to consume, and (b) not to know how much they were paying for that care; and (2) that the nation accordingly made a political choice to have the system that emerged.¹⁴³ But market and political choices made by a public that is kept in almost total ignorance about costs can legitimize nothing, certainly not the systematic exploitation of the majority by affluent minorities that we observe in U.S. health care.

3. Will Shifting Overt Cost Burdens to Consumers Change Things?

Over time, and particularly recently, employers have increased the share of health care costs that employees pay directly, making them more cost-conscious—and consequently, we presume, somewhat less dependably supportive of public policies limiting their opportunities to economize on health care. Consumers, however, still see only the tip of the iceberg of health care costs. And they have no way of knowing the opportunity costs the system forces them to bear by restricting their economizing options to a relatively

141. Although proposals to “cap” the tax exclusion have been offered from time to time, they have always fallen on deaf political ears. See HAVIGHURST, *HEALTH CARE CHOICES*, *supra* note 24, at 103 (“[C]apping the tax subsidy is a notion that only a policy wonk could love, a meritorious policy idea with no natural political constituency.”).

142. See generally MARIE GOTTSCHALK, *THE SHADOW WELFARE STATE: LABOR, BUSINESS, AND THE POLITICS OF HEALTH CARE IN THE UNITED STATES* 42–44 (2000) (observing how, after World War II and the introduction of the tax subsidy, the labor movement divided its efforts between bargaining for health benefits and advocacy of national health insurance, but failing to highlight the tax subsidy as a key explanation for the movement's priorities).

143. For the view that “[c]onsumers have sought the kind of health insurance they have . . . precisely because they don't wish to be forced to make rational trade-offs when they are confronted with medical care consumption decisions,” see Bruce C. Vladeck, *The Market v. Regulation: The Case for Regulation*, 59 MILBANK MEMORIAL FUND Q. 209, 211 (1981). Although it is true that people buy coverage to avoid difficult choices, Vladeck's statement begs the question whether people have in fact been offered either market or political choices requiring them to face the high marginal cost of the extra levels of protection he says they demand.

narrow range. Thus, while the movement to make consumers more cost-aware may be creating market and political demand for new cost-saving options, the shell game by which the health care system hides its costs from those who pay them still results in a market failure *cum* political failure especially disadvantageous to less-than-affluent payers of health insurance premiums.¹⁴⁴

One way in which employers have overtly shifted health care costs to their employees is by increasing the share of the employer's premium for health coverage that employees pay via explicit deductions from their take-home pay.¹⁴⁵ Since 1978, it has been possible for an employer to arrange for its employees' share of the premium, as well as its own, to be paid with untaxed dollars.¹⁴⁶ This change made it possible for individuals whose employers would not pay, or pay in full, for family coverage to obtain such coverage with pre-tax dollars. Moreover, many employers now offer their workers a menu of coverage options, requiring them to contribute, usually from pre-tax income, some or all of the added cost of the more expensive packages. Surprisingly, a number of employers that have increased their employees' share of their premium cost have done so *without* enabling them to pay that share with pre-tax dollars, thus making the employees' contributions more costly, after taxes, than they have to be. Analysts have found evidence that some employers following this strategy have done so in order to induce employees, who for some reason do not value coverage very highly, to forgo it altogether, thus saving money for the employer.¹⁴⁷ In any event, as consumers become increasingly responsible for paying for their own health coverage, demand for health insurance may become more price-elastic, inspiring more cost-reducing innovation in both insurance and health care itself and perhaps even voter interest in deregulatory moves facilitating more such innovation.

The recent CDHC reforms are also notable in this context because they are expressly intended to make consumers pay more of the cost of their own health

144. For recent survey data demonstrating the increasing salience of costs in consumer attitudes toward health care, see EMPLOYEE BENEFIT RESEARCH INSTITUTE, 2006 HEALTH CONFIDENCE SURVEY: DISSATISFACTION WITH HEALTH CARE SYSTEM DOUBLES SINCE 1998 (2006), available at http://www.ebri.org/publications/notes/index.cfm?fa=notesPrint&content_id=3758. For fuller elaboration of the "shell game" metaphor, see Havighurst, *How the Revolution Fell Short*, *supra* note 24, at 78–80.

145. Jonathan Gruber & Robin McKnight, *Why Did Employee Health Insurance Contributions Rise?*, 22 J. HEALTH ECON. 1085, 1085 (2003) (observing that between 1982 and 1998 the percentage of employees whose employers paid the full cost of their coverage fell from forty-four percent to twenty-eight percent).

146. I.R.C. § 125 (LEXIS 2005) (providing for so-called cafeteria plans).

147. Helen Levy, *Who Pays for Health Insurance? Employee Contributions to Health Insurance Premiums* 9–10 (Princeton Univ. Indus. Relations Section, Working Paper No. 398, 1998); see also Gruber & McKnight, *supra* note 145, at 1088–89. Although the latter source suggests that this strategy may cause employees simply to seek coverage available under a spouse's plan or to rely on Medicaid to provide for their dependents, the decline in the rate of employee "take-up" of employer-offered coverage has also contributed to the growth of the uninsured population. See MICHAEL A. MORRISEY, PRICE SENSITIVITY IN HEALTH CARE: IMPLICATIONS FOR HEALTH CARE POLICY 36–37 (2d ed. 2005) (summarizing evidence that decline in take-up rates, rather than in the number of employers offering coverage, is principally responsible for the increased number of uninsured).

care—in this case, at the point of service rather than in purchasing health coverage. To be sure, the CDHC reforms were not adopted in the interest of consumers of moderate means,¹⁴⁸ and they may, at least in the short run, exacerbate some of the regressive tendencies noted in earlier discussion.¹⁴⁹ On the other hand, as high-deductible coverage and increased cost sharing of other kinds cause consumers to be more aware of health care costs, there may be more market pressure on health plans to discover new (or rediscover old) ways of counteracting moral hazard and less public support for cost-increasing regulation.¹⁵⁰

C. Distributive Consequences of Substantive Health Care Law and Regulation

There are numerous identifiable ways in which political and legal systems in the United States directly or indirectly foreclose opportunities for lower- and middle-income consumers to enhance their own, as well as aggregate, welfare by purchasing low-cost, arguably lower-quality health care and health coverage. It is no coincidence that the various laws and policies criticized here all tend to restrict consumers' freedom of contract for the benefit of influential minorities, principally industry stakeholders and high-income users of health services. The overregulation summarized below is objectionable in large part because, in markets for both health services and health coverage, it impedes what has been called disruptive innovation—that is, offering new products that, while they might be less good, or in some other way out of keeping with conventional standards, put competition on a different, perhaps more affordable plane, thereby serving many consumers better.¹⁵¹

148. See *supra* notes 96 & 108 on distributional implications of the CDHC reforms.

149. Some purport to fear that high-deductible coverage will cause healthier, often wealthier employees to contribute less than they currently do to the support of coworkers with more or chronic health problems. See generally BETH FUCHS & JULIA A. JAMES, NAT'L HEALTH POL'Y FORUM, HEALTH SAVINGS ACCOUNTS: THE FUNDAMENTALS (2005), available at http://www.nhpf.org/pdfs_bp/BP_HSAs_04-11-05.pdf (reviewing arguments for and against HSAs). Yet, as noted previously in Part III, our conjecture is that, when people with disparate risks and preferences are arbitrarily pooled in the same health plan, subsidies may actually run the other way, with higher-income insureds, as a class, getting more out of the plan than their lower-income coworkers. See *supra* note 107 and accompanying text.

150. See Hall & Havighurst, *supra* note 97 (arguing that HSAs and other innovations could make the public more comfortable with health plans' predetermination of benefits and other methods of rationing coverage).

151. For an overview of disruptive innovation and the view that competition to create radically different, often lower-cost, alternative products has been crucial in destabilizing and ultimately improving the performance of many industries, see CLAYTON CHRISTENSEN, THE INNOVATOR'S DILEMMA (1997). In our view, many potential innovations stymied by overregulation in the health care sector would be helpfully destructive of conventional paradigms and beneficial from the standpoint of efficiency and consumer welfare. For an application of disruptive innovation theorizing to the health care sector and to the thesis of this article, see Lesley H. Curtis & Kevin A. Schulman, *Overregulation of Health Care: Mustings on Disruptive Innovation Theory*, 69 LAW & CONTEMP. PROBS. 195, 197–206 (Autumn 2006).

1. Overregulating Providers

The most pervasive kind of regulation of the health care sector is entry control through occupational licensure.¹⁵² In theory at least, exclusionary licensure, barring from the market individuals who do not meet minimum standards of competence in the regulated field of endeavor, can enhance consumers' welfare by minimizing both their exposure to risks of bad service and their uncertainty in purchasing complex services, thus reducing what economists call their "search costs."¹⁵³ Entry controls also raise costs, however, by excluding providers who might serve some clients adequately and cheaply, thus forcing those clients (mostly lower-income individuals) to pay higher prices for arguably more reliable services. Nevertheless, despite these costs, entry regulation could be calibrated in such a way that, according to one theory at least,¹⁵⁴ overall welfare is improved. Indeed, regulation may arguably be efficient even if the resulting higher prices cause some consumers to forgo needed services, with adverse health consequences.¹⁵⁵ But, whatever economic theory may say, it is relevant for present purposes that the lower-income segment of the population, even if protected against costly mistakes, bears many more of the costs of exclusionary licensure than more affluent interests.

Even though exclusionary licensure may in theory sometimes be economically efficient, the nature of majoritarian politics makes it predictable that in any field in which government regulates entry, entry standards will be inefficiently high, causing more hardship than is even arguably optimal. Indeed, if consumers feel at significant risk in purchasing some good or service on their own, then the political majority they constitute can be expected to demand more "consumer protection" and more peace of mind than is consistent with

152. See generally FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *supra* note 25, ch.2, at 25–28; Morris M. Kleiner, *Occupational Licensing*, 14 J. ECON. PERSP. 189 (2000) (overview of economic literature on licensure, with emphasis on the need for empirical studies of cost and other impacts); Morris M. Kleiner & Robert T. Kudrle, *Does Regulation Affect Economic Outcomes?: The Case of Dentistry*, 43 J.L. & ECON. 547 (2000) (estimating that state licensure causes thirty percent increase in dentists' fees).

153. See *supra* note 139. An alternative to exclusionary licensure is public certification, sometimes called title licensure. This intermediate form of regulation, which addresses the information problem by limiting not who may practice in a field but who may use certain titles, was famously advocated by economist Milton Friedman. MILTON FRIEDMAN, *CAPITALISM AND FREEDOM* 144–49 (2d ed. 1982).

154. In economic theory, regulation is not deemed inefficient as long as the gains to the winners exceed the losses to the losers, whether or not the losers are compensated in some way. See RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 13–15 (5th ed. 1998) (discussing this so-called Kaldor-Hicks definition of efficiency). Even if regulation passes this test, however, social justice is obviously implicated if lower-income persons are regularly on the losing end. See Uwe E. Reinhardt, *Can Efficiency Be Left to the Market?*, 26 J. HEALTH POL. POL'Y & L. 967, 984 (2001) (admonishing that "Kaldor's expedient normative dictum is never an excuse for setting aside moral thought"). Moreover, even in the event that lower-income wage earners are not net losers once all social programs (which serve mostly the poor) are taken into account, there is no good reason why the health care system should be organized and regulated to their disadvantage.

155. See, e.g., Sidney L. Carroll & Robert J. Gaston, *Occupational Restrictions and the Quality of Service Received*, 47 SO. ECON. J. 959 (1981) (stressing that social costs of regulation, which must be compared to benefits, include harms resulting from consumers' forgoing of valuable services because of regulation-induced higher prices).

aggregate welfare, let alone the welfare of those with less than median income. Public choice theory, of course, anticipates that members of a regulated industry will organize themselves and lobby effectively for high standards that limit supply and increase both the duration and market value of their incumbency. But majority rule is alone sufficient to explain the unfair burdens imposed on those below the middle of the income spectrum.¹⁵⁶ In the health care sector, moreover, as we have previously observed, the welfare of the sub-affluent is in special jeopardy because the middle-class majority tend not to appreciate the economic costs of regulation even to themselves and therefore regularly lean against their *own* self-interest.¹⁵⁷ Indeed, occupational licensure is a paradigm case illustrating how policies effectively obscuring the incidence of health care costs from consumer-voters, when combined with tendencies captured by public choice theory, consistently and systematically produce distributive injustice.

Occupational regulation has other costs besides those flowing from state-imposed restrictions on entry. State legislatures typically also delegate responsibility for regulating practice of a licensed occupation to its licensing board, which is usually staffed by members of the licensed occupation itself. In the nature of things, such boards discharge these responsibilities very much as state-chartered cartels, making rules not only curtailing the supply of competitors but also suppressing advertising, corporate or commercial practice, and other practices that might intensify competition and foster consumer choice.¹⁵⁸ Moreover, at the same time that they largely control the regulatory apparatus, the licensees in each field generally organize themselves privately not only to advance their political objectives, but also to set private standards for professional practice, educational programs, and institutional providers of services. Although such private entities may not directly enforce the standards they set, these standards and their accompanying certifications of compliance usually carry decisive weight in the marketplace and with state regulators.¹⁵⁹ With the public generally unaware of the cost and competitive implications of such publicly sanctioned self-regulatory regimes, the interests of the regulated are commonly advanced at consumers' expense, with cost increases a natural result. Because the actions taken are always rationalized by reference to quality concerns, elite observers tend to be generally supportive and, in any event, less

156. For further discussion and a graphic bell curve illustrating how majority rule is likely to yield overregulation, see Havighurst, *How the Revolution Fell Short*, *supra* note 24, at 82–86.

157. *See id.* (illustrating how majority rule under conditions of systematic consumer-voter ignorance about the incidence of health care costs might produce “hyper-regulation”).

158. *See* Clark C. Havighurst, *Contesting Anticompetitive Actions Taken in the Name of the State: State Action Immunity and Health Care Markets*, 31 J. HEALTH POL. POL’Y & LAW 585 (2006) (discussing the limited extent to which federal antitrust law limits state authority to immunize anticompetitive actions by state licensing and regulatory boards).

159. *See generally* Symposium, *Private Accreditation in the Regulatory State*, 57 LAW & CONTEMP. PROBS. (Autumn 1994).

concerned about higher costs than lower- and middle-income consumers should be.

Institutions in the health care field, particularly hospitals, also frequently enjoy substantial benefits from the regulatory regimes to which they are subject and from the activities of private standard-setting and accrediting organizations. Once again, although quality-enhancing standards limit opportunities for cost-reducing innovations, they are rarely controversial politically, both because the rank-and-file electorate fails to see any connection to their own pocketbooks and because elite consumer-voters tend to value disproportionately the added security they supply. In addition, institutional providers may enjoy the protection of certificate-of-need regulation, which operates to curb new market entry threatening to their market power. Though repealed in some states after Congress repealed, in 1986, the federal law that compelled states to enact them, certificate-of-need requirements still operate in many places.¹⁶⁰ Originally put in place under the rationale that competition could never work in medical care,¹⁶¹ these laws remain on the books today largely to prevent competition (with, say, freestanding ambulatory surgery centers or specialty hospitals) from undermining the ability of hospital monopolies to cross-subsidize unspecified good works that hospitals presumably do.¹⁶² As noted earlier, to rely on monopolist providers to carry out public responsibilities is to impose the equivalent of a regressive head tax on premium payers.

2. Overregulating Health Plans

Financial oversight of insurance companies is essential to obviate, or at least to deal with, the problem of insolvency, and consumers certainly need substantial tort as well as contract remedies to deter insurers from stonewalling valid claims in the hope that the claimant will go away. Also, the complexity of insurance contracts is such that consumer welfare can be enhanced by having at least individual policies vetted by insurance regulators. Some features of current insurance regulation and insurance law, however, are less clearly advantageous for all premium payers as a class. Fortunately, state regulation, which can clearly provide helpful protection for individual insurance purchasers, is far less intrusive in the case of group health insurance, where employers act as agents for their employees and can be assumed to have (or be able to hire) the requisite sophistication. In addition, some HMOs, and all health plans in which the employer itself bears the insurance risk, are

160. See generally CLARK C. HAVIGHURST ET AL., *HEALTH CARE LAW AND POLICY* 709–52 (2d ed. 1998).

161. See CLARK C. HAVIGHURST, *DEREGULATING THE HEALTH CARE INDUSTRY: PLANNING FOR COMPETITION* (1982); see also *supra* note 136.

162. See, e.g., Sujit Choudhry et al., *Specialty versus Community Hospitals: What Role for the Law?*, 2005 HEALTH AFF. (WEB EXCLUSIVES) W5-361 (proposing certificate-of-need regulation to protect community hospitals against opportunistic competition from specialized providers); Clark C. Havighurst, *Monopoly Is Not the Answer*, 2005 HEALTH AFF. (WEB EXCLUSIVES) W5-373 (criticizing Choudhry et al. proposal).

significantly protected by federal law against burdensome state regulation and state-created liabilities.¹⁶³ But many aspects of the legal environment prevent modern health plans from selling low-cost coverage that many consumers would find well suited for their situations.

A common feature of insurance regulation is mandated coverage for certain services, including mental health care, substance-abuse treatment, home health care, certain organ transplants, treatment of jaw disorders, infertility treatment, minimum hospital stays following normal births, and post-mastectomy breast reconstruction.¹⁶⁴ State laws also frequently require that health plans permit certain covered services to be provided by non-physician providers to the extent of their authorized scopes of practice. Each such mandate is a different story, of course, and there may be an arguable rationale for some of them based on the possibility that minority needs or preferences will be neglected in designing health coverage for heterogeneous employment groups. But the usual story is one of special-interest lobbying—often a combined effort of provider and patient-advocacy groups—in an atmosphere of general consumer-voter disinterest.¹⁶⁵ In any event, the overall tendency of mandated benefits is to raise costs unnecessarily.

The backlash against managed health care in the 1990s resulted in significant cutbacks in health plans' use of administrative methods—previously employed with mixed results—to contain the effects of moral hazard.¹⁶⁶ Not only did employers, responding to new employee fears and complaints, rapidly retract their early support for HMOs employing limited provider networks or aggressively rationing financing for marginally beneficial services, but consumers themselves supported legislative efforts to rein in health plans' economizing efforts. These legislative measures included new coverage (for example, length-of-stay) mandates, “any-willing-provider” laws limiting health

163. See Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001–03 (LEXIS 2005) (preempting state laws relating to employee health benefits); *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) (finding certain health plans immunized by ERISA from state-imposed liability for wrongful denials of health benefits).

164. See generally Gail A. Jensen, *Regulating the Content of Health Plans*, in AMERICAN HEALTH POLICY: CRITICAL ISSUES FOR REFORM 167 (Robert B. Helms ed., 1993).

165. Ironically, only small employers and their workers are affected by such cost-increasing benefit mandates because employers large enough to self-insure their employees' health benefits are exempted from such state requirements by federal legislation. See *supra* note 163 and accompanying text. A recent federal legislative proposal to exempt health plans offered to pools of small businesses from various state coverage mandates, S. 1955, 109th Cong. (2006), was opposed by a broad-based coalition of health care providers, patient-advocacy groups, insurance regulators, and state attorneys general. See From the CQ Newsroom: Industry Group Backs Health Association Bill as States Push for Their Rights, http://www.cmwf.org/healthpolicyweek/healthpolicyweek_show.htm?doc_id=370240#doc370242 (last visited Nov. 10, 2006).

166. See generally Mark A. Hall, *The Death of Managed Care: A Regulatory Autopsy*, 30 J. HEALTH POL. POL'Y & L. 427 (2005) (concluding that health plans scaled back earlier efforts to manage health care costs less because of new regulation than for other reasons); Havighurst, *How the Revolution Fell Short*, *supra* note 24 (extensive account of reasons, both legal and non-legal, for the failure of the 1970s–1990s movement to empower consumers to make health care choices through competing health-plan agents).

plans' ability to reward with increased volume providers who would reduce their fees, and new "external review" procedures for challenging health plans' denials of coverage.¹⁶⁷ This outpouring of "patient-protection" legislation led many to conclude that the majority of voters, as well as physician interests, rejected an active role for health plans in deciding how health care dollars should be spent. But the backlash provides a near-perfect illustration of how consumer-voters' unawareness of their own stake in cost-saving measures can yield market and political outcomes contrary to their interests.¹⁶⁸ Ever since the virtual demise of managed care, health care costs have risen at staggering rates,¹⁶⁹ causing many employers to require their employees to shoulder a bigger share of the premium and other costs.

A major obstacle to meaningful economizing by consumers in the purchase of health coverage has been the near-universal acceptance by the health care industry and other elite interests of the medical profession's preferred paradigm of medical care. This perspective treats health care as a non-economic good and questions the wisdom of giving patients opportunities to make consequential choices with costs or prices in view. To be sure, the professional paradigm is not exactly incorporated in law. But its influence remains pervasive in part because the tax subsidy has for so long minimized the chances that consumers would come to defy the dominant paradigm or that health plans would strive to customize coverage to fit, not the paradigm, but the pocketbooks of the consumers they seek to serve. Thus, instead of differentiating their products in meaningful ways, health plans universally undertook, as the paradigm dictated, to pay for any service that was both medically necessary under professional standards and of sufficiently proven effectiveness to be accepted by the medical profession. De facto, therefore, if not de jure, health care is delivered and paid for under standards set by professional interests, not in contracts with consumers. Notably, some external review statutes have flirted with finally enshrining the professional standard in substantive law by having coverage denials reviewed by medical experts applying their own professional knowledge to the case without reference to the language of the insurance contract.¹⁷⁰

167. See Frank A. Sloan & Mark A. Hall, *Market Failures and the Evolution of State Regulation of Managed Care*, 65 LAW & CONTEMP. PROBS. 169 (Fall 2002) (reviewing so-called patient-protection legislation).

168. See Havighurst, *How the Revolution Fell Short*, *supra* note 24, at 86 (extending bell-curve illustration, *see supra* notes 156–57, to the account for the "hyper-regulation" of managed care).

169. Cynthia Smith et al., *National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending*, 25 HEALTH AFF. 186, 187 ex. 1 (2006) (showing health care expenditures as stable around 13.8% of GDP from 1993–2000, when managed care was dominant, but rising to 16% of GDP in 2004).

170. Cf. Bipartisan Patient Protection Act, S. 1052, H.R. 2563, § 104, 107th Cong. (2001) (proposal to mandate external professional review of any coverage decision based on "medical necessity or appropriateness" would have freed external reviewers from honoring contractual limits unless the applicable exclusion is categorically or numerically "exact"); *see also supra* note 110.

Freedom of contract has also languished in health care because of the immense difficulty of writing unambiguous contracts specifying patients' entitlements in the myriad situations that can arise. But it is possible to imagine economizing contracts with coverage criteria other than "medical necessity"—perhaps incorporating by reference, for example, specific clinical guidelines developed by reputable medical experts with economizing as a principal objective.¹⁷¹ Although there is no solid legal obstacle to courts' enforcing economizing contracts with primary regard to the intentions of the parties rather than to professional standards, one cannot count on courts to cooperate with such a project. Instead, under the interpretive principle of *contra proferentem*, a court might feel constrained to interpret any contractual ambiguity against the party that drafted the contract, regardless of whether a significantly less ambiguous contract could have been written. Although it is certainly not too late to resurrect freedom of contract in the health care field, the regulatory and legal environment has long limited, both de jure and de facto, the options available to consumers, forcing them to pay for the Cadillac coverage designed by professional interests and preferred by the industry's elite customers as well as some academic critics.¹⁷² It remains to be seen whether the CDHC movement, by making consumers pay for much of the coverage they enjoy and for many of the services they consume, will change perceptions enough to widen the range of economizing options available to consumers.¹⁷³

3. How the Malpractice Liability System Overburdens Consumers

Typical trial-lawyer rhetoric paints America's tort system as a venue in which the ordinary citizen can obtain justice against the wealthy and powerful. But, in reality, the nation's system for redressing injuries resulting from medical malpractice is another cornerstone of an overall health policy that disproportionately benefits elite classes at the expense of middle- and lower-income consumers of health services. It is, of course, not obvious how a system that permits injured patients to recover large amounts of money from professionals and elite institutions might ultimately serve the interests of the latter groups. But the rules defining medical malpractice are in the last analysis made by the health care industry itself and consequently embody the medical

171. See HAVIGHURST, HEALTH CARE CHOICES, *supra* note 24, at 222–64.

172. See *generally id.* Economists and other policy analysts rarely recognize the unavailability in the market of economizing choices and the legal risks that inhibit the offering of such choices as the serious policy problems they are. See *supra* note 65. But see Pauly, *supra* note 24, at 1528 (recognizing that, for legal and other reasons, “[p]eople cannot generally choose knowledgeably among a variety of plans characterized by explicitly different policies toward new technology.”). Although Pauly’s discussion focuses principally on encouraging private rationing of “new” technology, it concludes, wisely, that “some type of legal safe harbor has to be created for insurers that implement well-designed plans for limiting technology [in general], and [that] the ‘community or standard practice’ and ‘medical necessity’ concepts need to be jettisoned.” *Id.* at 1534.

173. See MICHAEL F. CANNON & MICHAEL D. TANNER, HEALTHY COMPETITION: WHAT’S HOLDING BACK HEALTH CARE AND HOW TO FREE IT 69, 116 (2005) (advocating still greater tax incentives for HSAs and suggesting that federal law widen consumer choice by enabling consumers to purchase health coverage from insurers regulated by states other than their own).

profession's norm that undervalues cost as a factor in clinical decisionmaking,

explicitly evaluated to determine their soundness as public policy. Yet, to the extent such standards require more than just the exercise of appropriate care and skill and presume to dictate what specific services providers must not omit to prescribe, they are suspect from an efficiency standpoint, having developed and evolved in a market fraught with moral hazard. In addition to not being vetted in the democratic policymaking process nor validated in a smoothly functioning marketplace, the standards constituting the legal standard of care are nowhere published to inform practitioners authoritatively of their specific obligations—contrary to an elementary due-process requirement of government regulation.¹⁷⁵ Moreover, because its standards must be discovered case-by-case through the adversarial efforts of well-compensated private lawyers and medical experts, the malpractice system is also far more costly to administer than a regulatory program presumably would be. Finally, tort rules are enforced more haphazardly than regulatory requirements since they can be invoked against a practitioner only after an injury has occurred, not whenever negligent behavior is detected.¹⁷⁶ Despite these many problems, our principal objection to the malpractice system as a regulatory program is the same as our objection to other forms of health-sector regulation: By motivating providers to prescribe services with only minimal regard to cost, it forces consumers either to

175. Indeed, the standard of care applied in any given lawsuit is rarely apparent even after the case is decided, but is instead merely implicit in a general jury verdict based on conflicting expert testimony about what the standard should be. Although a movement to create so-called clinical practice guidelines began in the 1980s and has evolved into widespread insistence that physicians practice so-called evidence-based medicine, practice guidelines, however well grounded they may be in evidence of efficacy and appropriateness (cost is still largely left out of the calculus), do not generally have official status but are only evidence of prevailing practice standards that juries may consider without being bound by them. See generally Troyen A. Brennan, *Practice Guidelines and Malpractice Litigation: Collision or Cohesion?*, 16 J. HEALTH POL. POL'Y & L. 67 (1991); Mark Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, 54 LAW & CONTEMP. PROBS. 119 (Spring 1991); Clark C. Havighurst, *Practice Guidelines as Legal Standards Governing Physician Liability*, 54 LAW & CONTEMP. PROBS. 87 (Spring 1991); Andrew L. Hyams et al., *Practice Guidelines and Malpractice Litigation: A Two-Way Street*, 122 ANNALS OF INT. MED. 450 (1995) (reporting survey of guideline use in actual cases); Michelle M. Mello, *Of Swords and Shields: The Role of Clinical Practice Guidelines in Medical Malpractice Litigation*, 149 U. PA. L. REV. 645 (2001); Arnold J. Rosoff, *Evidence-based Medicine and the Law: The Courts Confront Clinical Practice Guidelines*, 26 J. HEALTH POL. POL'Y & L. 327 (2001).

176. Although the licensure system might seem to provide protection for consumers against negligent physicians, discipline is only rarely administered because of simple incompetence. Gary L. Gaumer, *Regulating Health Professionals: A Review of the Empirical Literature*, 62 MILBANK MEMORIAL FUND Q. 380, 407 (1984) (“[R]esearch on credentialing shows that contemporary credentialing procedures may not be reliably screening actual practice competence.”). On the other hand, private credentialing and other measures in well-run hospitals provide some assurance of quality. Significantly, however, neither these efforts nor the tort system itself—the high cost of which seems justifiable only if it effectively deters numerous patient injuries—has worked well enough in preventing or deterring patient injuries to preclude some strong, authoritative adverse criticism of the overall quality of U.S. health care. E.g., INSTITUTE OF MEDICINE, *CROSSING THE QUALITY CHASM: A NEW HEALTH CARE SYSTEM FOR THE 21ST CENTURY* (2001); INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (1999). Recent industry efforts to respond to this embarrassing criticism have yet, it appears, to yield substantial improvements. See Lucian L. Leape & Donald M. Berwick, *Five Years After TO ERR IS HUMAN: What Have We Learned?*, 293 J.A.M.A. 2384, 2384 (2005) (“[L]ittle evidence exists from any source that systematic improvements in safety are widely available.”).

pay for costlier care than many of them would otherwise choose or to go without health coverage, and possibly health care, altogether.

Most of the foregoing shortcomings of malpractice law as a system for regulating medical practice would largely disappear, of course, if consumers and providers were free to negotiate, particularly through health-plan intermediaries, for a less costly set of patient rights and provider obligations than the law prescribes. For example, to obtain reduced health insurance premiums, consumers might agree to a less demanding rule governing the prescription of services of only marginal value¹⁷⁷ or a less extensive set of remedies if malpractice should occur.¹⁷⁸ But freedom of contract is not the rule in health care. Indeed, the regulatory character of the malpractice regime is founded on the legal system's monopoly over the definition and administration of patients' rights, a monopoly that persists in large part because common-law courts are hostile to claims by malpractice defendants that the injured plaintiff waived, by contract, some right that the law confers.¹⁷⁹ Being concerned primarily with the rights of injured plaintiffs *ex post*, judges rarely acknowledge that some consumers, in order to save money, might rationally elect *ex ante* a less demanding standard of care or less lucrative remedies for injuries they suffer. Despite the many objections that can be raised to the legal system's insistence on its own rules, there is little chance that the courts can be

177. See HAVIGHURST, HEALTH CARE CHOICES, *supra* note 24, at 284–302 (suggesting various strategies for modifying overly demanding standards of care, including dispensing altogether with fault as the basis for liability). For the suggestion that selected clinical practice guidelines could be incorporated in health care contracts to establish the standard of care, see *supra* text accompanying notes 171–72; Havighurst, *supra* note 175.

178. See HAVIGHURST, HEALTH CARE CHOICES, *supra* note 24, at 271–84 (suggesting various modifications of remedies for negligence and malpractice).

179. Virtually the only contractual modifications of traditional tort rights that courts have shown much willingness to enforce are arbitration clauses. *E.g.*, Buraczynski v. Eyring, 919 S.W.2d 314 (Tenn. 1996) (enforcing agreements with two different patients undergoing knee reconstructions and finding that although the agreements were contracts of adhesion because presented by the physician on a take-it-or-leave-it basis, they were not unconscionable or oppressive); Hawkins v. Superior Court, 152 Cal. Rptr. 491 (Cal. Ct. App. 1979) (holding arbitration agreement signed by husband as part of comprehensive contract with Kaiser plan was binding on his enrolled spouse). *But see* Obstetrics & Gynecologists v. Pepper, 693 P.2d 1259 (Nev. 1985) (holding arbitration agreement offered by a clinic on take-it-or-leave-it basis was an adhesion contract, unenforceable in absence of evidence of plaintiff's knowing assent). This exception to the usual hostility to contractual reforms helps to prove the general rule, however, since an arbitration clause changes no more than the forum in which a claim is heard, not the substance of the claim nor the remedy available. *See, e.g.*, Madden v. Kaiser Foundation Hospitals, 552 P.2d 1178, 1186 (Cal. 1976) (enforcing arbitration clause in HMO contract because it “does not detract from Kaiser’s duty to use reasonable care in treating patients, nor limit its liability for breach of this duty, but merely substitutes one forum for another”). Interestingly, arbitration clauses have been uncommon in health-plan contracts because, by lowering the cost of suing, they tend to increase the number of suits—hardly a result a health plan would desire. *Cf.* Engalla v. Permanente Med. Group, Inc., 938 P.2d 903 (Cal. 1997) (finding Kaiser arbitration system cumbersome and costly, contrary to how it was represented to consumers, suggesting that Kaiser did not want arbitration to make its doctors any easier to sue than in the civil courts). On the other hand, HMOs might offer arbitration clauses more widely—for the mutual benefit of both the plan and its subscribers—if such clauses could be accompanied by other contract terms limiting substantive rights and obligations.

persuaded to treat malpractice law as a set of default rules—that is, as the point of departure for negotiating different arrangements if the parties so desire.¹⁸⁰

Why courts so effectively deny consumers freedom of contract in this field is unclear.¹⁸¹ Explanations no doubt vary with individual judges, but probably include ignorance of, or unconcern for, the cost and other welfare consequences of judicial actions for ordinary people; attachment to things as they have always been; moral discontent with any but a nominally egalitarian health care system in which all citizens enjoy on paper the same rights as judges would want for themselves; acceptance of the medical profession's own paradigmatic view that health care is too important to be left to consumer choice; a belief that the legal system of which he or she is a part knows best what is good for people;¹⁸² or simply an unacknowledged interest in maintaining the legal system's lawyer-enriching, judge-empowering monopoly.¹⁸³ In addition to having an elitist flavor, all of the foregoing possible explanations for courts' treatment of malpractice rights and obligations as matters of positive law rather than implied contract, variable by explicit agreement, betray an element of moral hazard, as

180. For scholarly discussions of the merits of letting consumers, with basic protections against fraud and overreaching, choose alternative liability regimes, see Symposium, *Medical Malpractice: Can the Private Sector Find Relief?*, 49 LAW & CONTEMP. PROBS. 143–320 (Spring 1986); see also Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. B. FOUND. RES. J. 87 (1976).

181. Of course, the ostensible justification for the legal system's skeptical attitude toward contracts limiting consumers' rights is the well-documented inability of consumers to make well-informed, rational choices. See *supra* note 134. It has never been clear, however, why consumers' difficulty in wisely choosing for themselves entitles privileged elites, with values, preferences, and economic interests of their own, to choose for them, thus forcing them to accept a legal regime in which they have virtually no voice at all. In our view, the often-impressive findings of psychology and behavioral economics should not be used only to discredit law-and-economics theorizing but should instead be seen as enriching it. See, e.g., Christine Jolls, Cass Sunstein & Richard Thaler, *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471 (1998) (providing an overview of ways experimental psychology can inform thinking about legal rules). For example, findings about the limitations of consumers as decisionmakers can be seen to strengthen the case for letting consumers select and rely upon more disinterested agents and for reforming legal procedures to assist consumers in making consequential choices by simplifying and clarifying options, "framing" issues, responsibly shaping perceptions, forcing reconsiderations, and otherwise. See generally Christine Jolls & Cass R. Sunstein, *Debiasing through Law*, 35 J. LEG. STUD. 199 (2006). On the phenomenon and pervasiveness of the framing effect, see Norbert Schwarz, *Self-Reports: How the Questions Shape the Answers*, 54 AM. PSYCHOLOGIST 93 (1999).

182. Note the strong similarity between such a belief on the part of the legal profession in its own benignity and the medical paradigm under which physicians deem themselves to be, as ethical professionals, superior makers of spending decisions.

183. Many state courts have been so protective of their authority over the tort system that, using various somewhat strained constructions of the judiciary's powers under their state constitution, they have invalidated numerous efforts by state legislatures to reform malpractice law. E.g., *Ferdon v. Wisconsin Patients Compensation Fund*, 701 N.W.2d 440 (Wis. 2005) (finding a cap on non-economic damages unconstitutional and reviewing cases from other jurisdictions); see also HAVIGHURST ET AL., *supra* note 160, at 941–89 (2d ed. 1998) (reviewing case law on state malpractice reforms); Carly N. Kelly & Michelle M. Mello, *Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation*, 33 J.L. MED. & ETHICS 515 (2005). One might expect contractual reforms, being consensual, to fare better than legislative prescriptions, but they have not. A possible justification for maintaining the inalienability of tort rights is to preserve the integrity of the tort system as a public good, a vital deterrent to future malpractice. But, whereas one might be concerned that those opting out of the tort system are free-riding on its continuing beneficial effects on the quality of care, the evidence that the system serves that useful purpose is not strong. See *supra* note 176.

legal decisionmakers indulge their own elite preferences or advance their own interests with other people's money. In any event, as currently administered, the legal system provides powerful support for the health care industry's undue claims on consumers' limited resources.

Unfairness is also detectable in the way the medical malpractice system spreads financial risk, collecting wealth on the one hand and redistributing it on the other in the form of administrative expenses and damages. On the collection side (who pays?), the malpractice regime's revenue is generated ultimately, as noted above, in roughly equal amounts from individuals who, directly or indirectly, pay health insurance premiums. As in our earlier exploration of possible disparities in health insurance, we are interested here in whether equal contributions, regardless of income, give rise to equal entitlements, not just on paper but in fact. Once again, significant unfairness to those lower on the income scale seems clear.

On the distribution side (who benefits?), the beneficiaries of the malpractice system include the lawyers and expert witnesses needed to ascertain fault in each case under vague legal standards. Most prominent in this elite class of beneficiaries are plaintiffs' attorneys, whose take is generally a substantial percentage of each settlement or award and whose political ability to defend their traditional domain is legendary. The rewards to all these stakeholders are substantial. Indeed, something less than half of liability insurance premiums collected remain available to compensate injured individuals after the system's heavy administrative costs are paid.¹⁸⁴ It would be hard to imagine a less efficient mechanism for compensating injured persons. Moreover, in accordance with previous discussion, we would reject the usual claim by plaintiffs' lawyers that, whatever it costs, the malpractice system deserves to be maintained in its present regulatory form because it deters negligence and ensures care of appropriate quality.¹⁸⁵

184. PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 17 (1993) (“[E]ven when one leaves aside the cost of securing and investing insurance funds and focuses simply on the process of claims administration and distribution, only about 40 percent of the total amount expended in the claims process actually reaches injured patients as compensation for their injuries.”).

185. *But see* Mello & Brennan, *supra* note 174 (mildly defending current system while suggesting modest reforms). For suggested ways of making the tort system pull more helpfully in the direction of quality assurance, see Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 N.Y.U. L. REV. 1929, 1996–98 (2003) (arguing that “entity-level liability” for physician torts, rather than traditional liability rules, would come closer to creating optimal incentives for quality); Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Care*, 26 AM. J.L. & MED. 7 (2000) (arguing that making organized health plans vicariously liable for the torts of their participating providers would both inspire integrated efforts to improve quality and restore needed legitimacy to managed health care by making plans responsible for the quality, as well as the cost, of care); Randall Bovbjerg & Lawrence R. Tancredi, *Liability Reform Should Make Patients Safer: “Avoidable Classes of Events” Are a Key Improvement*, 33 J.L. MED. & ETHICS 478 (2005) (expanding earlier proposals to impose automatic, i.e., strict, liability for certain, normally preventable adverse outcomes as a way both to ensure fair compensation at low administrative cost and to strengthen incentives to avoid such compensable events); Clark C.

To the extent the money that malpractice victims finally receive as damages is intended to compensate them for lost employment income, higher-income victims stand to receive larger awards than victims whose income loss is less.¹⁸⁶ In addition, because the willingness of a plaintiff's lawyer to accept a case depends heavily on the size of the potential award, some lower-income victims of malpractice will find it harder to get lawyers to prosecute their claims. On the other hand, the largest tort awards, while relatively few compared to the incidence of malpractice injuries, are intended to cover the future medical expenses of severely disabled individuals, who may be disproportionately poorer rather than richer because the care they receive may be disproportionately poorer as well. Nevertheless, we still hypothesize that lower-income premium payers stand, on average, a poorer chance of benefiting from the insurance funds collected partly at their expense to compensate for patient injuries. It seems evident, for example, that, whereas a few lower-income patients may receive substantial recoveries under the tort system, working-class individuals are less likely to pursue claims aggressively because of, say, their lesser ability to discover that a bad medical outcome resulted from negligence, a lesser willingness to sue powerful authority figures or institutions, a greater willingness to accept a low settlement offer, or greater difficulty in getting a competent lawyer to take their case.

Although empirical evidence on which income classes benefit most from the tort system is thin, we suspect that lower- and middle-income consumers, whose health insurance premiums include roughly equal contributions to support the malpractice insurance system, do not enjoy equivalent, or equally valued, protection against losses they might incur from a negligence-caused injury.¹⁸⁷ To the extent that this is true (or perceived by providers to be true), providers might provide better and more costly care for higher-income patients because they perceive them to be generally in a better position to bring a legal action in

Havighurst & Lawrence R. Tancredi, "Medical Adversity Insurance"—A No-Fault Approach to Medical Malpractice and Quality Assurance, 51 MILBANK Q. 125 (1974) (earlier proposal to the same effect).

186. To be sure, reforms in roughly half the states now allow juries to reduce damages for income losses to the extent that the plaintiff has been compensated for such losses already by various so-called "collateral sources" (public or private income-replacement programs, for example). See generally NAT'L ASS'N OF MUTUAL INS. COMPANIES, COLLATERAL SOURCE RULE REFORM, <http://www.namic.org/reports/tortReform/CollateralSourceRule.asp> (last visited Feb. 19, 2006) (summarizing collateral-source reforms by state). But, whereas some such reforms appear to diminish regressivity, many reforms focus only on denying double recovery for medical expenses, thereby increasing the relative significance of lost income as an element of tort damages. Under some new rules for calculating damages, therefore, higher-income persons stand to profit even more from the malpractice system than lower-income premium payers.

187. There is unfortunately only limited empirical evidence supporting our perception here. Nevertheless, some research finds disparities in malpractice awards correlated with race, gender, and age, factors that may also correlate with income. See Martha Chamallas, *Questioning the Use of Race-Specific and Gender-Specific Economic Data in Tort Litigation: A Constitutional Argument*, 63 FORDHAM L. REV. 73 (1994) (finding evidence that the tort system's emphasis on economic over non-economic damages enables white men to recover more in tort awards than women and minorities); Lucinda M. Finley, *The Hidden Victims of Tort Reform: Women, Children, and the Elderly*, 53 EMORY L.J. 1263 (2004) (concluding that elderly plaintiffs and young children rely disproportionately on non-economic damages and would be adversely affected by certain tort reforms).

the event of injury.¹⁸⁸ Disparities of this kind, if they exist, would add physical injury to financial insult, providing yet another basis for questioning the welfare effects of the tort system on those lower on the income scale.

Finally, past and present moves to cap the amount of non-economic damages that an individual plaintiff may recover seem likely—indeed, seem intended—to further reduce the prospects that injured patients with relatively less lost income will find lawyers willing to take their cases. Indeed, it would seem fairer to lower-income premium payers for a legislature to cap *economic* damages, expecting those at risk for greater income losses to protect themselves by purchasing life and disability insurance. In addition to causing compensation funds to be distributed more fairly, such a cap would help to equalize providers' incentive to exercise care in treating all patients rather than encouraging treatment disparities based on an income-correlated disparity in access to the tort system.¹⁸⁹ In any event, capping non-economic damages seems likely to make the malpractice system even more regressive than it already is. By the same token, addressing the medical malpractice system's regressive features would reduce both monetary and non-monetary injustices, bringing more fairness both to the distribution of compensation and the distribution of medical mistakes. At the very least, this discussion has identified another series of important questions in need of more examination and research.

V

CONCLUSIONS, WITH POLICY IMPLICATIONS

Some readers may think that, in purporting to discern unfairness in the form of “distributive injustice” in American health care, we have entered the domain of philosophy and must prove, rather than simply assume, that one particular distribution of wealth is definitively less just than another.¹⁹⁰ But there should be little disagreement, philosophical or otherwise, with the two main premises of this article: (1) that the burden of paying for public goods such as health care for the uninsured, medical education, and pharmaceutical research should not fall disproportionately on those with less ability to pay and (2) that persons with lower incomes should not be compelled to pay, as part of the price of having

188. See text accompanying *supra* notes 109–11.

189. No court, it appears, has ever been asked to consider whether a statutory cap on non-economic damages denies equal protection—or its equivalent under a state constitution—to lower-income citizens. See Kelly & Mello, *supra* note 183, at 521–23 (outlining arguments accepted and rejected in state litigation). The usual equal-protection objection to damage caps—that they particularly disadvantage the most seriously injured victims—is hardly credible, one would think, when, *ex ante*, all consumer-patients are similarly situated. On similarly close analysis, however, there would seem to be merit in the argument that caps disproportionately affect lower-income persons and are particularly unfair to those who, having purchased standard health coverage, have reason to expect that a legislature will not deny them equal value for their money.

190. *But see* JOHN RAWLS, A THEORY OF JUSTICE (1971) (purporting to prove logically, by reasoning behind a “veil of ignorance,” that economic inequality can be justified only as a necessary side effect of an incentive system beneficial to the least advantaged). As noted *supra* note 18, economists' work on distributional effects is generally descriptive rather than judgmental.

any health insurance at all, either for coverage designed by and for elite interests or for health care that is consumed disproportionately by the well-to-do. This article has observed many ways in which, under these premises, the U.S. health care system unfairly exploits ordinary payers of health insurance premiums.

To be sure, the health care system's unfairness also extends to those whom the high cost of health coverage has priced out of the insurance market altogether. Our analysis suggests, however, that lower-income premium payers deserve equivalent sympathy. The uninsured, after all, are generally not the poorest of the poor, and many of them are, in varying degrees, uninsured by choice;¹⁹¹ moreover, by virtue of not paying thousands of dollars in health insurance premiums, the uninsured have more money in their pockets to spend on health care and other things, while also being eligible for charitable care or personal bankruptcy in many worst-case scenarios. The overriding fact, however, is that the lower-income insured and the uninsured are both victims of a system that denies them reasonable choices. And, with premiums continuing to rise faster than incomes, many of today's insured will be among the uninsured tomorrow. Unfortunately, current sympathies focus disproportionately on the uninsured and clamor only for expansions in coverage when concern should also extend to premium payers and the causes of excessive costs that victimize both groups. Although in the last analysis the plight of the uninsured and the plight of the lower- and middle-income insured are two sides of the same coin, this article has emphasized the cumulatively large and seriously unfair financial burdens the U.S. health system imposes on working people having private coverage, arguing that these burdens merit far more attention than they have been given by researchers and policymakers alike.

A. Impositions on Working Families

In essence, the U.S. health care system causes payers of health insurance premiums to bear two kinds of excessive costs without their knowledge or consent—except insofar as the decision to insure at all can be deemed voluntary. First, they pay excessive prices for many goods and services, mostly because U.S.-style health insurance makes it relatively easy for sellers of insured services or products to exploit dominant market positions. Indeed, health-sector monopolists are able to charge prices much higher than an equivalent monopolist could charge in the absence of such insurance and thus to capture substantially more of (and possibly even more than) the surplus that consumers would enjoy in purchasing at the competitive price. As earlier discussion showed, the enhanced redistributive effects of monopoly in the health sector would be objectionable even if hospitals and other providers spent all their monopoly profits in socially worthwhile ways and even if the prospect

191. See Barak D. Richman, *Behavioral Economics and Health Policy: Understanding Medicaid's Failure*, 90 CORNELL L. REV. 705, 715 (2005) (concluding that "for [certain] individuals, insurance status is a choice variable much more than an unavoidable consequence of poverty").

of monopoly returns stimulated only socially worthwhile innovative activity; that wasteful spending is also induced only adds additional insult to the injury. In our view, the high costs of meeting the health care system's alleged needs should not fall like a (regressive) head tax on the subset of the working population that bears the costs of private health insurance.

Although it is difficult to quantify the total burden that falls on U.S. premium payers because their health insurers facilitate the exercise of providers' and suppliers' market power, Gerard Anderson, Uwe Reinhardt, and coauthors have suggested that the very large excess of per-capita health care spending in the United States over similar spending in other countries (totaling more than a half trillion dollars per year¹⁹²) "is mostly attributable to higher prices of goods and services."¹⁹³ A more direct estimate of the "tax" burden that consumers must bear for the privilege of being insured would begin by identifying hospitals' "community service" costs, a large part of which they cover from surpluses earned at the expense of private insurers. These costs have been roughly estimated to be "as much as \$80–95 billion a year (in 2003), or a little more than 15 percent of the total economic activity of this \$500 billion industry";¹⁹⁴ even after taking account of state and federal subventions to cover such costs, the burden on premium payers remains substantial.¹⁹⁵ Another, more problematic, factor in the total "tax" on premium payers is the inflated prices paid by U.S. health insurers for some prescription drugs and medical devices.¹⁹⁶ Although monopoly profits yielded by such prices serve to motivate and finance future innovation, the burden on premium payers may substantially exceed any resulting benefits they can expect to enjoy.

The second way in which lower- and middle-income premium payers overpay for health care in the United States is by being forced to buy more of it, or better quality, than they can reasonably afford. A variety of regulatory and legal requirements incorporating high minimum standards developed and favored by industry interests—and supported without question by elite policy advocates and higher-income consumer-voters—foreclose many low-cost options. In addition, the almost universal convention of covering any medical service that qualifies as "medically necessary"—a professional standard that

192. See *supra* note 8.

193. Anderson et al., *supra* note 13, at 90. To be sure, these authors compare U.S. prices only with prices that are depressed in some measure by government-sponsored monopsony power, not with competitive prices equal to marginal cost. Moreover, some of the higher charges in the U.S. may be borne—not altogether fairly, see *supra* note 1—by taxpayers rather than by premium payers as such. Nevertheless, these authors' observation of substantially higher prices in the U.S. system strongly supports our concern about the redistributive effects of U.S.-style health insurance.

194. Vladeck, *supra* note 36, at 41.

195. See *supra* notes 36–38 & 47–48 and accompanying text.

196. For data on the significant extent to which U.S. prices for brand-name pharmaceuticals exceed prices in other OECD nations (except Japan), see Patricia M. Danzon & Michael F. Furukawa, *Prices and Availability of Pharmaceuticals: Evidence from Nine Countries*, 2003 HEALTH AFF. (WEB EXCLUSIVES) W3-521 (also noting that generic drug competition, when patents do not preclude it, is generally stronger in the U.S. than in other countries). See also *supra* note 27.

takes virtually no account of benefit-cost ratios—prevents consumers wanting health insurance from buying low-cost versions of it. Finally, the legal system's propensity to appraise health insurance contracts and their consequences *ex post* rather than *ex ante* effectively precludes consumers from minimizing the consequences of moral hazard by agreeing in advance to unconventional restrictions on their freedom to dip into common premium pools. Although there is no sure basis for estimating the actual gap between the cost and quality of health care that today's consumers enjoy and the choices they would make if a full menu of choices were available,¹⁹⁷ the unfairness of limiting their choices should be apparent from the high proportion of their family incomes that most consumers must spend if they are to have any health coverage at all.¹⁹⁸ Essentially, the median family faces a Hobson's choice: either to pay a significant fraction of its total income for standard health coverage¹⁹⁹ or take its chances with the safety net.

Consumption patterns also suggest regressivity in the U.S. system because lower-income premium payers appear to get less out of their health plans than do higher-income persons paying the same premiums. Part III presented our hypothesis that lower-income insureds are systematically subsidizing the health care of their higher-income coworkers because the latter are in a better position to meet cost-sharing requirements and otherwise take maximum advantage of the available coverage. Although our reasons for suspecting that equal nominal benefits do not equate to equal value for equal outlays are quite plausible, evidence to establish this particular unfairness remains to be collected. Confirmation of our suspicions on this point is not necessary, however, to establish our broad claim that U.S.-style private health insurance has seriously regressive effects on premium payers below the high end of the income spectrum.

Most of the defects in U.S. health insurance that produce the consumer burdens noted here flow both directly and indirectly from the way the nation subsidizes the purchase of health coverage through the tax system. Unlike most

197. Anderson et al., *supra* note 13, provide evidence that, even as the United States spends far more than other nations on health care, the rates at which Americans consume many important health services are generally no higher than in several other countries. Although these authors suggest that their data shows that overutilization is not a serious problem in the United States, evidence on national averages is not helpful in answering the question whether some Americans whose private insurance enables them to consume more and better than average health care are in fact buying more of it than is good for them in welfare terms. See *supra* text accompanying notes 79 & 80.

198. Antitrust law treats so-called tying arrangements as unlawful when used by a seller of a unique and valuable product to force consumers desiring it to purchase an additional, perhaps unwanted good. See, e.g., *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 12 (1984) (deeming a hospital's maternity and anesthesia services to be separate products that, if bundled, might be subject to antitrust law's prohibition on tying and stating that "the essential characteristic of an invalid tying arrangement lies in the seller's exploitation of its control over the tying product to force the buyer into the purchase of a tied product that the buyer either did not want at all, or might have preferred to purchase elsewhere on different terms"). Antitrust doctrine thus supports our view that consumers wanting basic health coverage should not also have to pay for unnecessary bells and costly whistles.

199. See *supra* note 11 and accompanying text.

other commentators on the tax subsidy, we have emphasized how, by fostering employer purchasing, the subsidy systematically hides the true cost of health coverage from those who ultimately pay it, thus not only distorting market choices—there is implausibly little discernible demand for radically low-cost health coverage²⁰⁰—but also enabling the political system to make regulatory and other policy with virtually no regard for the costs imposed on consumer-voters. The net result is a U.S. marketplace in which consumers are effectively denied important opportunities to economize in purchasing health care. On the other hand, if public policy encouraged (and allowed) middle- and lower-income premium payers to economize in reasonable ways, the great majority of them would be able to substantially improve their welfare, both by reducing their support of the larger health care enterprise (through involuntary indirect payments to providers possessing market power) and by agreeing to reasonable limits on their own access to costly, marginally valuable care. Not only would freedom to economize enable ordinary insured consumers to make their incomes, increasingly lagging behind the affluent classes, go further, but it would also put the cost of health insurance back within reach of many of the uninsured. It would also reduce the cost to government of reducing the ranks of the uninsured still further with new public subsidies.²⁰¹

B. The Indifference of Elite Interests

We anticipate great difficulty in persuading stakeholders in the American health care industry to share our concern that the health system is imposing a huge, unjustified cost burden on ordinary premium payers and payroll-tax payers.²⁰² Although provider interests regularly profess distress over the plight of the uninsured, we suspect that many of them are troubled at least as much by the failure of uninsured Americans to contribute their share of the health care system's finances as by their reduced access to care. As to the burden on those who do pay premiums, the health care industry and its allies usually acknowledge only that the industry has a duty to act responsibly in incurring

200. Occasional experiments with “barebones” coverage have found few takers for it. See MARK A. HALL, *REFORMING PRIVATE HEALTH INSURANCE* 57 (1994); FAMILIES USA, *NO SALE: THE FAILURE OF BAREBONES INSURANCE* (1993). The apparent explanations are several. One of these is the difficulty that employers would face in offering potentially controversial coverage to workers who do not see the trade-off with their take-home pay. Second, low-cost options must compete with the safety net, which, though deficient in many respects, carries no up-front price tag at all. Third, “barebones” offerings, such as they were, were designed with most of the usual legal and conventional constraints intact. Thus, even when a state waived some mandates with respect to benefits, the effect was only to allow some additional categorical exclusions; “medical necessity” continued to govern basic coverage, and providers, partly because of legal compulsions, continued to practice in their usual costly ways. See Havighurst, *How the Revolution Fell Short*, *supra* note 24, at 71 (“Unless and until a critical mass of employers offer benefits in forms that invite real economizing at the core of clinical practice, consumers whose welfare would be enhanced by purchasing revolutionary low-cost coverage will find no health plans offering it.”).

201. See *supra* note 75.

202. See *supra* note 99 and accompanying text.

costs—by practicing only “evidence-based” medicine, for example.²⁰³ Otherwise, industry leaders appear to take comfort in the belief that insured Americans have access to the world’s best health care and to focus their attention on improving quality²⁰⁴ and reducing racial and class disparities in the way care is delivered.²⁰⁵ Although such efforts to justify the public’s trust may be praiseworthy, *noblesse oblige* is not the answer to the large and regressive redistribution of wealth wrought by today’s health system.²⁰⁶

Whereas industry stakeholders’ disinterest in distributional concerns is understandable, it is harder to explain why so few of the industry’s progressive critics have ever questioned the large amounts of money taken disproportionately from ordinary working people to support the health care system.²⁰⁷ To be sure, the high cost of health care in the United States is a matter of frequent comment and concern, and for-profit enterprises regularly draw populist fire. But the unfair degree to which high health care costs are paid unknowingly by lower- and middle-income premium payers is almost never observed as the specific injustice it is. Instead, progressive complaints about unfairness in U.S. health care focus almost exclusively on government’s refusal to spend more on the poor and the uninsured and on socioeconomic inequalities in health status and treatment patterns. But those who urge coverage of the uninsured ought to appreciate that many who lack health coverage are uninsured more or less by choice and that their decisions to go bare are a direct reflection of the unfair cost burdens against which this article protests. Similarly, those who support legal and regulatory moves to equalize entitlements and to narrow treatment disparities should be careful that they, too, are not simply advancing the health care industry’s interest in spending ever more money at the expense of working people.

Both industry stakeholders and progressive critics may discount consumers’ cost burdens because they assume that all consumers attach the same high value to the right to spend freely on costly health care as the elite classes themselves. But the truest tests of preferences generally come in markets in which people

203. See, e.g., David M. Eddy, *Evidence-Based Medicine: A Unified Approach*, 24 HEALTH AFF. 9 (2005) (summarizing industry reactions over time to revelations of widespread, unexplained variations in medical practice and of shortcomings in the way clinical policies are developed and implemented). The cited article appears in a symposium showing the field’s current efforts and mixed success in improving medical decisionmaking. Symposium, *Putting Evidence into Practice*, 24 HEALTH AFF. 7 (2005).

204. See Symposium, *The Quality Conundrum*, HEALTH AFF., July–Aug. 2002, at 12.

205. See Symposium, *supra* note 111.

206. Although the various activities reviewed in the cited symposia, *supra* notes 203–205, illustrate how the medical profession and health care industry as a whole regularly respond to revelations of inadequate performance, such efforts to do better, however sincere they may be, are also well calculated to maintain the profession’s and the industry’s elite status and to head off radical, exogenous reforms that would introduce real accountability to either government or consumers in the marketplace.

207. For a recent example of how even thoughtful commentators focus single-mindedly on how fairly health services are distributed while neglecting to consider where the cost burden falls, see POWERS & FADEN, *supra* note 86.

with limited resources must choose among many desirable things, each with its own price tag.²⁰⁸ In health care markets today, the sobering reality is that more and more consumers are revealing a preference far different from the one imputed to them by elite interests—by dropping health coverage altogether. Indeed, the force of our observation that U.S. health policy is unfairly designed and operated by and for elite interests, though powerful in itself, is significantly amplified by the income-elasticity of consumer demand for health care.²⁰⁹ Precisely because ordinary consumers necessarily attach relatively less value to the added services and better quality they may enjoy by virtue of good, egalitarian intentions expressed in legal mandates and industry standards of practice, a health care system tailored to the values, preferences, and resources of higher-income consumers does a *special* disservice to those who would prefer to spend less. This observation multiplies the significance of everything we have said in this article about how the divergence of the interests of lower-income and high-income consumers results in unfairness to the former in both the marketplace and the political process.

In our view, the cumulative inequity that results from the many discrete unfairnesses we have observed in this article should be the dominant concern of health policymakers today, to be addressed either before or in conjunction with the problems of the uninsured and disadvantaged. Those who dispute this priority need to say exactly why. We doubt that maintaining egalitarian appearances alone, however morally satisfying to some, can excuse the injustices we see.

C. Implications for the Policy Debate

The ability of the U.S. health care system to finance itself by loading ever-higher costs on unsuspecting premium payers may finally be reaching its high-water mark. Most of the resistance to paying higher costs will probably not come, however, from insurers finally acting as consumers' cost-conscious agents and refusing to pay health-sector monopolists' extraordinarily high prices or to cover every health service that medical experts will not declare medically unnecessary. Nor will consumers spending their own money with the backing of health savings accounts be a major force in curbing rising costs. Instead, the nation may be nearing a point at which continuing to raise health insurance premiums faster than consumers' incomes grow will actually generate less, not more, revenue for the industry because of the rate at which employers or consumers drop health coverage altogether.²¹⁰ If this point is finally reached, the

208. To be sure, consumers are generally ill-informed and cognitively challenged, and their preferences, as expressed in either market or political choices, are often incoherent. *See supra* note 181. But these circumstances do not automatically qualify elites, with interests of their own as well as different values, to make choices on their behalf.

209. *See supra* note 101.

210. *See* Todd Gilmer & Richard Kronick, *It's the Premiums, Stupid: Projections of the Uninsured through 2013*, 2005 HEALTH AFF. (WEB EXCLUSIVES) W5-143 (predicting very substantial increases in number of uninsured as cost increases continue to outpace increases in personal income). Once they

nation would confront a far greater health care “crisis” than any previously declared, because burgeoning health care budgets could no longer be balanced on the backs of the working population.²¹¹

The day of reckoning in U.S. health policy could be hastened if populist politicians (liberal or conservative, as the case may be) would tell consumer-voters the truth about the extortion-like protection scheme being practiced on them by the health care system—which essentially forces them to choose between paying what the system demands and putting their families’ health in danger. This unpleasant truth has heretofore been kept from consumer-voters for complex reasons. Certainly, politicians have reason to fear that voters would react badly if asked to think of health care as an economic good which they, rather than someone else, must pay for and make choices about. Nevertheless, once the health care industry and the political system no longer have the luxury of seeing rising costs passed on to unresisting premium payers, some members of the political class might begin to see a partisan advantage in appealing to the large subset of consumer-voters that the system has exploited so successfully for so long. Indeed, this article’s greatest contribution to the health policy debate may be to translate arcane, seemingly technical concerns about moral hazard and the misallocation of resources into more human terms that stand some chance of arousing the body politic. Allocative inefficiency naturally provides a poor rallying cry for health reform, to such an extent that even health economists rarely express concern about it in health policy discussions;²¹² instead, one finds mostly articles discussing whether *rising* costs

become uninsured, of course, patients are much less likely to pay providers’ bills, as the increasing number of bankruptcies caused by health-care-related liabilities reveals. *See supra* note 51.

211. *See* Altman et al., *supra* note 34 (predicting economic instability for hospitals as demands for uncompensated care grow and revenue sources dry up). Other articles in the same symposium make similar predictions. *E.g.*, Dobson et al., *supra* note 40, at 30 (“This secular trend in combination with technology-driven health care cost increases has the potential to destabilize the U.S. health care financing system to the extent that low-wage (if not median-wage) workers will no longer be able to afford health care coverage.”); Vladeck, *supra* note 36 (noting potential for a “death spiral”).

212. There are other reasons, to be sure, why economists are slow to assert that resources are being under- or over-allocated to a particular sector of the economy. For one thing, demand curves, while useful in theory, are a poor indicator of social welfare in markets for merit goods—which, by definition, should not be distributed solely on the basis of ability and willingness to pay. *See* Reinhardt, *supra* note 154, at 978–90 (noting the questionable social implications of relying exclusively on willingness-to-pay criteria, which demand curves incorporate, and of employing so-called Kaldor-Hicks cost-benefit criteria to evaluate welfare effects in health care markets). Another reason why allocative efficiency is problematic for economists is the so-called “problem of second best.” *See generally* F.M. SCHERER & DAVID ROSS, *INDUSTRIAL MARKET STRUCTURE AND ECONOMIC PERFORMANCE* 38 (3d ed. 1990) (“[O]ne might conclude that the whole question of allocative efficiency is so confused and uncertain, once second-best considerations are introduced, that policy-makers would be well advised to give up trying to achieve the best possible allocation of resources.”); Havighurst, *How the Revolution Fell Short*, *supra* note 24, at 80–81 (suggesting that, despite its force in weakening confidence that competition is always allocatively efficient, “second-best theorizing” should magnify, not diminish, concern that the nation is allocating excessive resources to underpriced health care). Despite the reasonableness of economists’ hesitancy about relying on economic theory, however, this Article has shown that health insurance, especially as we know it in the United States, creates a situation with serious misallocative tendencies. *But see supra* note 68 (“Whatever its magnitude, inefficiency that is

are affordable by society, are worth worrying about, or require government intervention.²¹³ In our view, however, a responsible reform movement might gain political traction if middle-class consumers were given some sense of how much they are paying to support a health care industry essentially unaccountable for its cost-increasing actions.²¹⁴

Although this article has made our general policy preferences reasonably clear, it takes no firm position on the particular health policy that should replace the one we criticize for giving ordinary premium payers a horrendously bad deal while also serving inadequately those without any insurance protection. Indeed, we would not object if our observation of the major burdens imposed on consumers by private health insurance were cited as a reason to adopt a monolithic national health program, scrapping private health insurance altogether (except insofar as it might supplement the national system's coverage). We hope, however, that populists and progressives invoking our concerns in such a cause will not simply claim that that market-oriented policies have proved unworkable and that big government is therefore needed to do the job. We have, after all, stressed that it is not private insurance as such but "U.S.-style" health insurance and government policy itself that generate the problems that concern us. Moreover, we have some confidence that, with altered subsidies and incentives for consumers, some deregulation of insurers and providers, substantial redesign of insurance products, and some tweaking at a few other points, the market would soon evolve so as generally to give consumers, in actuarial terms, both no more and no less than they choose, with limited public subsidies, to pay for. All we ask here, however, is a fair hearing for proposals to let consumers, with as much financial and other help as public institutions and private agents can give them, choose more or less freely the style of health care they want to purchase for their families.

Of course, no public policy (and no market) can be perfect, and much might be said against as well as in favor of our preferred strategy.²¹⁵ We are not overly

already embedded in the economy is simply never going to be viewed as a problem by the political class.").

213. *E.g.*, Michael E. Chernew, *Increased Spending on Health Care: How Much Can the United States Afford?*, HEALTH AFF., July–Aug. 2003, at 15; Henry J. Aaron, *Should Public Policy Seek to Control the Growth of Health Care Spending?*, 2003 HEALTH AFF. (WEB EXCLUSIVES) W3-28; Mark V. Pauly, *Should We Be Worried About High Real Medical Spending Growth in the United States?*, 2003 HEALTH AFF. (WEB EXCLUSIVES) W3-15. The Pauly article, however, does address concerns similar to ours. *See also* Pauly, *supra* note 24. On the importance of focusing on marginal, rather than the more politically potent aggregate, benefits of health care spending in appraising allocative efficiency, see *supra* note 68.

214. For reasons why any such hope may be unrealistic, see David A. Hyman, *Getting the Haves to Come out Behind: Fixing the Distributive Injustices of American Health Care*, 69 LAW & CONTEMP. PROBS. 265, 273–82 (Autumn 2006).

215. Some health economists, for example, like to emphasize the limitations of both economic theory and markets in general and to criticize advocates of market-oriented policies for having simplistic, theory-driven views. *E.g.*, THOMAS RICE, *THE ECONOMICS OF HEALTH RECONSIDERED* (2d ed. 2003); Reinhardt, *supra* note 154. Yet to argue, as so many non-economists also do, that markets should not be trusted simply because they do not satisfy the rigorous conditions necessary to achieve Pareto optimality is also to use the unrealistic textbook model as the benchmark for a policy

concerned, however, as so many purport to be, that consumers might have to make market choices in some ignorance, both of their future health needs and of health plans' or providers' characteristics. It would be seriously destructive of insurance markets, after all, if consumers knew too well what their future health needs would be; indeed, the risk of adverse selection makes it actually preferable that they purchase behind a veil of ignorance about such matters and not be free to upgrade their coverage when a serious need arises. As for other informational difficulties that consumers face, we anticipate that they could be significantly ameliorated by limited regulation defining new contract terms, by comparative information available from private and public sources, and by consumers' continued reliance on purchasing agents (including employers in purchasing health plans and health plans in purchasing services). The potential benefits of a policy based on the principles of managed competition²¹⁶ seem to us to be great and uncontroversial enough that responsible policymakers of different ideological persuasions should be able to find common ground on which to build bipartisan reform.²¹⁷ Although highly threatening to special interests, such a policy would not be radical in itself but would instead, we think, be entirely in keeping with American values.

It is highly possible, of course, that influential members of the body politic will never be permanently comfortable in the presence of explicit, income-correlated disparities in insured individuals' legal entitlements to medical care—even if those inequalities result from reasonable choices by consumers, spending not just their own limited resources but also whatever earmarked subsidies democratic legislatures choose to provide. For some observers (apparently), the symbolic significance of any such disparities will always trump efficiency and welfare concerns, overriding respect not only for private choices

prescription. In fact, real-world markets do many things quite well despite their limitations, particularly in comparison with real-world government. Moreover, government can improve the market's performance by such measures as providing information, strictly policing fraud, and enforcing private contracts and the antitrust laws. Ideally, health policy debates should focus on such practical, rather than ideological, considerations. *See supra* note 181.

216. This model, which features menus of health-plan options maintained and explained to consumers by employers or other "sponsors," has been described most helpfully by its principal architect, Alain Enthoven. *See generally* ALAIN C. ENTHOVEN, *THEORY AND PRACTICE OF MANAGED COMPETITION IN HEALTH CARE FINANCE* (1988) (outlining the structure of a system of managed competition based on the principle that "cost-conscious consumer choice is necessary to create incentives for people to develop and demonstrate less costly alternative ways of organizing medical care of acceptable quality"); Alain C. Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy*, 320 *NEW ENG. J. MED.* pt. 1, at 29 & pt. 2, at 94 (1989).

217. *See supra* note 131, recalling the Clinton administration's proposed Health Security Act, which was based, ostensibly at least, on the managed-competition model and might have had a better chance of enactment had it been truer to that model. An easy way to ensure near-universal participation might be to offer a substantial, refundable tax credit to those who could demonstrate that they (or their employer) had spent at least that much on acceptable health coverage; then, anyone going uninsured would, by forgoing the tax credit, be effectively financing his share of the safety net (perhaps a residual public financing program) rather than free-riding on the health system's charitable impulses and capacity.

but also for government's legitimately established budgetary priorities.²¹⁸ Faced with such inequalities, legislators wanting popular credit for good intentions may continue to enact quality- and access-enhancing measures for which consumers, mostly, must pay, and the legal system may too often be tempted to discover and vindicate individual rights without concern for costs or due recognition of the legitimacy of other decisionmaking mechanisms, private or public. If such cost-increasing, destabilizing forces seem too likely to frustrate a sound market-based reform strategy, it may be necessary to embrace a second-best alternative,²¹⁹ perhaps a government-defined, government-financed basic entitlement with consumers able to supplement that coverage as they see fit. In any event, we hope that our observation of the serious unfairness of the burdens that the current system imposes on the majority of consumer-voters will help both to inflame and to enlighten a political debate leading to a more responsible national health policy—whatever that policy may turn out to be. The crucial thing is to find a fairer way to distribute the costs of health care.²²⁰ Other nations, it seems, have more or less arranged their health care systems so that those who want more or better care than is deemed suitable for the median citizen must pay more for it. The United States, on the other hand, has structured things so that lower- and middle-income premium payers bear heavy burdens so that elite interests can continue to provide or enjoy, as the case may be, the style of health care that best satisfies their needs. This is the situation that needs to be corrected.

218. Perhaps what we have witnessed in the last thirty years, and what is in store for the indefinite future, is a continuous playing out of the cycle that Guido Calabresi and Philip Bobbitt observed some years ago in public policies affecting so-called “tragic choices.” See GUIDO CALABRESI & PHILIP BOBBITT, *TRAGIC CHOICES* (1978). Their insight was that there are some situations (tragic choices) in which, even though economic efficiency may clearly dictate that unlucky individuals should bear some serious hardships rather than having them prevented or alleviated by public action, our political and legal institutions cannot, and will not, indefinitely accept such apparently avoidable tragedies. Instead, they predicted, public policy in such cases is destined to evolve endlessly in cycles, emphasizing at each stage some value—efficiency, compassion, fairness, or openness, for example—that previous policy had neglected. Under the Calabresi–Bobbitt hypothesis, it may be that seriously consequential choices about health care can never be permanently removed from the public agenda and placed finally (even with public subsidies) in private hands. On the other hand, there are other factors, including the tax subsidy, special-interest politics, and the peculiar division of policymaking responsibilities among federal and state legislatures and courts, that may account for the nation's failure, over many years, to put a coherent health policy permanently in place. Our hope is that this long-standing gridlock can be broken by publicizing the serious unfairnesses of the present system.

219. For the observation that a system based on private financing may not justify its high administrative and other costs unless it enables consumers to make consequential, welfare-enhancing choices, see Havighurst, *supra* note 12. Because the costs of a private system include those associated with legal and political uncertainties, it may be simply impossible for the American polity to adopt successfully and for all time the policy that strikes us not only as the ideal one but also as the one best suited for the diverse American people.

220. Given our emphasis on distributional issues, it is relevant to ask how a new public financing program, whatever its form, would be financed. The options include increasing progressive rates under the income tax, a flat tax on payrolls or total income, and a consumption tax. Although any of these would be fairer than the methods by which the health care industry currently finances the production of many public goods, a recent proposal by Victor Fuchs and Ezekial Emanuel sounds especially fair to us. Ezekial J. Emanuel & Victor R. Fuchs, *Health Care Vouchers—A Proposal for Universal Coverage*, 352 *NEW ENG. J. MED.* 1255 (2005) (suggesting value-added tax as revenue source).

Finally, we acknowledge that some of our observations of unfairness in U.S. health care, although seemingly well grounded in theory and observation, lack as much empirical confirmation as responsible observers might like to see. Although we doubt that further research could significantly weaken the case we have made against the current system's unjust impositions on premium-paying American workers, we conclude by inviting health services researchers to pursue the extensive agenda for new investigations that this article provides.