GETTING THE HAVES TO COME OUT BEHIND: FIXING THE DISTRIBUTIVE INJUSTICES OF AMERICAN HEALTH CARE

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> When government does, occasionally, work, it works in an elitist fashion. That is, government is most easily manipulated by people who have money and power already. This is why government benefits usually go to people who don't need benefits from government. Government may make some environmental improvements, but these will be improvements for rich bird-watchers. And no one in government will remember that when poor people go bird-watching they do it at Kentucky Fried Chicken.[1]

I

INTRODUCTION

It is unusual to find the words "social justice" in an article written by market-oriented policy scholars (MOPS) and startling to find those words in the first paragraph of that article.[2] MOPS generally use words like "efficiency" and "liberty," and spend most of their time cataloging the virtues of the invisible hand. "Social justice" is historically the province of the collectivist-oriented policy scholars (COPS), the political and ideological opposites of MOPS. COPS generally use words like "fairness" and "equality," and spend most of their time trying to deploy the visible hand (and invisible foot) of government.[3]

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1. P.J. O'ROURKE, ALL THE TROUBLE IN THE WORLD: THE LIGHTER SIDE OF FAMINE, PESTILENCE, DESTRUCTION AND DEATH 199 (1994).

2. Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care,* 69 LAW. & CONTEMP. PROBS. 7, 9 (Autumn 2006). Although Professor Havighurst is clearly a MOPS, it is less clear whether Professor Richman is one as well. In response to my inquiry, Professor Richman authorized me to refer to him as a pragmatic political economist (E-mails from Barak D. Richman to author (April 2, 2006) (on file with the author)), which I unilaterally changed to pragmatically oriented policy scholar (POPS). However, their article is co-authored, and it is sufficiently awkward to use a separate acronym for Professor Richman that I have decided to treat Professor Richman as a MOPS for purposes of this article. Professor Richman might not want to be labeled a MOPS, but I doubt he would think it was an improvement if this article referred to Havighurst and Richman as "MOPS and POPS." So, MOPS it is.

3. *See* David A. Hyman, *Medicine in the New Millennium: A Self-Help Guide for the Perplexed,* 26 Am. J. L. & Med. 143, 151 n. 38 (2000) [hereinafter Hyman, *Self-Help*] (quoting Dick Armey: "While the concept of the invisible hand of the marketplace is well-understood (if too often ignored), we also need to recognize and accept the visible foot of the market, which plays a necessary role in eliminating inefficient industries. Even more important, we must understand that there is an invisible foot of the

This market division between MOPS and COPS was neither inevitable nor desirable. Adam Smith may be the father of modern economics, but he held a chair in moral philosophy at the University of Glasgow. Smith's first book was titled *The Theory of Moral Sentiments*,[4] and he did not publish *The Wealth of Nations* until seventeen years later.[5] More recently, both Milton Friedman and Walter Williams have argued that the real comparative advantage of markets is not their efficiency and wealth-creation, but their promotion of individual autonomy and freedom.[6] Larry Summers has similarly suggested that "properly functioning markets are the best way to organize human activity" and "advocates of market-based solutions have nothing to concede at the moral level."[7]

Havighurst and Richman's brief against our current health-care system bridges this long-standing gap and offers an explicitly normative MOPS perspective on American health policy. However, their rhetoric goes well beyond the garden-variety normative into what can only be described as white-hot rhetorical territory: industry and other elites "manipulate people's thinking" and the system is "rigged against the true interests of the political majority."[8] This "systematic exploitation of the majority by affluent minorities"[9] is both an "injustice" of "breathtaking magnitude"[10] and an "extortion-like protection scheme."[11] The rhetoric is so inflammatory, I expected Havighurst and Richman to offer "Old Testament Wrath of God-type" remedies as the necessary corrective to the injustices they identify.[12]

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government too, which generally does unnecessary damage even as the visible hand of the government seems to do good.").

4. ADAM SMITH, THE THEORY OF MORAL SENTIMENTS 1 (D.D. Raphael & A.L. Macfie eds., Clerdon Press 1976) (1759).

5. The full title is AN INQUIRY INTO THE NATURE AND CAUSES OF THE WEALTH OF NATIONS (Edwin Cannen, ed., Modern Library 1994) (1776).

6. MILTON FRIEDMAN, CAPITALISM AND FREEDOM (2002); Walter E. Williams, *The Argument for Free Markets: Morality vs. Efficiency,* 15 CATO J. 179 (Fall/Winter 1996), *available at* http://www.cato.org/ pubs/journal/cj15n2-3/cj15n2-3-3.pdf.

7. Lawrence H. Summers, President, Harvard Univ., Remarks at Resources for the Future's 50th Anniversary Symposium and Gala Dinner: Governance and Global Markets (Oct. 15, 2002), http://www.president.harvard.edu/speeches/2002/global.html. President Summers went on to argue,

> There is a tendency for these debates to be framed as the practical, hardheaded, slightly amoral market advocate versus the moral, but, perhaps, wishy-washy advocates of a better world. I don't think there is anything morally attractive about telling people who chose to take jobs working for $1.25 a day that they can't have them because we don't want to buy the fruits of their labor, leaving them with the inferior alternatives that result. . . . [T]o say that the establishment of market institutions is complex and needs to be done with enormous care is not to suggest that there is any moral superiority to discretionary non-market means of regulation or allocation of resources. *Id.*

8. Havighurst & Richman, *supra* note 2, at 10.

9. *Id.* at 56.

10. *Id.* at 54 n.136.

11. *Id.* at 78.

12. *See* GHOSTBUSTERS (Columbia Pictures 1984).

Venkman: [T]his city is headed for a disaster of biblical proportions.

Mayor: What do you mean, biblical?

They don't. Indeed, Havighurst and Richman do not say much of anything about concrete reforms they want enacted, except by negative implication from the market failures they identify. Worse still, Havighurst and Richman say nothing at all about how to get there from here. Both are important failings. As Professor Ted Marmor has aptly observed, "the expected value of a policy option is . . . its idealized results times the likelihood of achieving them."[13] Havighurst and Richman have plenty of company in ignoring the ways and means of policy, but even if they are right in every detail of their bill of particulars, their indictment is not going to have the intended effects (or, dare one say it, any effect whatsoever) without a concrete plan for implementation.

Accordingly, this article offers a "how to" guide for those interested in moving from diagnosis to treatment. Part II briefly recapitulates Havighurst and Richman's analysis. Part III offers tactics and logistics for implementing the policy reforms that one might pursue based on Havighurst and Richman's diagnosis. Part IV briefly addresses whether government or the private market should be in charge of Havighurst and Richman's brave new world of health policy. Part V concludes.

II

DIAGNOSING THE PROBLEM AND PRESCRIBING THE APPROPRIATE TREATMENT

Havighurst and Richman weigh our current health-care system in the balance and find it wanting.[14] A partial list of their complaints would include the following:

(1) U.S.-style health insurance weakens price elasticity and makes it possible for providers to reap supra-supra competitive profits from their monopoly position.[15]

(2) Providers behave like self-appointed, reverse-Robin Hoods, exploiting the poor and the working–middle classes, and redistributing the resulting wealth and medical resources to the upper-middle class and the wealthy.[16] The result is highly regressive.[17]

Ray: What he means is Old Testament, Mr. Mayor . . . real Wrath-of-God-type stuff. Fire and brimstone coming down from the skies. Rivers and seas boiling!

Egon: Forty years of darkness, earthquakes, volcanos.

Winston: The dead rising from the grave!

Venkman: Human sacrifice, dogs and cats, living together—mass hysteria!

Id.

13. Ted Marmor, Commentary, *Policy Options: A Response to* Justice is Good for Our Health, 25 BOSTON REVIEW 13, 14 (2000), *available at* http://www.bostonreview.net/BR25.1/marmor.html ("[T]here is no reason to treat a theoretical possibility as a compelling policy option unless both the worth of that aim and its implementability dominate the alternatives. . . . The expected value of a policy option is, in short, its idealized results times the likelihood of achieving them.").

14. *See Daniel* 5:27 ("Though art weighed in the balances, and art found wanting") (King James).

15. Havighurst & Richman, *supra* note 2, at 14–20.

16. *Id.* at 11–41.

17. *Id.* at 28–30.

(3) Providers reject efforts to control moral hazards and implement cost benefit trade-offs, resulting in "nothing but the best" health insurance coverage terms and delivery systems.[18] These efforts are greatly aided by the tax subsidy for employment-based health insurance.[19] Unfortunately, "nothing but the best" costs much more than many Americans are willing and able to pay.[20]

(4) The fact that costs are hidden while benefits are immediately evident encourages everyone to demand more and better health care than they would want if they faced the true costs of their decisions.[21]

(5) Low and moderate-income Americans get shortchanged on the delivery side because they are less assertive and die sooner.[22]

(6) Regulation of the health-care sector serves the interests of elites and incumbent providers of services, and not those of consumers.[23]

Havighurst and Richman have performed an important service by exhaustively cataloging the regressive consequences of the current financing, regulatory, and legal framework, and by showing how the system has been rigged to serve the interests of providers and high-income consumers of health-care services. Not at all coincidentally, they have created a list of targets for those interested in fixing these problems. The cumulative effect of their bill of particulars should move even the most jaded of policy analysts, regardless of their position on the political spectrum, to entertain serious doubts about the trajectory of our health care system.

I have considerable sympathy for Havighurst and Richman's public-choice-inspired brief against our current health-care system. Indeed, a considerable portion of my academic career has been devoted to bushwhacking through the same territory, including articles on how the Patient Bill of Rights serves the interests of providers, and not those of consumers;[24] how poor information and

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18. *Id.* at 31–41.

19. *Id.* at 36–39.

20. *Id.* at 13.

21. *Id.* at 37–38.

22. *Id.* at 41–49.

23. *Id.* at 50–71. Obviously, such conduct is not limited to health care, but is a pervasive problem in regulation. *See* Williams, *supra* note 6, at 187 ("Another explanation of low income is that the rules of the game have been rigged. That is, people do have an ability to provide goods and services valued by their fellow man but are restricted from doing so. Among those rules are minimum wage laws, occupational and business licensure laws and regulations, and government-sponsored monopolies. Hence, another argument for free-market capitalism is that it is good for low-income, low-skilled people.")

24. *See* David A. Hyman, Commentary, *What Lessons Should We Learn from Drive-Through Deliveries?*, 107 PEDIATRICS 406, 406–08 (2001) ("The first victim of the managed care backlash was rapid postpartum discharge, more commonly known as 'drive-through delivery.' The issue was framed as a morality play, with corporate greed on one side and the health and safety of mothers and infants on the other."); David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights*, 73 S. CAL. L. REV. 221 (2000) [hereinafter Hyman, *What's Wrong*] (concluding that the patient bill of rights is actually provider protection, instead of consumer protection); David A. Hyman, *Accountable Managed Care: Should We Be Careful What We Wish For?*, 33 U. MICH. J. L. REFORM 785 (1999) [hereinafter Hyman, *Accountable Managed Care*] (analyzing whether creating legal accountability for

inadequate incentives help explain the state of health-care quality;[25] how "bad" anecdotes skew public discourse on the trade-offs that must be made by a sensible health policy;[26] and how well-intentioned regulation of fraud, abuse and capital investment can readily interfere with efficiency-enhancing initiatives.[27] I have also addressed tax subsidies for employment-based health insurance,[28] the merits of the non-profit form for hospitals,[29] physician entrepreneurism,[30] agency

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managed-care organizations is in consumers' interests); David A. Hyman, *Managed Care at the Millennium: Scenes from a Maul*, 24 J. HEALTH POL. POL'Y & L. 1061 (1999) (evaluating the merits of three managed-care reform initiatives (prohibition of gag clauses, mandated access to emergency care, and prohibition on drive-through deliveries)); David A. Hyman, *Drive-Through Deliveries: Is "Consumer Protection" Just What the Doctor Ordered?*, 78 N.C. L. REV. 5, 99 (1999) [hereinafter Hyman, *Drive-Through Deliveries*] (discussing the failure of reform to target the real health-care problems of mothers and babies, and noting that "[o]utrage is cheap, but healthcare is expensive"); David A. Hyman, *Consumer Protection and Managed Care: With Friends Like These . . .*, HEALTH L. HANDBOOK 283, 290–93 (Alice G. Gosfield ed., 1998) (critiquing patient bill of rights initiatives); David A. Hyman, *Consumer Protection in a Managed Care World: Should Consumers Call 911?*, 43 VILL. L. REV. 409 (1998) [hereinafter Hyman, *911*] (noting that "consumer protection" initiatives to ensure access to emergency care will likely compound the problem they were intended to solve).

25. *See* David A. Hyman, *Does Medicare Care About Quality?*, 46 PERSPS. IN BIO. & MED. 55 (Winter 2003) (criticizing Medicare quality-control efforts); David A. Hyman & Charles Silver, *You Get What You Pay for: Result-Based Compensation for Health Care*, 58 WASH. & LEE L. REV. 1427 (2001) [hereinafter Hyman & Silver, *You Get What You Pay For*] (making the case for result-based compensation in health care); David A. Hyman & Charles Silver, *Just What the Patient Ordered: The Case for Result-Based Compensation in Health Care*, 29 J.L. MED. & ETHICS 170, 170–73 (2001) (critiquing the American Medical Association's ethical prohibition on result-based compensation in health care).

26. *See* David A. Hyman, Report from the Field, *Do Good Stories Make for Good Policy?*, 25 J. HEALTH POL. POL'Y & L. 1149, 1154 (2000) (explaining why "narratives provide an inadequate basis for [the] framing and resolution of matters of social policy"); David A. Hyman, *Lies, Damned Lies, and Narrative*, 73 IND. L.J. 797 (1998) (discussing the problems of anecdotal evidence).

27. *See* David A. Hyman, *HIPAA and Health Care Fraud: An Empirical Perspective*, 22 CATO J. 151, 152 (2002) (discussing "what we know, don't know, and know that isn't so about health care fraud, abuse, and fraud control"); *David A. Hyman, Health Care Fraud and Abuse: Market Change, Social Norms, and the Trust "Reposed in the Workmen,"* 30 J. LEGAL STUD. 531, 534 (2001) (assessing the merits of the Medicare and Medicaid fraud control regime, including their "fit" with the medical marketplace). *See also* CATO INSTITUTE, POLICY FORUM: IS AMERICA'S HOSPITAL SECTOR OPEN TO COMPETITION, Mar. 22, 2005, http://www.cato.org/event.php?eventid=1881 (presenting a panel discussion on "the nature of 'free' versus 'fair' competition among hospitals, and what solutions exist that allow for both full-service and single-specialty hospitals"). The efficiency-dampening problems of regulatory intervention are worsened when the regulatory apparatus is hijacked by incumbent providers for use against their actual and incipient competitors.

28. *See* David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23 (2001) (assessing the existing employment-based health insurance market from a comparative institutional perspective).

29. *See* David A. Hyman & William Sage, *Subsidizing Health Care Providers Through the Tax Code: Status or Conduct?*, 25 HEALTH AFF. (WEB EXCLUSIVES) 312 (2006); David A. Hyman, *Hospital Conversions: Fact, Fantasy, and Regulatory Follies*, 23 J. CORP. L. 741 (1998) (evaluating empirical evidence relating to hospital conversion from non-profit to for-profit); David A. Hyman, *The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals*, 16 AM. J. LAW & MED. 327 (1990) [hereinafter Hyman, *Conundrum*] (challenging the merits of tax subsidies for non-profit hospitals).

30. *See* David A. Hyman, *Commentary: CEO Salaries in For-Profit and Nonprofit Health Plans*, *in* ETHICAL CHALLENGES IN MANAGED CARE: A CASEBOOK 176, 176–80 (Karen G. Gervais et al. eds., 1998) (commenting on a case study of a nonprofit health plan considering whether it should match an outside offer to its top executive and whether the executive should take the outside offer); David A. Hyman, *Professional Profiteering? The Ethics of Physician Entrepreneurship*, 35 PERSP. BIOLOGY &

costs in professional relationships,[31] the impact of Medicare,[32] and malpractice,[33] and the lessons to be learned from our incessant efforts to "reform" health care.[34] Finally, I have explored the intersection of antitrust and health care in a number of articles,[35] and served as principal author and project leader for the 2004 joint report by the Federal Trade Commission (FTC) and U.S. Department of Justice that prescribed "a dose of competition" to improve health care in the United States.[36]

MED. 317 (1992) (analyzing the ethics of physician investment in facilities to which they refer patients); David A. Hyman, Commentary, 20 HASTINGS CTR. REPORT 34 (1990) (commenting on a case study considering whether a physician should invest in a facility to which he refers patients).

31. *See* David A. Hyman & Charles Silver, *And Such Small Portions: Limited Performance Agreements and the Cost/Quality/Access Trade-Off*, 11 GEO. J. LEGAL ETHICS 959, 959 (1998) (evaluating whether the legal profession should "abolish disciplinary rules that prevent or discourage lawyers from tailoring their services in light of their clients' willingness to pay"); David A. Hyman, Commentary, *A Second Opinion on Second Opinions*, 84 VA. L. REV. 1439 (1998) (analyzing the frequency and utility of second opinions in litigation as a solution to lawyer–client agency problems); David A. Hyman, *Professional Responsibility, Legal Malpractice, and the Eternal Triangle: Will Lawyers or Insurers Call the Shots*?, 4 CONN. INS. L.J. 353 (1997) [hereinafter Hyman, *Eternal Triangle*] (evaluating whether legal-malpractice insurers can solve agency problems within law firms).

32. *See* DAVID A. HYMAN, MEDICARE MEETS MEPHISTOPHELES (Cato, 2006) (satirizing the Medicare program); David A. Hyman, *Medicare Meets Mephistopheles*, 60 WASH. & LEE L. REV. 1165 (2003) (same).

33. *See* David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085 (2006) (presenting a rational-choice model explaining why the malpractice system looks the way that it does); David A. Hyman & Charles Silver, *Speak Not of Error: Does Legal Fear Increase the Risk of Medical Error?*, REGULATION 52, 57 (2005) ("[I]t [is] exceptionally likely that [medical] providers are blaming the legal system for undesirable behaviors (i.e., errors, failures to report errors, and failures to improve delivery systems) that occur for other reasons, and those behaviors would continue to occur if the tort system were scrapped."); David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 95 CORNELL L. REV. 893, 894 (2005) (discussing various medical malpractice myths, including the assertion that it discourages providers from reporting errors and improving the quality of care they deliver); David A. Hyman & Charles Silver, *Medical Malpractice Reform Redux: Déjà vu All Over Again?,* 12 WIDENER L. REV. 121 (2005) (considering whether the latest malpractice crisis is "déjà vu all over again"); David A. Hyman & Charles Silver, *Believing Six Improbable Things: Medical Malpractice and "Legal Fear,"* 28 HARV. J.L. & PUB. POL'Y 107 (2004) (outlining six myths of medical-malpractice litigation); David A. Hyman *Medical Malpractice: What Do We Know and What (if Anything) Should We Do About It?*, 80 TEX. L. REV. 1639 (2002) (evaluating what is known about medical malpractice litigation and the merits of a no-fault enterprise liability-based, reform proposal).

34. See Hyman, *Self-Help supra* note 3 at 143–54 (advising various interest groups how best to improve health-care policy).

35. *See* David A. Hyman & William E. Kovacic, Perspective, *Monopoly, Monopsony and Market Definition: An Antitrust Perspective on Market Concentration Among Health Insurers*, 23 HEALTH AFFAIRS 25, 25–28 (2004) (analyzing whether market concentration among health insurers should prompt federal antitrust investigation); David A. Hyman, *Five Reasons Why Health Care Quality Research Hasn't Affected Competition Law and Policy*, 4 INT'L J. OF HEALTH CARE FINANCE & ECON. 159 (2004) (discussing translational barriers health-care-quality researchers must overcome to influence antitrust and consumer-protection law); William M. Sage, David A. Hyman & Warren Greenberg, *Why Competition Law Matters to Health Care Quality*, 22 HEALTH AFFAIRS 31, 31 (2003) ("Competition law is a bellwether for changes in the way healthcare quality has been understood over the years.").

36. *See generally* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, ANTITRUST DIV., IMPROVING HEALTH CARE: A DOSE OF COMPETITION 5–6 (2004), http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf ("The Report addresses two basic questions. First, what is the current role of competition in health care, and how can it be enhanced to increase consumer welfare? Second, how

Thus, I am not the best person to criticize Havighurst and Richman's diagnosis of the problem, because I generally share their assessment of the status quo. Like them, I have argued that the insistence on a unitary standard of health-care quality is not in the interest of consumers.[37] Like them, I have argued that no one elected health-care providers to play private-sector Robin Hood with our resources, and that providers' attempts to do so (let alone their attempts to protect and expand their privileged position) have had a variety of adverse consequences.[38] Like them, I have argued that government action generally favors the concentrated interests of incumbent providers and hurts, rather than helps, consumers.[39] Like them, I have argued for revisions in the design of tax subsidies for health insurance,[40] and greater transparency on price

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has, and how should, antitrust enforcement work to protect existing and potential competition in health care?"). The author served as Special Counsel to the FTC when the report was written. *See id.* at 2.

37. *Compare* Havighurst & Richman, *supra* note 2, at 50–52 (explaining how quality control regulation precludes some low-cost health-care options) *with* Hyman, *Eternal Triangle, supra* note 31, at 394 n. 177 ("Given the choice between something and nothing, most people would have little difficulty choosing the former, but our legal system and ethical framework directly and intentionally preclude[] that option.") (internal citation omitted); Hyman, *Accountable Managed Care, supra* note 24, at 802–03 ("[G]iven the choice between unaccountable but affordable insurance coverage and accountable insurance coverage which is unaffordable for some percentage of those currently insured, why are we so quick to conclude that the latter should be not just the default term, but a mandatory minimum? . . . Once we insist that health care coverage must be bundled with legal accountability, we will predictably close down the low end of the market. Perhaps that result accords with our ethical sensibilities, but it is cold comfort to those who must now choose between nothing but the best and nothing.") (internal citation omitted).

Unitary malpractice standards have a similar effect. *See* John A. Siliciano, *Wealth, Equity, and the Unitary Malpractice Standard*, 77 VA. L. REV. 439, 486–87 (1991) ("Tort law instructs health care providers to treat the poor the same as the rich, but then blithely ignores the fundamental impact that resource scarcity and the provider's freedom to refuse care to the poor have on the efficacy of its command. . . . By embracing the chimera of equality between the rich the poor, [tort law] effectively disables health care providers from offering reasonable, low-cost care to large numbers of the medically indigent. Thus, through its adherence to the unitary ideal, tort law may end up killing the poor with an unthinking and misguided kindness.").

Once again, this problem is not unique to health care, but is the predicable consequence of setting the minimum terms of trade above the efficient market-clearing price, whether the issue is price controls, the minimum wage, working conditions, or discovery in the civil justice system. *See* Allen R. Myerson, *In Principle, a Case for More "Sweatshops,"* N.Y. TIMES, June 22, 1997, at E5 ("'A policy of good jobs in principle, but no jobs in practice, might assuage our consciences . . . but it is no favor to its alleged beneficiaries.'") (quoting Professor Paul Krugman); William W. Schwarzer, Query, *Slaying the Monsters of Cost and Delay: Would Disclosure Be More Effective than Discovery*?, 74 JUDICATURE 178, 182 (1991) ("It may be that in the disclosure system, on occasion, some information helpful to a party that exhaustive discovery would uncover will not come to light. But the question must be asked whether the marginal value of preventing such occasional failures is worth the great cost of unrestrained discovery. As Donald Elliott has observed, 'Nourishing the fiction that justice is a pearl beyond price has its own price.'") (internal citation omitted).

38. *Compare* Havighurst & Richman, *supra* note 2, Part II, at 11–41, and Part IV, at 50–71 *with* Hyman, *Conundrum, supra* note 29, at 372.

39. *Compare* Havighurst & Richman, *supra* note 2, Part IV, at 50–71 *with* Hyman, *What's Wrong, supra* note 24.

40. *Compare* Havighurst & Richman, *supra* note 2, Part II.B.2, at 36–39 *with* Hyman & Hall, *supra* note 28. Havighurst and Richman are unremittingly negative about any form of tax preference for health insurance given horizontal and vertical inequity issues, but also because the tax subsidy funnels resources into health care that might be better spent elsewhere. Although in general I agree with Havighurst and Richman, I think it unlikely there is any political constituency in favor of "leveling-

and quality.[41] Like them, I have argued that consumers have heterogeneous but different preferences than providers and other elites,[42] including greater willingness to trade off cost against quality,[43] and less enthusiasm about underwriting care for the indigent.[44] Finally, we agree that the reason we have

down" the exclusion, and there are some benefits to a tax preference for health insurance that should not be ignored. See *supra* note 28.

41. *Compare* Havighurst & Richman, *supra* note 2, Part IV.B.2, at 54–56 *with* Hyman & Silver, *You Get What You Pay for, supra* note 25.

42. *Compare* Havighurst & Richman, *supra* note 2, Part IV.A, at 50–52 *with* Hyman, *What's Wrong, supra* note 24. Provider preferences are often skewed by self-interest—a problem that is not unique to health care. *See* Rebecca Buckman, *Merrill Says Online Trading Is Bad for Investors,* WALL ST. J., Sept. 23, 1998, at C1 (noting that a representative of Merrill Lynch has attacked Internet-based, discount stock trading because "it encourages people to trade too much at the expense of long-term returns," but "[s]ome industry experts contend Merrill is attacking Internet trading simply because it fears the lower-cost trading mechanism could threaten its 'full-service, higher commission business'"); Mary Helen McNeal, *Redefining Attorney-Client Roles: Unbundling and Moderate-Income Elderly Clients*, 32 WAKE FOREST L. REV. 295, 301, 301 n.32 (1997) (cataloging concerns about providing unbundled legal services that allow a client to choose representation only for some tasks, and noting that "some of my concerns about unbundling reflect my personal beliefs about how I want to conduct my professional life").

43. *See* Barbara Marsh, *The Health Care Revolution: Remaking Medicine in California*, L.A. TIMES, Aug. 31, 1995, at A14 ("One day late in June, with a moving van parked outside his office, Dr. Steven Kotner fought back tears as he told how HMOs had lured away his patients with cheap insurance prices. 'The majority would have stayed with me if they could,' he says."); Ha T. Tu, Ctr. For Studying Health System Change, *Medicare Seniors Much Less Willing to Limit Physician-Hospital Choice for Lower Costs*, ISSUE BRIEF 96, June, 2005, http://www.hschange.org/CONTENT/744/744.pdf (reporting a study showing that only forty-five percent of seniors sixty-five and older "were willing to trade broad provider choice to save money, compared with more than" seventy percent of people aged eighteen through thirty-four). *See also The Quality Health-Care Coalition Act of 1999: Hearing on H.R. 1304 Before the H. Comm. on the Judiciary* (1999) (statement of Robert Pitofsky, Chairman, Fed. Trade Comm'n), http://www.ftc.gov/os/1999/06/healthcaretestimony.htm ("The collective judgment of health care professionals concerning what patients should want can differ markedly from what patients themselves are asking for in the marketplace."); James F. Blumstein & Michael Zubkoff, *Public Choice in Health: Problems, Politics and Perspectives on Formulating National Health Policy,* 4 J. HEALTH POL. POL'Y & L. 382, 401 (1979) ("[T]he quality of care recommended as a norm by the medical profession may not be either a realistic or desirable standard to be adopted by individuals as consumers or by government as third party payer.").

On the results of the growing disjunction between elite normative preferences and those of the rest of the population, see Carl E. Schneider, *Elite Principles: The ALI Proposals and the Politics of Elite Law Reform*, *in* RECONCEIVING THE FAMILY: CRITICAL REFLECTIONS ON THE AMERICAN LAW INSTITUTE'S PRINCIPLES OF THE LAW OF FAMILY DISSOLUTION 489, 493 (Robin Fretwell Wilson ed., 2006) ("Elite law professors believe the programs they favor are not just wise; they are essential if bigotry and its consequences are to be purged from American life. If this is so, are not the left's opponents at least dupes of bigots, if not actually bigots themselves? Many parts of the academic left's agenda, then, are not just issues of policy; they are moral issues on which only one opinion can be tolerated.").

44. Public opinion polls indicate very high support for universal access to health-care services. Willingness to pay is a different matter, indicating that this may be another example of "cheap talk." *See, e.g.*, Norbert Goldfield, *Efforts to Implement National Health Insurance in the United States*, 18 PHYSICIAN EXECUTIVE 23, 23 (1992) ("Several years ago, Uwe Reinhardt, PhD, an economist from Princeton, sent out a Christmas card which excerpted results from polling data asking Americans their opinions of national health reform: Should we have universal health care in the United States? [85%], yes. Whose responsibility is that? [75%], federal government. How would you finance this? More taxes, [65%]. Would you be willing to spend more than fifty dollars more a year in taxes to finance this? [20%], yes. Merry Christmas.") (internal citation omitted). *See also* Mark Pauly, *Trading Cost, Quality, and Coverage of the Uninsured: What Will We Demand and What Will We Supply?*, *in* THE FUTURE U.S. HEALTHCARE SYSTEM: WHO WILL CARE FOR THE POOR AND UNINSURED? 364

so many uninsured is that we have priced the minimum level of coverage above the ability and willingness of Americans to pay,[45] although it is important to be clear about the marginal trade-offs that are being made.[46]

Thus, I am in general agreement with Havighurst and Richman on their assessment of the specific manifestations of the underlying problem(s). I am less persuaded by their ultimate diagnosis that "distributive injustice" is to blame. Deciding whether there is "distributive injustice" requires specification of (and agreement on) a baseline of "distributive justice"—and setting that baseline requires a theory of distributive justice. Even those of us who are law-and philosophy-challenged know there are competing (and hotly contested) theories of distributive justice. Havighurst and Richman try to elide the problem by flatly asserting that "there should be little disagreement,

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(Stuart Altman et al. eds., 1998) (noting that "worsening of the lot of the uninsured under market competition". . . [is an example of markets] doing what they do best . . . . Market competition will have abolished a type of charity that citizens, when faced with the challenge to pay for it explicitly and consciously, determined to be not worth its cost.").

The larger dynamic of the disjunction between elite and consumer preferences, and whether they are appropriately described as "market failures" is nicely addressed by Frank Easterbrook:

> It is ironic that just as a global network and automation are reducing the costs of contracting, and moving us closer to the world in which the Coase Theorem prevails, people promote more and more contract-defeating schemes. One is tempted to think that they are concerned not about market failures but about market successes—about the prospect that the sort of world people prefer when they vote their own pocketbooks will depart from the proposers' ideas of what people ought to prefer. Next thing you know, why, economic transactions between consenting adults will break out right in public view!

Frank H. Easterbrook, *Cyberspace Versus Property Law?*, 4 TEX. REV. L. & POL. 103, 111 (1999).

45. *Compare* Havighurst & Richman, *supra* note 2, at 51 *with* Hyman, *911, supra* note 24, at 456 ("[C]ost-quality trade-offs must be faced within and across every field of human enterprise. Regulations that hide those choices or (not so) arbitrarily pick a uniformly expensive floor do no one any favors—least of all those who are priced out of the market entirely. The usual response—that health is priceless—is of little help in a world of scarcity. Cost must always be considered, and those for whom price is no object are never those who ultimately foot the bill."). *See also* Hyman & Hall, *supra* note 28, at 26 ("Commentators wax poetic about the social role of health insurance, and treat the decision to offer and purchase such coverage in morally weighted terms. However, the evidence is fairly clear that potential subscribers approach coverage decisions in traditional economic terms . . . . When faced with a choice of health care coverage, price is the key driver of the decision-making process, and a significant number of individuals who have access to coverage through their employer decline it on the grounds it is too expensive.") (footnotes omitted); Uwe E. Reinhardt, *Employer-Based Health Insurance: R.I.P.*, *in* THE FUTURE U.S. HEALTHCARE SYSTEM, *supra* note 44, at 325, 327 (arguing that United States does not have universal health care "not because Americans are unusually callous toward the poor, but in part because the American health system has priced kindness out of the nation's soul").

46. Under normal circumstances, a rational individual would be willing to invest his resources in health care until marginal costs exceed marginal benefits. As Havighurst and Richman note, studies of health care expenditures that find aggregate improvements exceed aggregate costs do not cast light on the marginal decision, or marginal decisionmaker. Havighurst and Richman, s*upra* note 2, at 32 n.68. A more subtle problem is that an individual might well choose to spend considerably less on health care than the marginal cost and marginal benefit trade-off would indicate, if spending in other areas resulted in a higher payoff and if resources were scarce. Given the choice between death by starvation tomorrow and death from a chronic disease at some time in the future, most people would conclude that it is rational to spend one's resources on food instead of medicine if one cannot afford both. Because the price of health insurance is a significant factor for many purchasers, trade-offs within this zone are not at all unreasonable. *See generally* Hyman, *Drive-Through Deliveries, supra* note 24, at 16–17 (describing cost–quality and quality–quality health-care trade-offs).

philosophical or otherwise, with the two main premises of this article"—that public good should not be financed regressively, and that low-income workers should not have to buy coverage "designed by and for elite interests or for health care that is consumed disproportionately by the well-to-do."[47] They couple these assertions with a throw-away reference to John Rawls, citations to the public-finance literature and an analogy to the antitrust doctrine of tying. To say the least, this is a long way from a theory of justice. I have serious reservations about Havighurst and Richman's ultimate diagnosis based on this slender reed. Those less charitably inclined might wonder whether Havighurst and Richman have imbedded their conclusion in the premise.[48]

More importantly, even if one concedes the ultimate diagnosis, it is hard to tell what Havighurst and Richman would prescribe as the course of treatment. The last section of their article is titled "Conclusions, with Policy Implications," but it explicitly "takes no firm position on the particular health policy that should replace the one we criticize."[49] The closest Havighurst and Richman get to concrete prescriptions comes a few sentences later, when they observe that things will work out fine "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."[50] Well, maybe so, but maybe not. The devil is, as always, in the details—and Havighurst and Richman's failure to provide a concrete plan creates ample opportunities for misunderstanding, misdirected initiatives, and mischief.

Consider a few specific examples. Obviously, the tax subsidy for employment-based health insurance has got to go, but should we make a frontal assault on it, or gradually erode the foundations? Havighurst and Richman do not say what approach they would recommend, but different strategies for addressing the tax subsidy could lead to rather different consequences. The alternatives include repealing the exclusion outright; continuing to exclude it from income, but capping its value and allowing it to erode over time; converting the exclusion to a tax credit; leaving the existing exclusion alone, but adding tax credits as a subsidy for the poor; making the exclusion more universal to solve some of the horizontal equity issues as a transition to outright repeal; excluding all out-of-pocket spending on health care; and, so on. Even scholars who agree that a more consumer-oriented system is the desired

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47. Havighurst & Richman, *supra* note 2, at 72. Havighurst and Richman's normative assessment is also reflected in the title of the pre-conference version of their paper: Health Care's Dirty Secret: Who Pays? Who Benefits? (working draft, circulated August 5, 2005) (on file with author).

48. *See* David F. Levi, *In Memoriam Philip B. Kurland*, 64 U. CHI. L. REV. 1, 4 (Winter 1997) ("[T]he key to establishment of an infallible argument has been most fully developed by the Supreme Court of the United States: it is to embed the conclusion in the premise. It is always easier to get from here to here than from here to there.").

49. Havighurst & Richman, *supra* note 2, at 79.

50. *Id.*

endpoint have come to different conclusions than Havighurst and Richman on how to approach this simple issue.[51]

In like fashion, antitrust law has not been able to prevent some anticompetitive conduct in the health-care marketplace, but is that the fault of the enforcers or of the law? How one answers that question has a lot to do with the reforms one considers—and their relative priority. The FTC has had considerable success in obtaining consent judgments in cases involving anticompetitive conduct by physician groups, but when the remedy is "go and sin no more," it is hard to create a credible deterrent. The record in cases against hospitals is much less impressive, but it is not for lack of trying. So, what should we fix, and how should we fix it? Is the best solution, as a former colleague at the FTC jokingly suggested, for the fountain in the courtyard of the FTC to periodically run red with the blood of price-fixers?

A few more examples help make the difficulties clearer. What do Havighurst and Richman think are the relative priorities among narrowing the state-action doctrine, repealing the moratorium on single-specialty hospitals, enhancing price and quality transparency (leave aside how, for the moment), eliminating all certificate-of-need proceedings and repealing all mandated benefits? Should we ban first-dollar insurance coverage? Will every insurer be required to offer a health savings account to all comers? What is the minimum amount of cost sharing required to create price sensitivity? Should there be different levels of cost sharing for preventive services, acute care, and chronic care? Should the level of cost sharing be risk-adjusted? Should cost sharing phase out entirely for catastrophic levels of spending? Is the desired redesign of insurance products the province of the sellers of those products, state insurance commissioners, or the federal government? Should the desired deregulation of providers and insurers be the result of a state-by-state campaign, or is federal preemption required? What kind of subsidies are necessary and how should they be deployed? How should we get insurers to offer "last year's medicine at last year's prices?"[52] What about Medicare and Medicaid? And what "tweaks" are required, and in what direction?

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51. *See* Hyman & Hall, *supra* note 28, at 39–40 (suggesting that leveling down is preferable, but leveling up is more likely); John F. Cogan, R. Glenn Hubbard & Daniel P. Kessler, HEALTHY, WEALTHY & WISE: FIVE STEPS TO A BETTER HEALTH CARE SYSTEM 27–33 (2005) (arguing for leveling up, by excluding all out-of-pocket expenditures from income). In a recent op-ed, Glenn Hubbard argued for this approach on the grounds that eliminating the exclusion entirely was a political non-starter. *See* Glenn Hubbard, *Health Care, Heal Thyself: Taxing Problems*, NAT'L REV. ONLINE, Jan. 30, 2006, http://www.nationalreview.com/comment/hubbard200601300837.asp ("Last fall, the bipartisan President's Advisory Panel on Federal Tax Reform suggested capping the tax deductibility of health-insurance premiums so that employers could extend only so much coverage to their workers. And, if we could do so, removing all tax subsidies for health care would be the best answer. That outcome is most unlikely, and the key is to stop the tax bias against low-cost individually purchased health insurance.").

52. *Cf.* Mark Pauly, Professor, Univ. of Penn., American Enterprise Institute for Public Policy Research Panel Discussion on Productivity and Health Care: The Value of Medical Technology (Feb. 28, 2001), (transcript available at http://www.aei.org/events/filter.,eventID.421/transcript.asp)

Havighurst and Richman offer no details, plans, or priorities. This makes their proposal harder for their political opponents to attack, but it also makes it less a proposal than a prayer.

III

IMPLEMENTATION: TACTICS AND LOGISTICS

It is no accident that Havighurst and Richman focus on the diagnosis side of the equation and ignore the implementation issues. This division of labor is quite common, and reflects a deeper underlying reality:

> Strip away the job titles and party labels, and you will find two kinds of people in Washington: political hacks and policy wonks . . . . After two decades in Washington as a wonk working among hacks, I have come to the conclusion that the gap between Republicans and Democrats is as nothing compared to the one between these two tribes. We wonks think we're smarter than hacks. Hacks think that if being smart makes someone a wonk, they'd rather be stupid. Wonks think all hacks are creatures from another planet, like James Carville. Hacks share Paul Begala's view that wonks are all "propeller heads," like Elroy on "The Jetsons." Wonks think the differences between hacks and wonks are as irreconcilable as the Hutus and the Tutsis. Hacks think it's just like wonks to bring up the Hutus and the Tutsis.[53]

As law professors, Havighurst and Richman are policy wonks' wonks. (It is less clear whether Havighurst and Richman are wonks with a song in their heart.)[54] But if they want to see their vision implemented, they are going to have to become hacks, or at least find some to work for them.[55]

What will the hacks tell them about how they should package and market their plans? What follows are six rules of hacking, derived from my time in Washington and years spent watching hacks and wonks at play in the fields of health policy. Those who object to these rules, or to the tone with which they are described are, by definition, wonks.

Rule Number One: People hate numbers but love a good anecdote.

It is one thing to quantify distributive injustice in health care, and quite another thing to get anyone to care about it. The key is to find and popularize a

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(explaining that health plans could distinguish themselves with the slogan "'Last year's technology at last year's premiums'").

53. Bruce Reed, *Bush's War Against Wonks: Why the President's Policies are Falling Apart*, 36 WASH. MONTHLY 14 (March, 2004), http://www.washingtonmonthly.com/features/2004/0403.reed.html. *See also* PEGGY NOONAN, WHAT I SAW AT THE REVOLUTION: A POLITICAL LIFE IN THE REAGAN ERA 72 (1990) ("In the Reagan administration there was an unending attempt to separate the words from the policy. A bureaucrat from State who was assigned to work with the NSC on the annual economic summits used to come into speechwriting and refer to himself and his colleagues as 'we substantive types' and to the speechwriters as 'you wordsmiths.' He was saying, We do policy and you dance around with the words.").

54. *Cf* Jay Nordlinger, *Cap, A Life,* NAT'L REV. ONLINE, Dec. 3, 2001, http://www.nationalreview.com/ flashback/nordlinger200603281203.asp (describing Caspar Weinberger as a "wonk with a song in his heart," based on his description of heading the Office of Management and Budget in the Nixon Administration as "particularly good fun").

55. This insight is not novel. *See* Timothy J. Brennan, *An Academic's Guide to the Way Washington Really Works,* CHRON. OF HIGHER EDUC., Jan. 12, 2001, at B11.

sad story—or better still, multiple sad stories—of people who suffered death or significant injury through no fault of their own but because of some aspect of the problem Havighurst and Richman are concerned about. It does not matter whether the stories are representative or not—only wonks would care about that question. If a story is good enough, it does not even matter what really happened! Havighurst and Richman need some anecdotes.

Rule Number Two: A good slogan is half the battle.

If you want to sell reform, you need a slogan with some zing to it. It is no accident that one political party is against "death taxes," "partial-birth abortion," and the "nanny state," while the other is in favor of putting social security into a "lockbox," being "pro-choice," and working "for the people, not the powerful." These slogans work because they have a normative resonance that attracts voters who are rationally ignorant of the details of the particular proposals and issues.

If Havighurst and Richman's slogan is that they are opposed to "distributive injustice in health care," they might as well just give up the ghost right now.[56] Anyone who hears those words will, at best, have no idea what Havighurst and Richman are proposing—and, at worst, will think Havighurst and Richman are proposing a new-fangled lawsuit they want nothing to do with. Telling people "we're going to make health care less expensive by making it more expensive" is even worse. Havighurst and Richman need a good slogan.

Rule Number Three: Find allies.

Havighurst and Richman's diagnosis ensures they will have plenty of enemies. If they want to win the war over distributive injustice in health care, they need some allies. Where are those allies to be found? If consumers were an effective interest group, the status quo would not look the way it does.[57] The challenge for Havighurst and Richman is to find allies among those who are currently disaffected, or to create allies by making those who are currently happy disaffected. One good way to create allies is to expand the pool of people participating in alternatives to the current, "somebody else is footing the bill" health-insurance system. Another good way is to enlist the assistance of providers who are marginalized by the current system, such as alternative

56. *See Acts* 12:23 ("And immediately the angel of the Lord smote him, because he gave not God the glory: and he was eaten of worms, and gave up the ghost.") (King James).

57. *See generally* MANCUR OLSON, THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS (Harvard University Press 1971) (1965) (exploring the problems of collective action). Had the Supreme Court had the benefit of a time machine in 1938, the justices could have read the book and they would not have suggested in footnote 4 of *United States v. Carolene Products Co.* that legislation targeting "discrete and insular" minorities was a particular problem. *See* 304 U.S. 144, 152 n.4 (1938). As Professor Olson points out, "discrete and insular minorities" are the exact groups that can best overcome the collective action problem and prevent such legislation from being enacted in the first place. OLSON, *supra*, at 2–3. Instead, the real problem is preventing discrete and insular minorities from exploiting everyone else.

health-care providers. Hacks will also try to find the invisible victims of the status quo and use them to "name and blame" their oppressors, a strategy that dovetails neatly with Rule Number One.[58] Ideally, the result will be allies in Congress and the state legislatures—a necessary but not sufficient precursor for reform. Regardless of how it is done, Havighurst and Richman need to find some allies.

Rule Number Four: Pick a good enemy.

It is good to be for something, but better to be for something while simultaneously being against something much worse. Just as every cowboy movie needs a villain (in a black hat) for the hero (in a white hat) to defeat, every good reform movement needs to have a good—that is, bad—enemy to oppose. One difficulty with picking an enemy in the health-care context is that the most likely candidates are either popular (physicians), not really responsible for the problems that are identified (insurers and pharmaceutical companies), or too inchoate to be effectively demonized (elites). Lawyers are an obvious candidate for the enemy, but it is unlikely that Havighurst and Richman will get much mileage out of that choice. Picking a good enemy is going to be a challenge for Havighurst and Richman.

Rule Number Five: Have a simple solution.

If a reform proposal can not be summarized in a few words, it is not worth pursuing. It does not matter if the ultimate legislation runs to hundreds, or even thousands of pages. What matters is whether the solution can be described on a bumper sticker. "Fixing the regressive distributive injustices of the American health care system" is not going to cut it. Havighurst and Richman may or may not have a simple solution—it is hard to tell because they do not actually spell out what their solution is, beyond the few cryptic hints noted earlier.[59] Once they figure out what their solution is, they need to boil it down to a short slogan. Havighurst and Richman's article weighs in at seventy-five pages and 220 footnotes—a long way from a simple solution.

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58. On naming and blaming, see generally William L. F. Felstiner et al, *The Emergence and Transformation of Disputes: Naming, Blaming, Claiming* . . . , 15 LAW & SOC'Y REV. 631, 631 (1981) (providing "a framework for studying the processes by which unperceived injurious experiences are—or are not—perceived (naming), do or do not become grievances (blaming) and ultimately disputes (claiming)"). On making the invisible visible, see Williams, *supra* note 6, at 183 ("Most often the victims of public policy are invisible. To garner greater public support against government command and control, we must somehow find a way to make those victims visible. . . . [For example,] a political strategy of those who support liberty should be that of exposing the invisible victims of minimum wage laws. We need to show those who have lost their jobs, or do not become employed in the first place, because their productivity did not warrant being employed at the minimum wage. We should find a way to demonstrate jobs destroyed by minimum wages such as busboys, gasoline station attendants, and movie ushers. We must show how marginally profitable firms have been forced out of business, though surviving firms may have the same number of employees. We should show how capital was artificially substituted for labor as a result of higher mandated wages and how firms have adjusted their production techniques in order to economize on labor.").

59. *See supra* text accompanying notes 49–50.

Rule Number Six: Never give up, never surrender.[60]

Winning the hack portion of the campaign requires iron discipline. Every day, a hack gets up and hammers away on his issue, regardless of what else is going on in the world. When a hack sees an opening, he runs as far and as fast as he can toward the goal line. When he gets knocked down, he gets up, dusts himself off, and tries something different. When he starts to feel paranoid because he spends a lot of his time anticipating traps laid by his enemies, he reminds himself that "even paranoids have enemies."[61] Most importantly, when he sees his opponents drowning, he throws them an anchor.[62]

IV

WHO SHOULD CONTROL THE COMMANDING HEIGHTS?

Havighurst and Richman are explicitly agnostic about whether to rely on private markets or a government-run system to deliver the type of health-care system they envision.[63] On the one hand, there is no particular reason to favor markets over government, or vice versa, in the financing and delivery of health care.[64] On the other hand, to date, provider capture of state and federal legislators and regulators is the rule, and the results have not been pretty. Indeed, the status quo that Havighurst and Richman criticize is the direct result of regulatory and legislative oversight, with its known susceptibility to symbolic blackmail, "motherhood and apple pie" initiatives, and other forms of government failure.[65]

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60. *Cf.* Galaxy Quest (DreamWorks Home Entertainment 2000).

61. This observation is widely attributed to Golda Meir. Joseph H. Berke et al., *General Introduction*, *in* EVEN PARANOIDS HAVE ENEMIES—NEW PERSPECTIVES ON PARANOIA AND PERSECUTION 1(Joseph H. Berke et al., eds. 1998) ("During the Sinai talks, in November 1973, when Henry Kissinger had been pressing Golda Meir for further Israeli concessions, when Meir hesitated, he called her 'paranoid.' To this she is said to have responded: 'Even paranoids have enemies.'").

62. This observation is widely attributed to James Carville, one of the premiere hacks. The underlying sentiment is bipartisan. *See* PETER BAKER, THE BREACH: INSIDE THE IMPEACHMENT AND TRIAL OF WILLIAM JEFFERSON CLINTON 42 (2000) ("This whole thing about not kicking someone when they are down is BS. Not only do you kick him—you kick him until he passes out—then beat him over the head with a baseball bat—then roll him up in an old rug—and throw him off a cliff into the pounding surf below!!!!!") (text of an e-mail from one Republican staffer to another when the House of Representatives was considering impeaching President Clinton).

63. Havighurst & Richman, *supra* note 2, at 79.

64. *See* Richard A. Epstein, *Why is Health Care Special?*, 40 U. KAN. L. REV. 307, 311 (1992) ("[T]he importance, so to speak, of importance is simple: it is important to get the right set of solutions, be it private or public, to the problem at hand. Importance does not create a presumption in favor of government, or for that matter against it. It only raises the stakes for making a correct decision in the matter at hand.").

65. *See* Blumstein & Zubkoff, *supra* note 43, at 389–90 ("Decentralized choices by nongovernmental decisionmakers . . . has greater potential for precluding symbolic concerns from becoming inextricably involved in policy formulation and will likely point more attention to necessary economic trade-offs. The design of institutions and policies should therefore take into account the 'susceptibility to symbolic blackmail' of governmental institutions when health issues are directly implicated."); Richard A. Epstein, *Living Dangerously: A Defense of Mortal Peril*, 3 U. ILL. L. REV. 909, 927–28 (1998) ("[B]efore embarking down the road to [regulation], one has to make some estimate

I described the basic dynamic in an earlier article:

> The critical institutional competence questions are whether legislators have the necessary information, incentives and preferences to beat the alternatives in setting the terms of trade. Unfortunately, the available evidence indicates that legislators do no better than the rest of us in dealing with these issues—and in certain respects they do substantially worse. Indeed, the potential for symbolic blackmail and the "motherhood and apple pie" implications of many regulatory responses virtually ensure that legislators will not be willing to make the trade-offs that any sensible and workable policy must make. The result is utterly predictable: "feel-good" legislation that creates systematic distortions and costs but provides little or no benefit.[66]

Before we "double down" our bets on the legislative–regulatory approach, we should recall past performance, which in this case is quite likely to predict future returns.

V

CONCLUSION

If changing the health-care system were easy, it would have been done already. Almost five hundred years ago, Niccolo Machiavelli concisely described the challenges that potential reformers face in redesigning the system and redirecting the flow of money:

> There is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things. Because the innovator has for enemies all those who have done well under the old conditions, and lukewarm defenders in those who may do well under the new. This coolness arises partly from fear of the opponents, who have the laws on their side, and partly from the incredulity of men, who do not readily believe in new things until they have had a long experience of them.[67]

These problems are compounded by the reality that every dollar of health care spending by someone is a dollar of income for someone else. The latter will make (and have made) every effort to ensure and increase the flow of funds

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of the relative chances of success or failure, given the danger of regulatory capture and excess that can subvert a legislative program from any direction. . . . Private markets are more resistant to these pressures because exit and entry possibilities keep established players in line. State monopolies, on the other hand, can easily misbehave . . . ."); Fred S. McChesney, *Economics, Law, and Science in the Corporate Field: A Critique of Eisenberg*, 89 COLUM. L. REV. 1530, 1549 (1989) ("Real-world private markets must be compared with real-world government, not some unrealistically benign caricature thereof. Students of regulation know too much about how government actually works to believe that its coercive intervention in markets will necessarily increase public welfare.")

66. Hyman, *Self-Help, supra* note 3, at 148. *See also* Hyman, *911, supra* note 24, at 45 ("Does regulatory intervention offer a solution or will it create a different (and potentially worse) set of problems? In drafting consumer protections, there is little guarantee that the legislature will actually target the right problem because its selection is heavily influenced by bad anecdotes and perceived public appeal. Even if the legislature fortuitously picks a reasonable target today, there is no guarantee it will do so tomorrow. 'Mom and apple pie' legislation, of which consumer protection against managed care is clearly an example, is particularly prone to legislative posturing and overreaching.") (footnotes omitted).

67. NICCOLO MACHIAVELLI, THE PRINCE 17 (William K. Marriott trans., 2002) (1513). In a 2001 article on the managed care backlash, Professor Havighurst cited the same passage. *See* Clark C. Havighurst, *The Backlash Against Managed Health Care: Hard Politics Make Bad Policy*, 34 IND. L. REV. 395, 395 (2001).

from the former. The opposition to any change that endangers the status quo will be brutal and unremitting.

A glimpse of the difficulties that lie ahead is demonstrated by the fate of two proposals of the President's Advisory Panel on Federal Tax Reform (Advisory Panel).[68] The Advisory Panel considered the desirability of tax preferences for health insurance and home ownership. Like Havighurst and Richman, the Advisory Panel emphasized the distributional unfairness of these tax preferences and argued for a tax system that was "[s]impler, [f]airer, and [m]ore [e]fficient."[69] The Advisory Panel ultimately recommended expanding the scope of the health-insurance preference[70] and restricting the scope of the homeownership tax preference.[71] The first proposal implicitly rejects Havighurst and Richman's strategy of cutting back on spending preferences, while the second is a soft version of Havighurst and Richman's proposal. Health-care interest groups largely ignored the first proposal. Homeownership interest groups declared war on the second proposal, and lobbied heavily against it.[72] A supportive editorial in the *Washington Post* described the proposal as a "crazy idea."[73] In short order, the proposal to cut back on tax preferences for homeownership was declared "D.O.A."

In the thirteenth most frequently cited law-review article of all time,[74] Professor Marc Galanter argued that the "haves come out ahead" in litigation because they are repeat players, with multiple opportunities to learn about the system and ensure that things come out their way.[75] Professor Galanter argued that the fundamental difference between repeat players and "one-shotters" helped explain the limits of implementing legal change through litigation.

A similar dynamic has obviously operated with respect to the design and implementation of American health policy. The "haves" come out ahead

68. For information about the panel and its findings, see President's Advisory Panel on Tax Reform, Home Page, http://www.taxreformpanel.gov/ (last visited Feb. 16, 2005).

69. *See* PRESIDENT'S ADVISORY PANEL ON FED. TAX REFORM, SIMPLE, FAIR, AND PRO-GROWTH: PROPOSALS TO FIX AMERICA'S TAX SYSTEM, 70 (2005), http://www.taxreformpanel.gov/final report/TaxReform_Ch5.pdf.

70. *Id.* at 78–82. The specific recommendation was that individuals be allowed to purchase health insurance with pre-tax dollars up to a specified amount. This proposal significantly expands the number of people who can take advantage of the tax preference, but does cap the magnitude of the benefit.

71. *Id.* at 70–74. The specific recommendation was to convert the deduction for mortgage interest on primary homes into a tax credit and cap its value, and to eliminate the deduction for second homes.

72. The interest groups included the National Association of Realtors, the American Banking Association, the National Association of Homebuilders, the National Association of Mortgage Brokers, the Mortgage Bankers Association, and the National Marine Manufacturers Association. As Machiavelli predicted, the proposal received limp support from advocates for low-income housing. *See* MACHIAVELLI, *supra* note 67.

73. David Brunori, Editorial, *Bush's Tax Panel Has a Crazy Idea. Let's Go For It; Why This Reform Should Begin at Home*, WASH. POST, Oct. 23, 2005, at B04.

74. Fred R. Shapiro. *The Most-Cited Law Review Articles Revisited,* 71 CHI.-KENT L. REV. 751, 767 (1996).

75. Marc Galanter, *Why the "Haves" Come Out Ahead: Speculations on the Limits of Legal Change,* 9 LAW & SOC'Y REV. 95 (Fall 1974).

because they have the knowledge and incentive to do so, while the have-nots remain (comparatively) uninformed and disinterested. Getting the "haves" to come out behind will not just happen. It will take the correct diagnosis, a good plan, a lot of hard work, and even more luck—and that may be one of the few things that hacks, wonks, MOPS, COPS, and POPS can all agree on.