THE POLITICAL ECONOMY OF UNFAIRNESS IN U.S. HEALTH POLICY

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I

INTRODUCTION

The American health care system presents an intriguing paradox: it is perennially in crisis, yet seemingly impervious to comprehensive reform. Throughout the twentieth century, reformers repeatedly failed to enact national health insurance.[1] The most recent effort at comprehensive reform, the Clinton administration's Health Security Act, ended in political disaster for the administration in 1994, with the Clinton plan failing to muster even the minimum support necessary to bring it to a floor vote in the House or Senate, and with the Republican party subsequently winning majorities in that year's midterm elections in both houses of Congress for the first time in four decades.[2]

The political lesson apparently learned in Washington from the Clinton-plan debacle was that comprehensive health reform was too politically risky to pursue.[3] Since 1994, even as conditions in the health care system have worsened, U.S. heath policymakers have embraced a strategy of inaction and neglect, with only the occasional interruption for incremental reforms.[4] As a result, the United States finds itself coping yet again with the familiar combination of rising health care costs and growing numbers of uninsured. This is not a dilemma that can be fixed by leaving the health care system to its own

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This article is also available at http://www.law.duke.edu/journals/lcp.

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devices: without policy interventions the problems of rising costs and eroding access to health insurance are likely to worsen substantially in coming years.

Although outrage at the inequities of U.S. health care policy, which leaves more than fifteen percent of the population without guaranteed access to medical care,[5] is nothing new, the focus of outrage in Clark Havighurst and Barak Richman's searing indictment of the health system is different.[6] For Havighurst and Richman, the major source of unfairness in the system is how health care is financed, particularly the regressive burden that health financing arrangements impose on privately insured lower- and middle-income Americans. At the same time, they posit that lower-income Americans are also shortchanged on the receiving end, as well, since utilization of medical care may vary substantially with income. Havighurst and Richman argue that this distributive injustice means ordinary Americans are unknowingly getting a raw deal in health care—paying proportionately more while getting less—to the benefit of their higher-income compatriots and the health care industry.[7]

This article provides both a critical perspective on Havighurst and Richman's argument and a broader commentary on inequality and health care politics. It focuses on the political economy of unfairness in U.S. health policy by first highlighting the moral issues raised by our system of financing medical care and then by analyzing the political dynamics that sustain that system. Part II explores the moral illogic that governs American health care, paying particular attention to the uninsured. Part III discusses the politics of U.S. health policy and explains the difficulties in reforming even strikingly regressive health policies. Part IV discusses the role of the tax subsidy in health politics and the development of comprehensive health insurance. Part V explores Health Savings Accounts (HSAs) and their implications for fairness in American health care. Part VI concludes the article with an explanation of why markets cannot ensure progressive health financing. I argue that although the U.S. health care system is exceptionally regressive, policy solutions now in vogue suggest it could well become even more regressive in the future, and only a move away from market-based health policy can reverse these trends.

II

THE DUBIOUS MORAL LOGIC OF AMERICAN HEALTH POLICY

Unfairness is inarguably a cornerstone of the U.S. health care system. Whether it is the moral philosophy Americans have consciously chosen or inadvertently stumbled into ultimately matters little to those who suffer the consequences of the unfairness. After all, in 2004, almost forty-six million

5. U.S. Census Bureau, Health Insurance Coverage: 2004–Highlights, http://www.census.gov/hhes/www/hlthins/hlthin04/hlth04asc.html (last visited March 9, 2006).

6. Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 LAW & CONTEMP. PROBS. 7 (Autumn 2006).

7. *Id.* at 8–10.

Americans lacked health insurance,[8] and they had demonstrably lower access to medical care than insured Americans. The uninsured are found mostly in working families[9] meaning that the system fails to the extent that one believes workers deserve health insurance as a reward for their economic contributions to the nation's well—being and for living up to the American work ethic. Moreover, the uninsured are disproportionately concentrated in small businesses;[10] thus, the only sin that many of the uninsured have committed is to work for the wrong size company. Insurance status is also a function of occupation: workers in construction, agriculture, and the service sector are less likely to have insurance than those employed in managerial, professional specialty, and government jobs.[11]

Insurance coverage varies predictably by education and income, with low-income and less-educated Americans significantly more likely to occupy the ranks of the uninsured than more-affluent and -educated classes. In 2004, about two-thirds of the uninsured lived in families with income below 200 percent of the federal poverty line,[12] or $32,180 for a family of three.[13] Race and ethnicity also play a crucial role; Hispanics' uninsured rate is more than double that of white Americans, while the uninsurance rate among African Americans is more than fifty percent higher than whites.[14] And age matters: Americans over age sixty-five are entitled to join Medicare, regardless of income;[15] this is the only age group that enjoys anything approaching universal coverage in the United States. End-stage renal disease patients also are covered by Medicare, a peculiar organ-based eligibility that reinforces the arbitrariness of U.S. health policy.[16]

Meanwhile, public insurance programs designed for the poor do not actually cover large segments of the poor. For example, because of rules establishing categorical eligibility for Medicaid, the government insurance program for low-

8. U.S. Census Bureau, *supra* note 5. See COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, INSTITUTE OF MEDICINE, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 25–44 (2002) for a discussion of the role of insurance in allowing access to medical case.

9. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE UNINSURED: A PRIMER 4 fig.3 (2006), *available at* http://kff.org/uninsured/upload/7451.pdf (reporting that 69% of the uninsured lived in families with one or more full-time workers in 2004).

10. In 2005, 98% of firms with more than 200 workers offered health insurance to their employees, compared with 59% of firms with fewer than 200 employees. *Id.* at 3.

11. *Id.* at 13; PAUL FRONSTEIN, SOURCES OF HEALTH INSURANCE AND CHARACTERISTICS OF THE UNINSURED: ANALYSIS OF THE MARCH 2005 CURRENT POPULATION SURVEY 12 fig.11 (2005), *available at* http://www.ebri.org/pdf/EBRI_IB_11-2005.pdf.

12. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *supra* note 9, at 4, 19.

13. *See* Annual Update of the HHS Poverty Guidelines, 70 Fed. Reg. 8,373, 8,374 (Feb. 18, 2005) *available at* http://aspe.hhs.gov/poverty/05fedreg.pdf (reporting $16,090 as the poverty level for a family of three in 2005).

14. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *supra* note 9, at 19.

15. Medicare Eligibility Tool, http://www.medicare.gov/ (follow "Search Tool" hyperlink; then follow "Find Out if You Are Eligible for Medicare and When You Can Enroll" hyperlink) (last visited March 12, 2006).

16. *Id.*

income Americans, childless adults usually cannot qualify for public coverage.[17] Federalism also generates geographical inequities: Medicaid eligibility standards vary by state, so low-income citizens' access to public insurance depends on where they live.[18]

To add insult to injury, the uninsured, lacking the purchasing power that comes with being part of a large insurance pool, are sometimes charged higher prices than insured patients.[19] Medical care is also a leading cause of bankruptcy in the United States,[20] an issue not just for the uninsured but for under-insured Americans as well.[21] Even well-insured and financially secure Americans can find themselves in financial distress if fate hands a family member an expensive, chronic disease.[22] And in perhaps the most fitting reflection of the American health care system's dubious moral logic, the sicker individuals without employer-provided health insurance are, the harder it is for them to buy health insurance.[23] On the individual market, those with preexisting conditions who are judged health risks by insurers are subject to higher premiums, limited coverage packages, or outright coverage refusals—the inevitable consequences of a system built on the principles of medical underwriting and risk rating.[24]

None of this is especially fair and, quite apart from the normative implications, little of it makes sense. Why should workers in small businesses have less access to health insurance than workers in large corporations? Why should workers who lose their jobs also lose their health insurance at precisely the moment when they are least able to afford to purchase coverage on their own?[25] What theory of justice is at work in a system in which Americans risk

17. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *supra* note 9, at 14; Catherine Hoffman et al., *Holes in the Health Insurance System: Who Lacks Coverage and Why,* 32 J.L. MED. & ETHICS 390, 392–93 (2004).

18. Hoffman, *supra* note 17, at 395.

19. Uninsured American Rebekah Nix discovered this lesson the hard way when a New York hospital billed her more than $14,000 for an appendectomy, as compared to the $2500, $5000, and $7800 it bills Health Maintenance Organizations, Medicare, and Medicaid, respectively. Lucette Lagnado, *Full Price: A Young Woman, an Appendectomy, and a $19,000 Debt*, WALL ST. J., Mar. 17, 2003, at A1.

20. *See* David U. Himmelstein et al., *MarketWatch: Illness and Injury as Contributors to Bankruptcy*, 2005 HEALTH AFF. (WEB EXCLUSIVES) W5-63, W5-66, *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.63v1.pdf (finding illness or injury to be the cause of bankruptcy in more than 25% of 1,771 people surveyed in 2001).

21. *Id.* at W5-63 (reporting that 75.7% of the people filing bankruptcy due to illness in 2004 were insured).

22. For example, one middle-class family "with health insurance that covered 90% of doctor's bills" lost its home and filed for bankruptcy as a result of medical bills they incurred in treating its son's immune system disorder. John Leland, *When Health Insurance Is Not a Safeguard,* N.Y. TIMES, Oct. 23, 2005, at 1.

23. *See* Hoffman et al., *supra* note 17, at 392 ("Most individually purchased (i.e., non-group) policies are expensive . . . and any preexisting health conditions are generally excluded from coverage.").

24. *Id.*; Donald Light, *The Practice and Ethics of Risk-Rated Health Insurance*, 267 J. AM. MED. ASS'N 2503, 2503–06 (1992).

25. The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides a partial answer to this problem. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat.

bankruptcy if they become too sick? Or in a nation that leaves over eight million children uninsured?[26] Why should patients with kidney disease qualify for federal health insurance while patients with a variety of other devastating diseases do not? Any moral philosophy or social ethic that seeks equity and compassion would have a hard time accommodating these staggering inequities.

To this familiar accounting of the moral pathologies of American health care, Havighurst and Richman add another lament: the unfairness inherent in the financing of private health insurance.[27] They argue that premium payers are forced to pay excessive prices because of medical providers' monopolistic market power, which commonly prevents even insurers from pursuing aggressive cost control.[28] Havighurst and Richman contend that in addition to paying for monopoly profits, the insured are unknowingly paying a regressive head tax (since the burden falls roughly equally on all premium payers rather than varying by income), a head tax that gives nonprofit hospitals the money to fund a range of activities, from uncompensated care and public insurers' low payments to research and education. They go on to argue that even if many of these cross-subsidized missions are worthwhile (and the same holds for financing advances in medical technology), current arrangements provide a particularly regressive (and hidden) way of financing them. [29]

Whether the injustices in health financing Havighurst and Richman describe (such as the head tax) for the insured rise in moral importance to the problems of the uninsured is debatable. Indeed, Havighurst and Richman's focus on the insured leads them at times to downplay the fate of the uninsured, who appear at one point in their article as relatively fortunate in comparison to low-income premium payers: because the uninsured do not have to pay insurance premiums, Havighurst and Richman report they "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."[30] These "benefits" of uninsurance likely would come as a substantial surprise to the millions of low-income Americans who want but cannot afford health insurance

82 (codified as amended in scattered sections of 7, 10, 15, 19. 29, 33, 38, 42, and 47 U.S.C. (2000)). COBRA provides temporary health insurance for former employees when coverage is lost due to certain statutorily defined events. Employee Benefits Sec. Admin., U.S. Dep't of Labor, Frequently Asked Questions About COBRA Continuation Health Coverage, http://www.dol.gov/ebsa/faqs/faq_consumer_cobra.html (last visited March 9, 2006). However, it is more expensive because unemployed workers have to pay up to 102% of the premiums—including amounts previously covered by the employer—a burden that many of those who lose their job cannot afford. *Id.*

26. *See* U.S. Census Bureau, *supra* note 5 (stating that in 2004, 8.3 million children were uninsured).

27. Havighurst & Richman, *supra* note 6, at 10.

28. Weak purchasing power, Havighurst and Richman believe, is also a consequence of U.S.-style health insurance's dilution of consumers' cost-consciousness and the absence of low-cost insurance options that deny people the chance to economize on medical care. *Id.* at 14–20.

29. *Id.* at 20–31.

30. *Id.* at 72.

and who have no guaranteed access to routine medical care and who therefore suffer medically and financially as a result.[31]

Nonetheless, the uninsured and the low-income insured are in one crucial respect two sides of the same coin, as Havighurst and Richman point out, since both groups are victims of high and rising health insurance premiums that threaten to price even more low- and middle-income Americans out of the health insurance market.[32] Rising medical care costs mean that many Americans who are now insured will become uninsured in the future. Since their fates are thus linked, there is no reason that health reform should not seek to improve the fortunes of both groups. Attention to securing access to health insurance should be accompanied by attention to making the financing of American medical care more progressive, an issue that Havighurst and Richman rightly note is too often neglected in health reform debates.

Moreover, the regressive features of health care finance that Havighurst and Richman describe (and still others they do not emphasize) are real, and the authors deserve credit for calling attention to these dynamics in private insurance, which heretofore have not attracted sustained attention either in political or policy circles. Just because people are insured does not mean that they are faring well in the health care system, nor does it shield them from the burdens and inequities that Havighurst and Richman discuss. To take an example the authors do not highlight, insurance policies that charge equal premiums have unequal distributional implications. It is hardly fair, for instance, that the $480-a-month family premium charged by the North Carolina state health plan to a housekeeper working at the University of North Carolina medical school is the same as that paid by a professor of medicine.[33] Such lower-income workers pay a greater portion of their income for health insurance, and they thus run a higher risk of not being able to afford premiums even when insurance is offered. Although I am not aware of empirical data showing how widespread the practice of charging equal premiums regardless of a worker's income is in the private sector, it is probably safe to assume that equal premiums are the rule rather than the exception. The exclusion from income and payroll taxes of employer-sponsored health insurance premiums paid on workers' behalf compounds this regressive premium structure, disproportionately benefiting higher-wage workers.[34] Cost-sharing

31. The legal access to emergency room care provided under the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2000), should not be taken in any way to mean that the medical needs of the uninsured are adequately met.

32. LISA CLEMANS-COPE, BOWEN GARRETT & CATHERINE HOFFMAN, KAISER COMM'N ON MEDICAID AND THE UNINSURED, CHANGES IN EMPLOYEES' HEALTH INSURANCE COVERAGE, 2001-2005 14 (2006), *available at* http://www.kff.org/uninsured/upload/7570.pdf

33. North Carolina State Health Plan: Monthly Contribution Rates, http://www.statehealthplan.state.nc.us/benefits/benefits_monthlyrates_new.html (last visited March 9, 2006).

34. It also cost the federal government an estimated $188.5 billion in foregone revenues in 2004. John Sheils & Randall Haught, *The Cost of Tax-Exempt Health Benefits in 2004*, 2004 HEALTH AFF. (WEB EXCLUSIVES) W4-106, W4-106, *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1.pdf.

requirements that do not vary by income can have similarly regressive effects if they induce lower-income workers to use fewer benefits.[35]

As Havighurst and Richman argue, the rising costs of health care exacerbate these regressive tendencies. Employers pay for workers' health care costs by restraining growth in their wages, which helps to explain why real hourly earnings have been largely stagnant in the United States during the past three decades.[36] The upward march of health care costs has gone on for so long that it is easy to become numb to such consequences, especially for low-income Americans.

Havighurst and Richman note that the injustices in financing health care exist in a health care system of plenty. The United States spends more on medical care than any other nation, and that spending creates both winners and losers.[37] Put bluntly, Havighurst and Richman's argument is that health care providers (the winners) are profiting at the expense of ordinary Americans (the losers), who are unknowingly subsidizing, through regressive financing arrangements, the unlimited appetite of the health care industry for more resources. Havighurst and Richman bemoan the excess prices, monopoly profits, and high rates of spending that finance medical providers and the supply side of American medical care. Health care spending is the allocation of lifestyle to providers, and American health care spending is buying, in part, better lifestyles and incomes for our providers (as well as for our insurers, drug companies, and so on).[38] Indeed, "doctors in the United States now earn twice what their counterparts earn in other countries"; this explains almost one-third of the spending gap between the United States and the average G7 nation.[39] In contrast to lower-income Americans, who are often shut out of the insurance system (or, to those who, if in it, are the unwitting victims of regressive financing, according to Havighurst and Richman), the health care industry is doing extraordinarily well.

That so many inequalities exist in the richest health care system in the world,[40] and that the United States appears to lead the industrialized world both in terms of high-paid providers and the proportion of its population without access to health insurance further illustrates the extent to which American medical care remains a striking "paradox of excess and deprivation."[41] In this sense—that something is fundamentally wrong in American medical care and

35. Havighurst & Richman, *supra* note 6, at 46–47.

36. ALEXIS M. HERMAN, FUTUREWORK: TRENDS AND CHALLENGES FOR WORK IN THE 21ST CENTURY 14 (1999), *available at* http://www.dol.gov/asp/programs/history/herman/reports/futurework/report.htm.

37. Havighurst & Richman, *supra* note 6, at 11–12 n.8.

38. Uwe E. Reinhardt, *Resource Allocation in Health Care: The Allocation of Lifestyles to Providers*, 65 MILBANK Q. 153, 153–56, 174 (1987).

39. David M Cutler, *Equality, Efficiency and Market Fundamentals: The Dynamics of International Medical-Care Reform*, 40 J. OF ECON. LITERATURE 881, 891 (2002).

40. I.e., as measured by total spending.

41. THOMAS S. BODENHEIMER & KEVIN GRUMBACH, UNDERSTANDING HEALTH POLICY: A CLINICAL APPROACH 1 (4th ed. 2005).

that the system as currently structured is inherently unfair and requires restructuring—Havighurst and Richman's indictment is echoed by those on the left who advocate single-payer national health insurance.[42]

III

THE POLITICS OF UNFAIRNESS

The seemingly endless litany of inequities in American medical care begs the question of why the U.S. health care system is so unfair. If health care financing arrangements are profoundly regressive and if so many Americans are hurt by those arrangements, then why does this unequal state of affairs persist? And why do we tolerate apparent excess health spending in the face of visible deprivation in access to care?[43]

The easy answer, of course, is that American political culture values liberty over equity, cherishes markets and individual responsibility over government and social solidarity, and therefore tolerates with equanimity substantial inequality in many spheres, including health care. From this perspective, we have the health care system that we want.[44] This argument is not lightly dismissed, yet the implications of American political culture for health policy are more complex than the above stereotype suggests. It is worth remembering that opinion polls indicate that health care is different: most Americans recognize a right to health care,[45] and compared to other social distresses, they are less likely to view illness as a matter of individual failing and are more likely to favor government intervention.[46]

Politically, the answer is that however regressive or inequitable the current health care system is, powerful interest groups literally profit from the status quo and consequently have a strong incentive to keep things as they are. After all, national health expenditures equal somebody else's income, and the recipients of that income can be expected to fight to maintain it. The $1.9 trillion the United States spends on medical care[47] guarantees the presence of a

42. For an example of single-payer models see The Physician's Working Group for Single-Payer National Health Insurance, *Proposal of the Physicians' Working Group for Single-Payer National Health Insurance*, 290 JAMA 798 (2003).

43. Havighurst and Richman, *supra* note 6, at 54–56, emphasize the political consequences of the tax subsidy for employer-sponsored insurance in explaining this puzzle; here I present my own explanations for the persistence of regressive financing, followed in the next section by commentary on their political analysis.

44. Jonathan Oberlander, *The Politics of Health Reform: Why Do Bad Things Happen to Good Plans?*, 2003 HEALTH AFF. (WEB EXCLUSIVES) W3-391, W3-395.

45. For example, in a 2004 Kaiser/Newshour survey, seventy-six percent of Americans agreed that access to health care should be a right. Kaiser Family Foundation, Spotlight: Health Care Should Be Provided Equally to Everyone, http://kff.org/spotlight/uninsured/6.cfm (last visited Apr. 14, 2006).

46. Mark Schlesinger & Taeku Lee, *Is Health Care Different? Popular Support of Federal Health and Social Policies*, *in* THE POLITICS OF HEALTH CARE REFORM 297, 334 (James A. Morone & Gary S. Belkin eds., 1994).

47. Cynthia Smith et al., *National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending*, 25 HEALTH AFF. 186, 186 (2006).

well-funded stakeholder lobby committed to maintaining the generous flow of funds to the health care sector. Put simply, more spending on medical care means more revenues for those who provide care and sell medical services and technology.[48] Cost containment, whether on behalf of the government or private insurance, whether through administered pricing or managed care, and whether in the name of social goals or corporate profits, simply means income reduction to this lobby. Government efforts to control costs are sure to catalyze political opposition, while it is unclear what constituency in favor of savings can be mobilized. Even market-based cost controls, such as managed care arrangements, are not immune to the pressures of stakeholders who can respond both politically and economically to private-sector efforts to curtail spending on medical care.

A comprehensive review of the institutional biases of American political arrangements is beyond the scope of this paper, but suffice it to say that fragmented political institutions provide ample opportunities for these lobbies and opposing political forces to block health care reform in a system biased towards incrementalism.[49] These same institutions make it difficult to generate and sustain a legislative majority in Congress for any one reform plan.[50] Even when a President who favors health reform and whose party has a majority in Congress is in office, there is no guarantee that comprehensive reform will succeed, as the Clinton administration discovered during 1993–1994.[51] If the United States had a parliamentary system, national health insurance arguably would have passed long ago. Unfortunately for health reformers, they continue to live in a political world that has no parliament but is governed instead by separation of powers, shifting coalitions, and fragmented authority.

Given these institutional constraints and the dynamics of interest-group politics, it is hardly surprising that the politics of health care have not produced cost containment or universal coverage in the United States. This is an imbalanced political arena, one in which the uninsured and their allies have proven no match for the health care industry. Indeed, the modern U.S. health care system was established on terms favorable to the medical profession: no national health insurance, private health insurance that did not control costs or interfere with physicians' clinical autonomy, barriers for prepaid group practices and alternative forms of insurance, and circumscribed authority for other health professionals that might compete with doctors.[52] The American Medical Association opposed both private and public insurance, and when private and public insurance programs finally were adopted they reflected

48. See Theodore R. Marmor et al., *The Politics of Medical Inflation, in* POLITICAL ANALYSIS AND AMERICAN MEDICAL CARE 61, 64–70 (1983) for information on the imbalanced political markets and their implications for health care.

49. For a more extensive discussion, see Oberlander, *supra* note 44, at W3-393 to -396.

50. *Id.* at W3-393 to -394.

51. SKOCPOL, *supra* note 2.

52. STARR, *supra* note 1.

major concessions to medical providers. Medicare, for instance, essentially gave doctors and hospitals a blank check through lenient reimbursement policies designed to secure their participation in the program when it began operations in 1966.[53] The United States, then, has traditionally been a physician's paradise, and altering those favorable arrangements, as managed care plans found out the hard way, is no easy task.

Yet the health care industry is not the only group that has benefited from the inequitable American system of financing medical care. Eighty-four percent of Americans are insured.[54] Well-insured Americans enjoy ready access to state-of-the-art medicine and a broad choice of providers, with most of the costs apparently paid by their employers. Most Americans like their own medical care arrangements, even as they are critical of the health care system.[55] And they want to spend more, not less, on health.[56] This is not an altogether irrational proposition, as David Cutler has shown, because key advances in clinical medicine made available to insured Americans have produced real gains in health outcomes and quality of life.[57]

Similarly, although the tax exclusion for employer-sponsored health insurance premiums is widely derided for its regressive consequences and for obscuring the burden of rising health care costs, the political fact is that middle- and upper-class Americans enjoy tremendous financial benefits from this program.[58] Moreover, the wealthier the employee, the greater the value of the tax exclusion. Although not exactly the hallmark of progressive financing, this is a political cornerstone that makes the current policy difficult to dislodge. For at least two decades, policymakers and analysts have entertained the idea of capping or eliminating this tax subsidy.[59] That this has never actually come to pass reveals how strongly the politics of the tax subsidy lean toward the status quo. It is doubtful that many Americans understand how the tax subsidy for employer-provided health insurance works or even know that it exists. But they would likely immediately understand any policy that ended or sharply limited

53. JONATHAN OBERLANDER, THE POLITICAL LIFE OF MEDICARE 108–11 (2003).

54. U.S. Census Bureau, Health Insurance Coverage: 2004, http://www.census.gov/hhes/www/hlthins/hlthin04/hlth04asc.html (last visited Aug. 28, 2006).

55. Robert J. Blendon & John M. Benson, *Americans' Views on Health Policy: A Fifty-Year Historical Perspective*, HEALTH AFF., Mar.–Apr. 2001, at 33, 40–41, 43–44.

56. *Id.*

57. DAVID M. CUTLER, YOUR MONEY OR YOUR LIFE (2004). Cutler argues that advances in care for heart attacks, depression, and premature infants have produced sizable health gains—gains that from an economic perspective, more than justify the costs of spending more on medical care.

58. *See* Sheils & Haught, *supra* note 34.

59. *See* Robert B. Helms, *Tax Reform and Health Insurance,* HEALTH POL'Y OUTLOOK (Am. Enter. Inst. for Pub. Policy Research, Washington, D.C.), Jan.–Feb. 2005, at 4, *available at* http://www.aei.org/docLib/20050203_HPOJang.pdf. Helms discusses a proposal to cap this tax exclusion during the Reagan administration. President Bush's advisory panel on federal tax reform has revived this idea by proposing to cap the tax exclusion at the average cost for health insurance premiums. *See* PRESIDENT'S ADVISORY PANEL ON FEDERAL TAX REFORM, SIMPLE FAIR, AND PRO-GROWTH: PROPOSALS TO FIX AMERICA'S TAX SYSTEM 80–82 (2005), *available at* http://www.taxreformpanel.gov/final-report/.

the scope of the tax subsidy and significantly raised their taxes. Tax expenditures can live on in obscurity for an eternity; in contrast, the political costs of visible tax increases are sufficiently burdensome that they often never see the light of day.[60] However regressive or inefficient the tax exclusion for employer-sponsored health insurance may be on the whole, it is beneficial for large segments of the population, who are precisely those Americans more likely to vote.[61]

For the well-heeled and well-insured, then, the health care system seems to work quite well; for many Americans, the uninsured and rising health care costs are distant issues that become problems only if they directly erode the insured's own access to affordable insurance and state-of-the-art medicine.[62] Instructively, the implosion of managed care removed barriers to care for the well-insured while exacerbating the plight of the uninsured by abetting the return of higher rates of growth in medical spending.[63] Havighurst and Richman are right that employees' acceptance of the status quo and preference for more medical care is partly built on ignorance: workers do not seem to understand that the rising health care bill is coming out of their wages—because total employer health care costs are a portion of their gross compensation package—and thus is hurting them.[64] But in health politics ignorance is bliss. Americans are quite happy with all the health care they can get as long as they believe someone else is paying the tab. This is not an illusion they want to end; life in the health care version of the Matrix[65] is too comfortable.

The puzzling persistence of regressive financing in American medical care is, in the end, not so puzzling. The American health care system is self-perpetuating—despite recurrent declarations of crisis and worries about its egalitarian and economic shortcomings—precisely because there is a considerable segment of the population and economy that benefit from the system while others suffer. Arguments about the immorality or unfair

60. These political dynamics are illustrated by the Clinton administration's efforts to enact universal coverage without significantly raising taxes; one political advantage of an employer mandate is that is privatizes (and thus hides) financing as an alternative to public taxes. On Clinton's desire to avoid being labeled as a "taxer" see SKOCPOL, *supra* note 2, at 40–46.

61. Voting rates climb with income. In the 2004 presidential elections, voters with incomes over $75,000 were twice as likely to vote as those with incomes below $10,000. *See* U.S. Census Bureau, Voting and Registration in the Election of November 2004, tbl. 9, http://www.census.gov/population/www/socdemo/voting/cps2004.html (last visited Apr. 14, 2006). Moreover, sixty-seven percent of insured Americans aged eighteen to sixty-four reported voting in the 2000 elections, compared to only forty-five percent of uninsured voters. Kaiser Family Foundation, Public Opinion Spotlight: The Uninsured and Voting, http://www.kff.org/spotlight/elections/9.cfm (last visited Apr. 14, 2006).

62. However, insured Americans may not appreciate how vulnerable they and their families are to losing health insurance over time. A Families USA study found that in 2002-2003 one out of every three Americans under age sixty-five was without health insurance at some point during that period. FAMILIES USA, ONE IN THREE: NON-ELDERLY AMERICANS WITHOUT HEALTH INSURANCE, 2002-2003 (2004), *available at* http://www.familiesusa.org/assets/pdfs/82million_uninsured_report6fdc.pdf.

63. On the fall of managed care see generally James C. Robinson, *The End of Managed Care*, 285 JAMA 2622, 2627–28 (2001).

64. Havighurst & Richman, *supra* note 6, at 54–56.

65. *See* THE MATRIX (Warner Bros. Studios & Village Roadshow Pictures 1999).

distributional consequences of this system, including those that highlight the fate of the low-income insured, are unlikely to persuade those who profit financially and benefit medically from the status quo to abdicate their privileged positions. Tolerating inequality, after all, is a hallmark of American political life.[66] And on those rare occasions when such arguments do prevail, or when the broader public is mobilized and political conditions are ripe for change, the bias of American political institutions towards incrementalism works against comprehensive reform.

IV

WHAT DOES THE TAX SUBSIDY HAVE TO DO WITH IT?

Havighurst and Richman's explanation of health politics alternatively emphasizes the impact of the tax subsidy. They argue that the tax subsidy hides the true cost of health coverage because workers do not understand that rising health premiums are coming out of their wages through employers' undisclosed reduction in their overall compensation packages.[67] As a result of these costs being hidden in employer purchasing, the authors contend, workers demand more health care than their true interests would allow and allocate more to health insurance than they would rationally choose. Havighurst and Richman cite the failure of bare-bones insurance policies to develop much of a market presence as an example of the distorting effects of the tax subsidy.[68] They argue that the tax subsidy also biases politics by giving "consumer-voters" little incentive to question the excessive regulations that protect providers, or the ever-rising flow of funds to the health care industry.[69] Furthermore, regulations like occupational licensure and mandated minimum benefits for health insurance foreclose the opportunity for people to economize by purchasing lower-cost health care coverage—coverage they might prefer and that might enhance their welfare.

Instead, Havighurst and Richman contend that standard comprehensive health insurance policies are designed by and for elites and the medical industry. These groups benefit financially from prevailing regulatory and legal systems that obscure the high costs of American medical care[70]—put another way, what you don't see is what the health care industry gets. Thus Havighurst and Richman argue that another dimension of lower- and middle-income Americans overpaying for health insurance and getting a raw deal from the

66. The United States has a higher rate of inequality than any other rich nation in the Organization for Economic Cooperation and Development. Timothy M. Smeeding, Public Policy and Economic Inequality: The United States in Comparative Perspective, (Feb. 20, 2004) (paper presented at the Campbell Public Affairs Institute's seminar on "Inequality and American Democracy"), *available at* http://www.maxwell.syr.edu/campbell/Events/Smeeding.pdf.

67. Havighurst & Richman, *supra* note 6, at 54.

68. *Id.* at 75.

69. *Id.* at 54–56.

70. *Id*. at 71–82.

system is that they are "forced to buy more . . . or better quality [medical care] than they can reasonably afford."[71]

What should we make of this argument? Ignorance surely does play a role (though not necessarily the dominant one) in the politics of health care: if more Americans understood how the tax subsidy works and who is really paying for their health insurance, perhaps there would be a stronger constituency for cost control.[72] Nonetheless, I believe Havighurst and Richman's assertion that the tax subsidy is to blame for high costs and comprehensive insurance in the U.S. is overstated,[73] and their presumption that low-income workers want less and lower-quality health insurance is wrong.

The authors do not note that the United States is hardly unique in having comprehensive health insurance; in fact, it is common in industrialized democracies.[74] Thus the development of comprehensive insurance in the U.S. may have much less to do with any consequences of the tax subsidy than with these facts: (1) people want comprehensive coverage; (2) they value health security; and (3) they are uncomfortable with the risk and uncertainty of high cost-sharing. Otherwise how do we explain the international embrace of comprehensive coverage? In other words, the causality that Havighurst and Richman posit may be reversed: the desire for comprehensive health insurance may be an explanation for and not a result of the tax subsidy. International experience suggests that were it not for the tax subsidy Americans likely would have found an alternative mechanism to deliver comprehensive insurance.

In this context, Havighurst and Richman's discussion of bare-bones insurance policies[75] is telling in that they do not discuss perhaps the most obvious reason for their failure to develop in the market: people do not like limited health insurance and do not regard radically low-cost policies as real insurance. If the market reveals preferences, then it appears that most

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71. *Id*. at 73.

72. It would be a mistake, though, to assume that the tax subsidy eliminates all pressures for cost control in private insurance. In particular, regardless of the economic evidence on wages, employers have tried very hard to control the costs of health insurance premiums, though without sustained success, at least judging by the historical record of premium increases.

73. Paul Starr writes, "No one who has studied the takeoff of private insurance in the 1950s and 1950s. . ." would accept that the growth and liberalization of private health insurance during that time was primarily due to the tax exclusion of employer-sponsored insurance. Paul Starr, *On the Origins and Cure of Warped Incentives*, *in* A NEW APPROACH TO THE ECONOMICS OF HEALTH CARE 121 (Mancur Olson ed., 1981). "Tax considerations were a relatively minor factor at the time"; instead, health insurance represented a private form of social security that unions could claim as a "virtue of collective bargaining" and that employers could use to strengthen worker loyalties. *Id.* Starr goes on to write that "the extent of the plans responded to the workers' demand for an inclusive system of prepayment, with certainty of coverage, rather than merely insurance against major risks." *Id.*

74. On international health systems, see generally Timothy Stoltzfus Jost, *Why Can't We Do What They Do? National Health Reform Abroad*, 32 J.L. MED. & ETHICS 433 (2004), and JOSEPH WHITE, COMPETING SOLUTIONS: AMERICAN HEALTH CARE PROPOSALS AND INTERNATIONAL EXPERIENCE (1995). White notes that "within this context of universal and compulsory coverage, all systems provide roughly equal standard benefits, with Japan's varied cost sharing the major exception." *Id*. at 272.

75. They write that "there is implausibly little discernible demand for radically low-cost health coverage." Havigurst & Richman, *supra* note 6, at 75.

Americans do not prefer the economizing options that the authors see as missing in the current system.

Similarly, Havighurst and Richman do not present any compelling evidence that low-income workers want lower-quality, more-limited health insurance. The notion that something is wrong because "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"[76] seems more grounded in the authors' preferences for economizing options than in the actual hopes and desires of the working class. It is doubtful that lower-income Americans believe it is an injustice that more of them are not in lower-quality insurance plans with less access to state-of-the-art medicine than their more affluent compatriots. Instead of more-limited insurance, is it not rational for workers of modest means to prefer comprehensive insurance paid for on a progressive financing basis by others? Instead of economizing choices, might uninsured workers instead prefer access to comprehensive national health insurance? Might not low-income workers also support regulations for occupational licensure and mandated minimum benefits that they believe promote quality care? And were low-income workers to wind up disproportionately in insurance plans that denied them access to the latest medical technologies, would the distributive injustices of financing not simply be replaced by a new injustice that, in essence, placed a higher value on the lives of those with higher incomes?[77]

Comprehensive insurance is not, as Havighurst and Richman would have it, designed simply for political elites and the health care industry or as a result of the tax subsidy's obscuring the true costs of health coverage—this is where their political analysis falls short. Rather, comprehensive insurance represents an understandable and predictable response to the insecurity and uncertainty created by illness and the high costs of medical care, and it cannot be presumed that low-income Americans want to be liberated from the "burden" of having good health insurance, even if they would whole-heartedly support reform of how that health insurance is paid for.

V

HEALTH SAVINGS ACCOUNTS AND CONSUMER-DIRECTED HEALTH CARE

Given how regressive American health policy already is, it is hard to believe it could become any more inequitable. Alas, that is exactly the direction in which the system appears poised to go.[78] The newest magic bullet in American

76. *Id.* at 27.

77. Indeed, Havighurst and Richman are not generally concerned "that health care is rationed or distributed unequally" but instead that cost sharing may lead lower-income insurance enrollees to get fewer benefits for equivalent premiums. *Id.* at 43. However, a more egalitarian moral vision would find it quite problematic that medical technology was rationed according to income.

78. In this section I am commenting on the direction of U.S. health policy, not on the prescriptions of Havighurst and Richman. The authors are ambivalent about consumer-directed health care. They

health policy, succeeding managed care, is consumer-directed health care. Under the rubric of consumerism, a variety of trends are touted, including the proliferation of Web-based medical information and Internet technology that allow employees to tailor their own custom-made health-benefits packages, cost-sharing arrangements, and provider networks.[79] In this vision of health care, patients are no longer just patients, but rather take on the role of sophisticated consumers who use newfound information and the Internet to comparison shop and make informed choices about their medical care, presumably much as they would in choosing between alternative vacation packages.

Yet the central instruments of consumer-driven health care are high-deductible health insurance plans (HDHPs) and tax-preferred Health Savings Accounts (HSAs) that are used to pay for "routine" expenditures until the deductible is met, at which point the HDHP's catastrophic coverage kicks in. Under current law, people must purchase insurance plans with a minimum deductible of $1050 for an individual or $2100 for a family to qualify for establishing an HSA.[80] Once established, individuals or their employers (or both) can deposit pre-tax dollars into HSAs (though the amount deposited cannot exceed the deductible) and those funds can be invested, with unused money rolled over to the next year.[81] Funds can then be withdrawn from the HSA, tax free, to pay for qualified medical expenses.[82] HSAs are portable, meaning workers can keep the accounts when they change employers.[83]

The core idea behind HSAs and HDHPs is that by making patients more cost-conscious (through high deductibles), they will become more price-sensitive consumers and consequently consume less medical care, particularly of the discretionary variety.[84] The diagnosis proffered by advocates of consumer-driven health care (one shared by Havighurst and Richman) is that health care costs are high due to overinsurance and overutilization because patients do not confront financial incentives to economize on health care.[85] The proposed cure is consequently to provide patients with financial incentives to use fewer

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praise its potential to combat the problems of over-insurance and moral hazard and appear to like its shifting of more costs to individuals. However, they also sharply criticize some of the regressive features of Health Savings Accounts discussed here and note HSAs may not serve the interests of low-income patients. *See id*. at 38–39, 39 n.96.

79. Jon R. Gabel, Anthony T. Lo Sasso & Thomas Rice, *Consumer-Driven Health Plans: Are They More than Talk Now?*, 2002 HEALTH AFF. (WEB EXCLUSIVES) W395, W395–96, *available at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.395v1.pdf.

80. U.S. Dep't of the Treasury, Health Savings Accounts (HSAs), http://www.ustreas.gov/offices/public-affairs/hsa/ (last visited March 9, 2006).

81. *Id.*

82. *Id.*

83. *Id.*

84. See, for example, the description of Health Savings Accounts in Aetna, *Health Savings Accounts (HSAs)*, ISSUE AT A GLANCE (Aetna, Hartford, Conn.), July 2005, *available at* http://www.aetna.com/public_policy_issues/data/HSA_IssueATAGlance_Rev.pdf.

85. *See* Malcolm Gladwell, *The Moral Hazard Myth*, THE NEW YORKER, Aug. 29, 2005, at 44, 47–48.

medical services. In addition, because these insurance plans carry higher deductibles, they may also come with lower premiums, thereby offering an insurance product that is more affordable than conventional plans.

The appeal of HSAs—generating, at least in theory, both cost savings and healthier behaviors, promoting values of personal responsibility and consumer empowerment, and invoking the politics of tax cuts and private investment—is easily understood. HSAs are the centerpiece of President Bush's health care policy and are in harmony with his ownership society; accordingly, the President recently proposed new subsidies designed to promote their adoption in the non-group insurance market.[86] High-deductible health plans also have been growing, albeit from a small base, in the employer-sponsored insurance market,[87] and that growth is likely to continue, if not accelerate.

The problem, from the perspective of health care financing, is that HSAs and high-deductible plans could exacerbate the regressive character of American health policy. These plans are highly regressive in two respects. First, as Havighurst and Richman note, their tax-preferred provisions are of substantially greater value to wealthier Americans in high tax brackets; low-income Americans not only fail to receive the same tax benefits, but they also have less disposable income than higher-income workers to contribute to their HSAs.[88] In a polity where recent tax cuts have favored the wealthiest Americans, HSAs would add yet another regressive tax shelter to benefit financially those who least need the help.[89]

The second sense in which HSAs are potentially regressive is in their impact on the sick and chronically ill. For healthy Americans, HSAs could amount to a good deal if these policies offered the prospect of lower premiums and, for the wealthy, the lure of accumulating tax-free funds. If one rarely uses medical care, then the high deductible is not an issue. But for patients who are not

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86. Sarah Rubenstein, *Is an HSA Right for You?*, WALL ST. J., Feb. 2, 2006, at D1.

87. KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2005 ANNUAL SURVEY 94 exhibit 8.1 (2005), *available at* http://kff.org/insurance/7315/upload/7315.pdf.

88. Havighurst and Richman, *supra* note 6, at 39 n.96; Milt Freudenhiem, *Though Enrollment Grows, Many Don't Bother to Save,* N.Y. TIMES, Jan. 26, 2006, at C1. The Government Accountability Office reports that in 2004 the average amount of tax deduction claimed by HSA enrollees—that is, the amount individuals contributed to their HSAs—increased with income. U.S. GAO, PUBL'N NO. GAO-06-798, CONSUMER-DIRECTED HEALTH PLANS: EARLY ENROLLEE EXPERIENCES WITH HEALTH SAVINGS ACCOUNTS AND ELIGIBLE HEALTH PLANS 22 (2006), *available at* http://www.gao.gov/new.items/d06798.pdf;
see also CATHERINE HOFFMAN & JENNIFER TOLBERT, KAISER COMM'N ON MEDICAID AND THE UNINSURED, HEALTH SAVINGS ACCOUNTS AND HIGH DEDUCTIBLE HEALTH PLANS: ARE THEY AN OPTION FOR LOW-INCOME FAMILIES? (2006), *available at* http://www.kff.org/uninsured/upload/7568.pdf.
On the differential tax value of HSAs, Hoffman and Tolbert write that "[a] family of four with income of $20,000 would receive no benefit from contributing to an HSA. In contrast, a family of four with income of $120,000 gains $620 in tax savings from a $2,000 HSA contribution . . . ." *Id.* at 14.

89. *See* Robert Pear, *Health Care, Vexing to Clinton, is Now at Top of Bush's Agenda,* N.Y. TIMES, Jan. 29, 2006, at 1 (reporting that economist Jonathan Gruber believes the Bush insurance "tax breaks would be expensive and regressive, offering the largest benefits to the highest-income taxpayers").

healthy, the high deductible means they will pay significant amounts out of their own pockets for medical care and will be hard-pressed to accumulate any savings in HSAs because they will have to deplete those funds to pay for their medical expenses. Traditionally, the healthy subsidize the sick in insurance pools, but HSAs and HDHPs reverse this principal of insurance by shifting the burden of health care financing to those who use medical care the most.[90] The flip side of responsibility and consumer cost-consciousness is that under HSA arrangements, the sick are punished financially simply for being sick and using more medical care. Consumer control of health expenses consequently might amount to little more than cost-shifting onto the shoulders of the sick. Not only is this morally repugnant, but it also makes little medical sense to discourage patients with expensive chronic conditions from seeking primary care. Additionally, HSAs threaten to further undermine risk-pooling and the ethic of collective responsibility in American health care; if healthier individuals leave insurance pools for HSAs, sicker persons may be left to pay higher premiums in traditional plans.[91]

Moreover, HSAs are unlikely to achieve much progress in covering the uninsured. High deductibles are not attractive to many low-income uninsured persons who will still find the premiums hard to afford and who will look skeptically at the financial risk imposed by high deductibles. HSAs could also have unanticipated consequences for employer-based coverage. Health economist Jonathan Gruber estimates that President Bush's proposals to expand HSAs would actually *increase* the number of uninsured because new tax policies would lead many private employers to drop health insurance coverage.[92]

In sum, HSAs will not ameliorate the distributive injustices and inequalities in American health care; they will only make them worse, redistributing even more advantages to the healthy and wealthy while penalizing the sick and poor. In other words, HSAs are a perfect embodiment of the perverse moral logic and political economy of U.S. health policy, which explains their current political appeal. The American response to the crisis of the uninsured is, bizarrely, to propose solutions that make people less insured.[93] If HSAs spread, there is a strong possibility that an already regressive health care system will become even more regressive in coming years.

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90. Uwe E. Reinhardt, Some Observations on High-Deductible Health Insurance Policies (Nov. 1, 2004) (unpublished paper, on file with author).

91. Victor Fuchs, *What's Ahead for Health Insurance in the United* States, 346 NEW ENG. J. MED. 1822–24 (2002). As Fuchs notes, the spread of consumer-driven plans could erode the cross-subsidization in health care that comes from healthier enrollees subsidizing sicker persons. If healthier employees leave traditional insurance plans for HSAs, those traditional plans will be left with a sicker risk pool and will have to charge higher premiums.

92. Jonathan Gruber, Ctr. on Budget Policy Priorities, The Cost and Coverage Impact of the President's Health Insurance Budget Proposals (Feb. 15, 2006), *available at* http://www.cbpp.org/2-15-06health.pdf.

93. Gladwell, *supra* note 85, at 44, 47–48.

VI

CONCLUSION: CAN MARKETS GIVE US THE HEALTH CARE FINANCING SYSTEM WE WANT?[94]

Clark Havighurst and Barak Richman provide a compelling indictment of the American health care system and its distributive injustices. They deserve much credit for calling attention to an often-neglected issue: the regressive mechanisms of financing private health insurance that disadvantage working Americans of modest means. As a solution to these problems, they clearly prefer market-based health reforms, and they voice "some confidence" that with deregulation, altered incentives and subsidies that enable consumers to freely choose their own style of medical care, and redesigned insurance products, the market could evolve to address the distributive injustices they highlight.[95] However, and surprisingly given the rest of their analysis, Havighurst and Richman "would not object if [their] 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)."[96] This is for them a second-best alternative, yet it represents an option they concede may become necessary if political forces intervene and frustrate market-based reforms.[97]

I believe Havighurst and Richman's preferred market-based strategy is likely to fail in redressing distributive injustices in health care; the problem in U.S. health policy is not with politicians distorting the market, but with the market itself. Indeed, Havighurst and Richman's documentation of injustices in the health care system supports an alternative conclusion: markets are inherently regressive, and the most important explanation for why the financing of medical care in the United States is unfair is that we have left much of its financing to markets. As a result, only some sort of national health insurance program is capable of making the U.S. health care system more progressive both in financing and utilization.

After all, what distinguishes the United States' health care from that of most other industrialized countries is the extent to which we rely on for-profit private insurance. Among industrialized democracies, only Switzerland and the United States fund their systems mostly through private sources (encompassing private insurance and direct out-of-pocket payments by patients).[98] Not surprisingly, Switzerland and the United States have been found to have the most regressive health financing systems among these nations, with the poor paying

94. This title is borrowed from Thomas Rice, *Can Markets Give Us the Health System We Want?*, 22 J. HEALTH POL. POL'Y & L. 383 (1997).

95. Havighurst & Richman, *supra* note 6, at 79.

96. *Id.*

97. *Id.* at 81.

98. THOMAS RICE, THE ECONOMICS OF HEALTH RECONSIDERED 254 (2d ed. 2003).

proportionately more than in countries such as France and the United Kingdom that rely more heavily on taxes to fund medical services.[99]

Markets ration by price and ability to pay, and the American experience demonstrates that they are predictably regressive in their distributional implications for medical care. There is no mechanism available to force health care markets to become more progressive in financing medical care and no reason to believe they will change for the better in this regard, short of government intervention. Nor is one of Havighurst and Richman's favored solutions—separating out low-income workers from higher-income workers in the same company and placing them into their own insurance pools—likely to work.[100] Indeed, this proposal is neither feasible nor desirable. Havighurst and Richman explain that separate pools would offer lower-income workers coverage with income-related (and thus lower) cost-sharing, but also with less comprehensive coverage than their wealthier co-workers would enjoy, thus exacerbating inequality in medical care.[101]

However, health status is correlated with income,[102] and it is not likely that insurers will be ecstatic about pools that by definition have a higher concentration of worse risks in them. For all their vices, and there are many, large employer pools do have the virtue of spreading risk. Moreover, Havighurst and Richman do not emphasize the main pathway of cross-subsidization in insurance pools, which flows not from the poor to the wealthy but from the healthy to the very sick—five percent of patients account for fifty-five percent of health expenditures.[103] If private insurance pools were segmented by income and if low-income pools attracted disproportionately sicker populations (a real possibility, given that health status is correlated with income), their financial viability could be threatened. Finally, one need look no further than Medicaid and the experiences of its low-income beneficiaries losing coverage in states like Tennessee to appreciate that isolating the poor into their own insurance programs carries with it significant political liabilities.[104]

In short, if the central goal is to make the financing of health services more progressive in the United States, markets simply will not do the job. They are part of the problem, not the solution, and if we continue to rely on markets in health care, they will continue to produce more uninsured, more health care spending, and more inequality. That is the inescapable conclusion of the history of U.S. health policy and (even if they do not fully embrace it) of Havighurst

99. *Id*.

100. Havighurst & Richman, *supra* note 6, at 45.

101. *Id*. at 46 (stating plans might not "undertak[e] to cover everything deemed 'medically necessary'").

102. Nancy E. Adler & Katherine Newman, *Socioeconomic Disparities in Health: Pathways and Policies*, HEALTH AFF., Mar.–Apr. 2002, at 60, 62–64.

103. Marc L. Berc and Alan C. Monheit, *The Concentration of Health Care Expenditures Revisited,* HEALTH AFF., Mar.–Apr. 2001, at 9, 12.

104. *See* Emily Berry, *Tenn. Care Cuts Some "Sickest, Neediest,"* CHATTANOOGA TIMES FREE PRESS, Dec. 4, 2005, at A1.

and Richman's analysis. As a consequence, the authors' preferred solution of market-based reform is likely to fail, though not for the reasons they delineate; instead, their second-best solution—a government health plan—is the only viable solution to the problems they document. In the end, if Americans are truly serious about correcting the regressive nature of their health care system, they will have to look away from markets, in a direction many will not be comfortable with, to find a framework for progressive financing—namely, toward tax-financed national health insurance.[105]

105. The progressive character of tax-financed national health insurance depends on what mix of taxes is used to fund it. But tax-funded national health insurance provides a framework to pursue more equitable financing of health care, something that health care markets cannot do. Similarly, national health plans cannot assure that the positive correlation between income and medical-care utilization that Havighurst and Richman hypothesize exists in private insurance—an eminently plausible hypothesis that awaits more empirical evidence—will disappear. But they offer the potential of reducing that disparity inasmuch as they eliminate financial barriers to care, a prospect that private health insurance does not hold. Indeed, some studies have found that lower-income Canadians receive more medical services than their wealthier compatriots, the reverse of the situation in the United States. BODENHEIMER & GURMBACH, *supra* note 41, at 48. On the relationship between income and utilization of medical care services, see Eddy van Doorslaer, Cristina Masseria & Xander Koolman, OCED Health Equity Research Group, *Inequalities in Access to Medical Care by Income in Developed Countries*, 174 CAN. MED. ASS'N J. 177, 177 (2006) ("We found inequity in physician utilization favouring patients who are better off in about half of the OECD countries studied. . . . In most countries, we found no evidence of inequity in the distribution of general practioner visits across income groups, and where it does occur it often indicates pro-poor distribution. However, in all countries for which data are available, after controlling for need differences, people with higher incomes are significantly more likely to see a specialist than people with lower incomes, and in most countries, also more frequently.").