

FIXING OBAMACARE: THE VIRTUES OF CHOICE, COMPETITION, AND DEREGULATION

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This paper was originally presented at a conference at the Brookings Institution on March 7, 2008, two full years before PPACA was enacted. It has since been substantially revised and updated to reflect subsequent developments. However, at several points we discuss the 2008 Obama campaign’s positions on health reform, since it is helpful in understanding how we ended up with PPACA.

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INTRODUCTION

After a tumultuous and extended legislative process, President Obama signed the Patient Protection and Affordable Care Act (“PPACA”) on March 23, 2010.¹ PPACA was “sold” to the public with an explicit promise that it would not interfere with existing coverage arrangements. President Obama repeatedly claimed, “[N]o matter how we reform health care, we will keep this promise to the American people: If you like your doctor, you will be able to keep your doctor, period. If you like your health care plan, you’ll be able to keep your health care plan, period. No one will take it away, no matter what.”² Better still, then-Senator Obama promised, “If you already have health insurance, the only thing that will change for you under this plan is the amount of money you will spend on premiums. That will be less.”³

It is now more than three years since PPACA was enacted—what lessons have we learned? How likely is it that the government’s ponderous bureaucracy can keep the promises of President Obama? And if government falters, as we think likely, what should the nation do instead? We sketch out our responses to each of these questions in this Article.

To summarize our argument, PPACA is extraordinarily unlikely to lower health care costs, but it has significant potential to

1. Congress also enacted a “sidecar” piece of legislation modifying various provisions in PPACA. President Obama signed the sidecar, the Health Care and Education Reconciliation Act of 2010, on March 30, 2010. We refer to both pieces of legislation collectively as PPACA.

2. President Barack Obama, Remarks at the Annual Conference of the American Medical Association (June 15, 2009), *available at* <http://www.whitehouse.gov/the-press-office/remarks-president-annual-conference-american-medical-association>.

3. Senator Barack Obama, Speech on Health Care at the University of Iowa (May 29, 2007), *available at* http://www.nytimes.com/2007/05/29/us/politics/28text-obama.html?pagewanted=print&_r=1&&gwh=DE61FA8693E7E154FFED2A8FE5DF1A9F.

destabilize existing coverage markets. Our prediction is that neither of the two Obama promises will or could be kept, even were PPACA implemented more or less as written, which with each passing day seems increasingly unlikely. In our view, the problems that have already materialized in the first three years of PPACA are merely precursors to greater difficulties to come—difficulties that virtually ensure that PPACA will turn out to be an expensive and misguided failure, assuming that it survives at all.

PPACA's fundamental design defect was to superimpose additional layers of regulation and subsidies on a system that was already top-heavy with both. These preexisting regulations and subsidies have already misaligned the incentives within the health care system. The next generation of rules will only compound the errors. In our view, the right approach to these problems is to promptly initiate a program of systematic deregulation that will introduce the choice and competition to which PPACA gives, at best, lip service. The right sequencing of reform is critical. It is far cheaper to remove regulations and subsidies than to add them. Each of these maneuvers should, as no regulatory scheme could, work to reduce costs and increase both access to and quality of health care. Then, and only then, is it prudent to consider further steps, such as additional regulations (to constrain costs) and subsidies (to increase access).

I.

PPACA 101

PPACA is a vast and sprawling piece of legislation, encompassing several thousand pages of statutory language, with changes both large and small to multiple parts of health care financing and delivery systems. Despite this length, PPACA defers many of the most difficult decisions, whether practically or politically or both, and requires them to be made by the Secretary of Health and Human Services ("HHS") at a later date. Indeed, PPACA states that the Secretary of HHS "shall," "may," or "determines" more than a thousand times. Thus the thousands of pages of PPACA are merely the opening move in a sweeping top-down reordering of one-seventh of the economy under a statute that works hard to limit judicial review of its major administrative actions.

PPACA's basic framework is set out in eight discrete statutory sections ("Titles"), each of which includes a diverse array of substantive provisions. The coverage provisions relating to the private market are found in Title I, which is named (in the understated rhetoric typical of over-reaching congressional reform initiatives)

“Quality, Affordable Health Care For All Americans.” Other Titles cover the expansion of Medicaid (“Title II”); changes to the health care financing and delivery systems (“Title III”); the prevention of chronic disease and the improvement of public health programs (“Title IV”); the health care workforce (Title V); health care transparency and program integrity (“Title VI”); increased access to innovative medical therapies (“Title VII”); and a long-term care insurance program (“Title VIII”).

We focus in this Article on the difficulties that have emerged, or seem likely to emerge, with Title I (the private insurance market reforms). There is however no shortage of difficulties in all of the Titles. For example, Title VII, the “Community Living Assistance Services and Supports Act” (“CLASS Act”), was so deeply flawed that the Obama Administration discontinued it in October 2011 before it was even launched, even as the Administration vigorously defended the Act’s long-term care insurance program against its critics until the very end.

We begin with a summary of the substantive provisions in Title I. Some provisions have already gone into effect, while others are scheduled to take effect over the coming years.

A. *Individual Mandate*

Starting in 2014, all U.S. residents will be required to maintain “minimum essential coverage.” Those who fail to maintain continuous health insurance coverage are liable for an annual penalty, which is set at the greater of a flat dollar amount (\$95 per person in 2014, \$325 per person in 2015, and \$695 per person in 2016) or a percentage of the individual’s taxable income, in excess of the filing threshold, 1% in 2014, 2% in 2015, and 2.5% thereafter. There are a variety of exceptions, including those for whom the cost of coverage exceeds 8% of their household income, individuals with a religious conscience exception, and illegal aliens.

B. *Exchanges*

PPACA authorizes the federal government to provide states with grants to set up an exchange to bring together buyers and sellers of health insurance. These government exchanges are quite different from the voluntary private exchanges organized to facilitate trade because they set entry requirements for listing costs, eligibility, and the like. But the government does not just want to erect a big tent under which firms can meet with customers. Rather, the government wants to impose minimum substantive conditions that

all listed firms must meet, both for minimum coverage and the acceptance of patients.

To carry out this extensive mission, PPACA imposes a wide array of requirements that a “qualified health plan” must meet, such as providing minimum or “essential” benefits. These essential benefits are set at specific levels to be determined by the Secretary of HHS, subject to an overriding limitation that each participant on the exchanges must offer benefits roughly comparable to the scope of benefits provided by a typical employer-based plan. PPACA also imposes on eligible firms limitations on cost-sharing and other requirements for participation.

In the event a state decides not to start its own exchange, the federal government can do so—although there is a serious question as to whether the subsidies for individuals (as detailed below) are available under these circumstances.⁴

C. Subsidies

PPACA supplies a broad array of subsidies to individuals and employers. The most significant subsidies go into effect in 2014 and are for those who obtain coverage through an exchange. The amount of the relevant subsidies is not small. A recent survey by the Kaiser Family Foundation⁵ anticipates that the subsidies provided over the exchanges will average about \$6,000 per person. Much of that cost will be needed in order for families of limited means to acquire the full set of minimum essential benefits that PPACA mandates.

D. Pay or Play

PPACA does not require employers to offer coverage to employees or their families. However, large employers (those with more than fifty employees) that do not offer “affordable” coverage (defined relative to the employee’s household income) must pay a penalty (\$2,000 x [the number of full-time employees – 30]) begin-

4. See IRS: Enforcing ObamaCare’s New Rules and Taxes Before the H. Comm. on Oversight and Reform, 112th Cong. 45–54 (2012) (statement of Michael F. Cannon, Director of Health Policy Studies, Cato Institute, and Jonathan H. Adler, Professor at the Case Western Reserve School of Law), available at <http://www.gpo.gov/fdsys/pkg/CHRG-112hrg76370/pdf/CHRG-112hrg76370.pdf>; see also Jonathan H. Adler & Michael F. Cannon, *Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA*, 23 HEALTH MATRIX 119 (2013).

5. THE KAISER FAMILY FOUND. & HEALTH RESEARCH AND EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2012 ANNUAL SURVEY (2012).

ning in 2014, as long as at least one full-time employee obtains coverage through the exchange. If the employer does not offer coverage at all, it is subject to a similar penalty, as long as at least one full-time employee obtains coverage through the exchange.

E. Substantive Provisions

Substantive regulation of coverage is extensive and includes (i) minimum coverage terms, (ii) no exclusion of preexisting conditions, (iii) limitations on rescission of coverage, (iv) no lifetime or annual limits, (v) limitations on Medical Loss Ratios (“MLRs”),⁶ and (vi) mandatory premium compression.⁷ With respect to the minimum coverage terms, all policies sold through the exchanges must cover ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services.

Some of these provisions have gone into effect already, while others are in the process of being phased in.

F. Additional Provisions

PPACA also contains several other critical provisions that are scheduled to go into effect in the next few years.

It creates the Independent Payment Advisory Board (“IPAB”), charged with reducing the cost of Medicare without compromising coverage or quality. IPAB’s recommendations go into effect unless they are blocked by a super-majority vote in Congress. IPAB can make recommendations as early as 2014 if Medicare spending projections exceed a targeted figure, which currently seems unlikely.

6. As we discuss later, the MLR refers to the permissible levels of expenditures on non-medical costs, which is capped at 15% for large plans and 20% for small-group and individual plans. For a detailed discussion, see Richard A. Epstein & Paula M. Stannard, *Constitutional Ratemaking and the Affordable Care Act: A New Source of Vulnerability*, 38 AM. J.L. & MED., 243, 259–61 (2012).

7. PPACA limits the “spread” between the minimum and maximum premiums charged to different age groups to 3:1, prohibits differential rates based on gender, and limits differential rates based on smoking to 1.5:1. Because the actual variation in claim cost is substantially higher, this restriction results in premium compression relative to what would be charged in a competitive market. More concretely, PPACA forces the young to overpay for their coverage in order to subsidize the elderly, who pay less than their actual cost. Ironically, PPACA was “sold” on the basis that it would prevent free riding by the young and healthy—but it ended up overcharging the young and healthy for the coverage they receive.

PPACA also imposes an excise tax on high-cost (“Cadillac”) private health insurance. This tax is scheduled to go into effect in 2018.

II. PROMISES, PROMISES

PPACA was sold as all dessert and no spinach. As we noted previously, then-Senator Obama repeatedly claimed, “If you already have health insurance, the only thing that will change for you under this plan is the amount of money you will spend on premiums. That will be less.” How much less? The Obama campaign settled on a figure of \$2,500 per household—although the campaign was less than clear on whether that was the dollar amount by which premiums would decline from the current levels, or the amount by which health care spending was expected to decline relative to some unspecified (but higher) baseline at some unspecified point in the future.

The great challenge is to realize these “savings” when coverage was simultaneously being expanded and improved—each of which was likely to prove costly in its own right. Although cost-containment was never a priority, the Obama campaign offered a laundry list of strategies and promises to keep reform affordable, without ever explaining exactly how it would all work. According to the campaign, prevention and improvements in the delivery of care would lower health care spending. Bundling of payments would dampen the incentives for physicians and hospitals to over-utilize various treatments to take advantage of third-party payers. The administrative costs needed to run the entire system would decline. Employers would be required to either provide coverage, or pay a set amount per employee (“pay or play”).

At the same time, the Obama campaign claimed that government subsidies would be provided to help ensure people could afford coverage, and Medicaid would be substantially expanded. Waste, fraud, and abuse would be attacked, along with “abusive” insurance company practices. Unspecified hidden taxes would be removed, and, independently, the Bush tax cuts for families earning more than \$250,000 would be allowed to expire in order to fund this program (and countless others, of course). The plan also counted as “savings” (and promptly spent on expanded coverage) the amount that was predicted to be attributable to any slowing of

increased spending on Medicare.⁸ Various demonstration projects, pilot programs, independent boards, and institutes were also folded into the plan.

However, as outlined above, the Obama campaign knew that these reforms would lose all their appeal if they disrupted existing health care arrangements. The basic sales pitch for PPACA was that individuals could either keep their current coverage (which would still be improved by adding parity for mental health coverage and various other sweeteners), or switch to coverage as good as that which Congress offers its members. To this day, the White House has a “Reality Check” web page that flatly states “you can keep your own insurance,” and is devoted to “debunk[ing] the myth that reform will force you out of your current insurance plan or force you to change doctors.”⁹

To be sure, designing the program in this fashion was intended as a concession to private markets, even though the left preferred a single-payer system in which payments for all health care services are funneled through the government. Although President Obama had previously made clear his personal preference for a single-payer system, the Obama Administration sensibly believed that health reform was a political non-starter if it promised to replace everyone’s existing insurance coverage—particularly if the costs showed up as on-budget expenses.

The 1993 demise of the Clinton health reform plan makes this point clear. That plan ran into heavy opposition from the membership of the AARP once they concluded that spreading the coverage wider would necessarily dilute their Medicare benefits.¹⁰ Lesson learned: today any health care plan that threatens an immediate

8. The Obama Administration’s decision to cut Medicare spending and use the “savings” to fund expanded coverage became a flashpoint in the 2012 Presidential election campaign. See Yuval Levin, *The Democrats’ Growing Medicare Dilemma*, THE CORNER (Aug. 15, 2012 11:48 AM), <http://www.nationalreview.com/content/democrats-growing-medicare-dilemma>.

9. *Health Insurance Reform Reality Check*, WHITEHOUSE.GOV, <http://www.whitehouse.gov/realitycheck/3> (last visited Aug. 27, 2013); see also Amy Lynn Sorrel & Emily Berry, *Obama Tells AMA, “I Need Your Help,”* AM. MED. NEWS (June 15, 2009), <http://www.ama-assn.org/amednews/2009/06/15/prsc0615.htm> (“No matter how we reform health care, we will keep this promise: If you like your doctor, you will be able to keep your doctor. Period.”); Macon Phillips, *Facts Are Stubborn Things*, THE WHITE HOUSE BLOG, <http://whitehouse.gov/blog/Facts-Are-Stubborn-Things>.

10. Robert Pear, *Clinton Fails to Get Endorsement of Elderly Group of Health Plan*, N.Y. TIMES, Feb. 25, 1994, at A1. For a more extended dissection of the plan, see RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* 2, 185–215 (1997). For a very different take, see THEDA SKOCPOL, *BOOMERANG:*

reduction in the health care coverage provided to Medicare beneficiaries and other politically powerful groups is a non-starter. To avoid that impression, the Obama campaign's and Administration's plan stressed consumer "choices," just as the White House's "Reality Check" web page still argues that the PPACA health care reforms will benefit small businesses, stop rationing, and eliminate insurance discrimination.¹¹ The sweep and ambition that culminated in PPACA was captured by the Obama campaign's website:

The Obama-Biden plan provides new affordable health insurance options by: (1) guaranteeing eligibility for all health insurance plans; (2) creating a National Health Insurance Exchange to help Americans and businesses purchase private health insurance; (3) providing new tax credits to families who can't afford health insurance and to small businesses with a new Small Business Health Tax Credit; (4) requiring all large employers to contribute towards health coverage for their employees or towards the cost of the public plan; (5) requiring all children have health care coverage; (6) expanding eligibility for the Medicaid and SCHIP programs; and (7) allowing flexibility for state health reform plans.

Although the Obama campaign's rhetoric was framed around improving the performance of the private market, its command-and-control regulatory strategies, including price controls, were never buried far beneath the surface. For example, consider the campaign's description of the proposed health insurance exchanges:

National Health Insurance Exchange: The Obama plan will create a National Health Insurance Exchange to help individuals who wish to purchase a private insurance plan. The Exchange will act as a watchdog group and help reform the private insurance market by creating rules and standards for participating insurance plans to ensure fairness and to make individual coverage more affordable and accessible. Insurers would have to issue every applicant a policy, and charge fair and stable premiums that will not depend upon health status. The Exchange will require that all the plans offered are at least as generous as the new public plan and have the same standards for quality and efficiency. The Exchange would evaluate

CLINTON'S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS (1996).

11. See *Health Insurance Reform Reality Check*, *supra* note 9.

plans and make the differences among the plans, including cost of services, public.

Interestingly, the Obama campaign's original proposal did not include a comprehensive individual mandate. Then-Senator Obama repeatedly attacked then-Senator Clinton's health reform proposal for its inclusion of a comprehensive individual mandate, instead of the more limited mandate on coverage for children included in the Obama campaign's proposal. Once elected, President Obama, presumably in response to strong political pressures from within his own party and from the health care establishment, reversed course and included a comprehensive individual mandate in PPACA, while insisting that this feature would not disrupt the private market. Further, in each of the court proceedings challenging PPACA, the Obama Administration insisted that the mandate was absolutely necessary for Obamacare to succeed. Not surprisingly, in *NFIB v. Sebelius*, Justice Ginsburg echoed these sentiments:

Aware that a national solution was required, Congress could have taken over the health-insurance market by establishing a tax-and-spend federal program like Social Security. Such a program, commonly referred to as a single-payer system (where the sole payer is the Federal Government), would have left little, if any, room for private enterprise or the States. Instead of going this route, Congress enacted the ACA, a solution that retains a robust role for private insurers and state governments. To make its chosen approach work, however, Congress had to use some new tools, including a requirement that most individuals obtain private health insurance coverage. See 26 U.S.C. §5000A (2006 ed., Supp. IV) (the minimum coverage provision). As explained below, by employing these tools, Congress was able to achieve a practical, altogether reasonable, solution.¹²

For reasons we turn to in the following sections, this rosy account of PPACA's prospects is implausible on its face, even leaving aside the constitutional issues.

12. *Nat'l Fed'n Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2612–13 (2012) (Ginsburg, J., concurring).

III. PROBLEMS WITH PPACA

A. *Generic Problems with PPACA*

PPACA was launched into stormy seas. Enacted after a bruising multi-year battle, the only bipartisan feature of PPACA was the opposition to it.

To make PPACA appear to be less expensive than it actually was, most of the promised benefits were back-loaded and a few of the taxes were front-loaded—a perilous combination if the fate of the Medicare Catastrophic Coverage Act is any indication.¹³ Nevertheless, such a structure initially makes the program appear cheaper than it actually is by deferring many of the costs to later years, thereby avoiding sticker shock on the part of taxpayers, who only learn the full cost once the program is already in effect. Indeed, it was this peculiar structure that allowed proponents to claim that PPACA would reduce the deficit. The poisonous politics of PPACA are exemplified by the fact that when Democrats ran advertisements about PPACA during the 2010 mid-term elections, it was to highlight that they had voted against it—but Democrats lost their majority in the House of Representatives anyway, in part because most of them could not make that claim.¹⁴

We highlight several problems that have already resulted from these circumstances. We then turn to the problems likely to materialize in coming years if PPACA is implemented as written.

1. Administrative and Appropriation Battles

As noted previously, many of PPACA's substantive provisions are phased in over an extended period—meaning that problems emerge in predictable cycles, as PPACA's provisions take effect. Paradoxically, the long rollout creates an incentive for the Obama Administration to churn out aggressive regulation as if there were no tomorrow, for the simple reason there may not be a tomorrow in which the Democrats control the presidency, the House of Repre-

13. The Medicare Catastrophic Coverage Act of 1988 was signed in July of 1988 and repealed in November of 1989, after withering attacks from senior citizens who thought that its costs and complexity outweighed its benefits—largely because Medicare beneficiaries would have financed the new benefits in their entirety, instead of having the benefits funded by non-elderly taxpayers. Thomas Rice, Katherine Desmond, & Jon Gabel, *The Medicare Catastrophic Coverage Act: A Post Mortem*, 9 HEALTH AFF. no. 3, Fall 1990, at 75–77 (1990) (discussing the various factors that led to repeal).

14. See David A. Hyman, *Convicts and Convictions: Lessons from Transportation for Health Reform*, 159 PENN. L. REV. 1999, 2003–04 (2011).

sentatives, or the Senate. At the same time, the long rollout encourages the Republicans in the House of Representatives to stall on appropriations and the Republicans in the Senate to hold up key appointments. The election of 2012 layered on further uncertainties. Since PPACA will always be a work in progress, we should expect the same every two years thereafter. Finally, even if PPACA's administrative framework is fully implemented, the entire structure will implode if the subsidies to purchase coverage are insufficient—and those subsidies provide an obvious target if both houses of Congress fall into Republican hands in 2014.

These dynamics help explain why, even though Democrats have a clear majority in the Senate, the Obama Administration had to use a recess appointment to temporarily put Dr. Donald Berwick in charge of the Centers for Medicare and Medicaid Services. Indeed, the Obama Administration withdrew Berwick's nomination before his paperwork was completed once it became clear that a confirmation hearing would be used by Republicans to renew their attacks on PPACA. It is hard to attract good people to administer the system or to get a coherent timeline for implementation in the face of such struggles. It is equally difficult for either public or private parties to engage in long-term planning in the face of pervasive short-term uncertainty.

2. Industry Consolidation

Regulation imposes high fixed costs on firms. To spread these costs across a larger patient base, smaller firms will predictably merge or be acquired. Those that cannot do either are likely to exit the industry. This two-sided dynamic has already led to higher concentration, which could well have anti-competitive implications. That process will be accelerated as new regulations set high minimum standards for all firms, which reduce the dimensions on which they can compete. The regulatory compliance issues will also create barriers to entry for new firms, which in turn will lead industry incumbents to cheer these regulations on, in ways that allow them to dress up their own protectionist impulses as evidence of their new-found social conscience.

As if this were not bad enough, PPACA affirmatively encourages consolidation through its promotion of Accountable Care Organizations ("ACOs")—while doing little to ensure that the re-

sulting combinations do not engage in anti-competitive conduct.¹⁵ The antitrust agencies have done their best to back-fill on the ACO issue, but one (now former) FTC Commissioner has expressed considerable skepticism on whether the Department of Justice will actually hold up its end if push comes to shove.¹⁶

3. Government by Waiver

Implementation of a complicated and sweeping statute is always challenging. Once challenging standards are imposed, regulated entities will predictably seek temporary and/or permanent dispensation. In the context of PPACA, employers and insurers have claimed that their line of business or employee base (or both) does not allow for them to comply with the standard and stay in business. Often (but not always) that claim is credible.

Responsible government officials have to decide whether to enforce the requirement as written (effectively playing “chicken” with the regulated entities), or waive the requirement for some or all of the regulated entities. HHS has publicly struggled with this dy-

15. See generally Thomas Greaney, *Regulators as Market Makers: Accountable Care Organizations and Competition Policy*, ARIZ. ST. L.J. (forthcoming 2013), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2124097.

16. See, e.g., Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 209 (Oct. 28, 2011); see also Press Release, U.S. Federal Trade Commission, FTC, DOJ Seek Public Comment on Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations (Mar. 31, 2011), available at <http://www.ftc.gov/opa/2011/03/aco.shtm> (“The Commission vote approving the proposed Policy Statement and related Federal Register notice was 4-1. Commissioner J. Thomas Rosch dissented. He generally agrees with the analytical framework described in the proposed Policy Statement but dissents because of the statement’s suggestion that the formation of ACOs will be reviewed by both the FTC and the DOJ. Commissioner Rosch believes that responsibility for reviewing the formation of ACOs should remain with the Commission because: 1) the Antitrust Division currently has far less expertise or experience than the Commission in reviewing the formation of ACOs or applying the antitrust laws to them; and 2) the Antitrust Division is more susceptible than the Commission, an independent agency, to lobbying and other political pressure. In his view, the evaluation of some ACOs by the Antitrust Division represents a victory for physicians and hospitals – as well as their lobbyists and political supporters – which have opposed Commission review and antitrust enforcement of clinically-integrated health care providers.”); Avik Roy, *FTC Commissioner: Accountable Care Organizations Will Likely Lead to ‘Higher Costs and Lower Quality Care,’* FORBES.COM (Nov. 21, 2011, 6:24 PM), <http://www.forbes.com/sites/aroy/2011/11/21/ftc-commissioner-accountable-care-organizations-will-likely-lead-to-higher-costs-and-lower-quality-health-care/>.

namic, issuing more than a thousand waivers, affecting millions of employed individuals, while turning down other supplicants.¹⁷

Waiver comes at a high price because it carries with it the serious risk of ad hoc behavior (if not out-and-out favoritism) over such key dimensions as who gets the waiver, over which product lines, for what period, and subject to what conditions. It is no accident that once published, each list of waivers is closely scrutinized by PPACA's opponents, who then criticize HHS for granting waivers to political allies (including vocal supporters of PPACA) while denying waivers to states with Republican senators.

The basic problem is that unappreciated differences in the internal structure of regulated firms and states can easily undercut government efforts to ensure uniformity by fiat. King Canute was unable to halt the advance of the incoming tide by decree, and PPACA's attempts to impose a top-down framework on health care financing and delivery systems are likely to be similarly unsuccessful.

B. *Specific Problems with PPACA's Title I*

The way in which PPACA's Title I is structured creates four distinct risks to existing coverage, which are individually and collectively likely to result in the destabilization of the private insurance market, notwithstanding the protestations of the Obama Administration and its apologists. We address each problem in turn.

1. Substantive Requirements

PPACA's substantive requirements seem likely to have a profound impact on existing coverage—and not in the direction of reducing health care spending. The MLR, a feature of PPACA that allocates the percentage of premium dollars that can be spent on clinical treatment versus other costs, offers one window into the difficulties that will be faced.

Right now, private insurers must spend large amounts of money on purposes other than clinical care. Examples of non-clinical expenditures include payments for general administration, regulatory compliance, advertisement and promotion, fraud control, long-term planning, shareholder dividends, and brokers' and other intermediaries' fees. Given the variations in the internal

17. For discussion, see Richard A. Epstein & David A. Hyman, *Why Obamacare Will End Health Insurance As We Know It*, MANHATTAN INSTITUTE FOR POLICY RESEARCH ISSUES 2012, no. 7, 3 (Mar. 2012), available at http://www.manhattan-institute.org/pdf/ir_7.pdf.

structure of each firm, its regulatory environment, and its customer base, it is not possible to determine just how much should be spent on these activities. But since these firms internalize all gains and losses and operate in a competitive environment, the expectation is that the last dollar spent on each of these non-clinical expenses will be worth the last dollar spent on other purposes. Of course, one obvious way to reduce expenditures purely attributable to administrative overhead is to stabilize the regulatory environment—but Congress instead opted for limitations on the MLR for each company and state.

It is easy to come up with multiple objections to the MLR, which represented Senator Jay Rockefeller's solution to a non-problem. First, the selected percentages are wholly arbitrary. The MLR caps the percentage of premium dollars that can be spent on purposes other than clinical treatment, with a higher percentage permissible for small plans (20%) than for large plans (15%). But why not cap non-clinical expenditures at 10% or even 5% if administrative costs are inherently suspect? Second, there is no empirical evidence for the choice of these numbers. Different plans with different patient populations could easily require substantially higher administrative costs but still provide good value for the money. Third, the fixed ratios will have the unfortunate effect of making it even less likely that the last dollar spent on insured medical care will generate as much plan benefit as the last dollar spent on direct health care services, adding yet another element of waste into the system. Fourth, introducing the MLR creates another unacknowledged implicit advantage for non-profit plans over their for-profit competitors, since the latter must pay dividends, which count against the 15% or 20% non-clinical spending cap, to their shareholders. This also creates an incentive to reclassify expenditures, which HHS sought to limit by issuing overly narrow regulations on what type of expenditures counted as relating to clinical services. Alternatively, one can seek dispensation from the requirement on the ground it would disrupt the coverage market, as many states did.

Another provision had a more immediate impact: effective six months post-enactment, PPACA banned the use of exclusions on preexisting conditions for coverage provided to children (aged eighteen and under).¹⁸ As noted above, the same prohibition is scheduled to go into effect for adults in 2014, accompanied by an

18. Patient Protection and Affordable Care Act, 42 U.S.C. §§ 300gg-1-18 (2012).

individual mandate, which requires every American to purchase coverage or pay a penalty.¹⁹ However, the ban on preexisting conditions for children's coverage that took effect on September 23, 2010 was not accompanied by a mandate to require the purchase of such coverage—at least not until 2014, when the mandate goes into effect for everyone. This combination was a recipe for disaster, which struck in short order. Insurers substantially raised prices, some announced plans to withdraw entirely, and some of those selling individual policies to children announced that they would no longer do so.²⁰ By August 2011, thirty-nine states had seen carriers leave the child-only market, with seventeen states reporting a complete collapse of that market.²¹ It takes real talent to close down a market by enacting legislation designed to expand it, particularly after repeatedly promising “if you like your coverage you can keep it.”

2. Subsidy Design

As noted previously, PPACA creates substantial subsidies for individuals who obtain coverage through the state-run exchanges because they are not able to find affordable coverage through their employers. Many of the persons covered are likely to be low-income, but the subsidies go sufficiently high into the income distribution that many middle-income individuals will qualify. These subsidies are scheduled to commence in 2014.

There are two distinct subsidy design problems that are likely to surface quickly. First, the combination of new PPACA subsidies with preexisting tax subsidies has the potential to be extremely destabilizing to existing coverage arrangements. For low-income workers (i.e., those with incomes lower than 200-250% of the federal

19. *Id.*

20. See, e.g., N. C. Aizenman, *Some Insurers to Halt New Child-Only Policies*, WASH. POST, Sept. 21, 2010, <http://www.washingtonpost.com/wp-dyn/content/article/2010/09/20/AR2010092006682.html> (“Some of the country's most prominent health insurance companies have decided to stop offering new child-only plans, rather than comply with rules in the new health-care law”); Julie Royner, *Health Insurers Skirt New Coverage Requirement for Kids*, Shots: NPR's Health Blog (Sept. 21, 2010, 9:04 AM), <http://www.npr.org/blogs/health/2010/09/21/130013723/colorado-insurers-skirt-new-coverage-requirement-for-kids> (cataloging numerous insurers dropping child-only plans in response to PPACA).

21. Michael B. Enzi, Ranking Member of S. Comm. on Health Educ., Labor and Pensions, *Ranking Member Report: Health Care Reform Law's Impact on Child-Only Health Insurance Policies 2* (Aug. 2, 2011), available at <http://www.help.senate.gov/imo/media/doc/Child-Only%20Health%20Insurance%20Report%20Aug%20202011.pdf>. See also Hyman, *supra* note 14, at 2027–28.

poverty level), PPACA provides substantial subsidies to those who obtain coverage through the government regulated exchange, but left in place the existing (relatively modest) tax subsidies for low-income workers who obtain coverage through their places of employment. For high-wage workers, the subsidy pattern is reversed; individuals receive low subsidies for obtaining coverage through the exchange and high subsidies for obtaining coverage through one's place of employment. After one factors in the penalty employers must pay whenever employees obtain coverage through the exchange, it turns out that low-wage workers and their employers are jointly better off financially if coverage is obtained through an exchange, while higher income workers and their employers are jointly better off if coverage is obtained through one's place of employment.

Another provision in PPACA creates an additional incentive for employers to drop coverage; if the coverage they offer is "unaffordable" they they must pay an additional penalty. "Affordable" is defined in terms of the percentage of an employee's household income that must be spent on health insurance premiums. According to one survey, roughly one-third of employers had some workers for whom coverage might be "unaffordable,"²² which is a necessary consequence of high minimums imposed by even the most modest of government plans.

The likely result is that when faced with all-or-nothing coverage decisions for their employees, some employers will favor "nothing," while others will experiment with changing the terms of coverage and the boundaries and staffing of the firm.²³ The only thing we can be certain of is that existing arrangements will not prove to be immutable, particularly when employers might gain large subsidies from the unbundling and rebundling of coverage for their respective workforces. Stated more concretely, the differential subsidies are likely to prove extremely destabilizing to the continuation of employment-based coverage—which in turn will dramatically increase the on-budget cost of PPACA. Indeed, the head of the Congressional Budget Office in the Bush Administration estimated that PPACA could encourage employers to drop coverage for up to 35

22. Robert Pear, *Study Points to Health Law's Penalties*, N.Y. TIMES, May 23, 2010, at A15, available at <http://www.nytimes.com/2010/05/24/health/policy/24health.html?gwh=0C25E0182B199343F778A7BCAD273414>.

23. David A. Hyman, *Employment-Based Health Insurance: Is Health Reform a "Game Changer?"*, in NEW YORK UNIVERSITY REVIEW OF EMPLOYEE BENEFITS AND EXECUTIVE COMPENSATION 1A-1, 1A-15 (Alvin D Lurie ed., 2010).

million Americans,²⁴ at which point the on-budget costs of reform will skyrocket and the exchanges are unlikely to be able to handle the surge in demand.

The second subsidy design problem is much simpler to describe. As noted previously, although PPACA authorizes the federal government to set up an exchange if the state chooses not to do so, PPACA only authorizes subsidies for coverage provided through state-run exchanges, and not for any coverage provided through a federal-run exchange.²⁵ Thus a state that refuses to set up an exchange will also be able to block the federal government from providing subsidized coverage to targeted workers through any exchange the federal government sets up.

In response the Obama Administration has finalized an IRS rule seeking to authorize subsidy payments irrespective of whether the exchange is run by state or federal government. It is not likely to work. Every law student learns that administrative rulemaking cannot contradict express statutory requirements, and the text of PPACA is crystal clear. Either the many fine lawyers in the Obama Administration will be able to carve out ad hoc exemptions to the rock-solid principles of administrative and constitutional law (which will then be readily available for use in batting from the other side of the plate when a Republican administration takes power), or PPACA's subsidies will be limited to the states that are willing to set up their own exchanges. Certainly, the current Congress is not likely to resolve the issue by a statutory amendment.

To be sure, these are not the only difficulties with the way the subsidies are designed.²⁶ But they are more than enough to destabilize a market that was providing coverage to approximately 170 million Americans, while simultaneously crippling the exchanges that are supposed to provide coverage for those previously uninsured and those shed from employer-based coverage.

24. Douglas Holtz-Eakin & Cameron Smith, *Labor Markets and Health Care Reform: New Results*, AMERICAN ACTION FORUM (May 27, 2010), http://americanactionforum.org/sites/default/files/OHC_LabMktsHCR.pdf.

25. See Cannon & Adler, *supra* note 4.

26. See, e.g., Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 176 (2011); David A. Hyman, *PPACA in Theory and Practice: The Perils of Parallelism*, 97 VA. L. REV. IN BRIEF 83 (2011), available at <http://www.virginialawreview.org/inbrief.php?s=inbrief&p=2011/11/04/hyman>.

3. Shared Oversight

PPACA provides a byzantine program of shared oversight of insurance of the sort that is only possible in a two-tiered federal system. The federal government has little experience regulating insurance plans, for this entire matter has typically been left to the states since the McCarran-Ferguson Act of 1945. It seems unlikely that the federal government will be able to develop on the fly administrative structures nimble and efficient enough to meet the new influx of patients subject to novel regulations—particularly when congressional oversight is likely to be heavily influenced by political considerations. The Obama Administration has taken multiple steps to try and enlist states in the implementation of PPACA. Recently it has taken the radical step of giving states discretion in specifying essential health benefits. But nonetheless, we think that this part of PPACA is doomed to fail.

4. The Combined Effect

No private insurance company can long survive a system of watchdog regulation that requires increased coverage mandates, imposes extensive price controls, and eliminates all underwriting discretion.²⁷ Even if employers want to keep offering coverage in this hostile environment, it is quite likely few sellers of health plans will be willing to navigate the extensive administrative guidelines sure to come from a multitude of government agencies.

These harsh conditions will undermine the stability of private plans. Recall the (exceedingly misleading) promise that the state would not force you to change coverage—which, if one read the fine print, actually meant only that the federal government would not ban one's existing coverage going forward. Even if that promise could be taken at face value, it does not guarantee that either the employer or health care provider would or could continue their current health insurance offerings once the new regulatory environment transforms economic conditions on both the demand and the cost sides of the market. In time, high taxes and large subsidies will combine to drive most of these plans out of business. The rate, standards, and reporting regulations will help finish off the job. Where and when the tipping point comes, no one can say in ad-

27. For more detailed explanations of this point in connection with the recent health care initiatives, see Epstein & Stannard, *supra* note 6, 248–49 (2012); Richard A. Epstein, *Impermissible Ratemaking in Health Insurance Reform: Why The Reid Bill Is Unconstitutional*, MED. PROGRESS TODAY (Dec. 18, 2009), available at http://www.medicalprogresstoday.com/pdfs/MI_Health_Care_act.pdf.

vance. Some private plans will tenaciously survive; but in the end, our gloomy prediction is that a cascade will develop whereby first some plans will fail, placing greater pressures on the overall health care system, which will in turn lead other plans to topple like ten pins.

For those who are skeptical of this prediction, it is worthwhile to reflect on the parallel history of workers' compensation plans.²⁸ These plans began on a voluntary basis in the 1860s in England, chiefly with high-risk industries like mining and railroads. These plans flourished for about thirty years until the adoption of mandatory coverage under the 1897 Workmen's Compensation Act, which contained a provision identical to that in the Obama campaign's proposal, requiring all private plans to provide benefits at least as generous as those in the state program.²⁹ The voluntary plans disappeared, as they could not meet these exacting mandates without access to the subsidies propping up the state program.³⁰

We think that the massive amount of redistribution built into these plans is, in the long run, wholly inconsistent with the maintenance of a competitive market. Over time, we expect these trends to converge, thereby allowing only one source of funding for health care in the United States to survive. In the end, we will have a single-payer system after several small steps, instead of one big step. The plan that could never sail into political headwinds will become the new standard without any popular vote to bless that development. Stated differently, the operation of a private market is dependent on the larger economic and social framework of which it is a part. Any system with universal aspirations always places private plans at risk—even if they are grudgingly and formally allowed to remain in business.

IV. GENERIC DIFFICULTIES WITH HEALTH REFORM

There are further structural problems with universal health care coverage that no one can wish away: the fundamental principle of diminishing marginal utility, and the questionable desirability of existing regulations. PPACA effectively punted on both of these issues.

28. Richard A. Epstein, *The Historical Origins and Economic Structure of Workers' Compensation*, 16 GA. L. REV. 775 (1982).

29. Workmen's Compensation Act, 1897, 60 & 61 Vict., c. 37, § 3 (Eng).

30. Had PPACA included a public option, this process would have likely been accelerated.

A. Rising Marginal Cost

In most institutional settings, the costs of treatment per person are not uniform over the population. Some people are much more costly to treat than others. Bringing these people into coverage will increase costs disproportionate to their numbers. This problem becomes more acute as the covered population becomes more heterogeneous along all relevant dimensions—including those not anticipated by the individuals designing the plan. Thus it is commonplace to observe that 10% of patients are responsible for 70% of the need for medical services.³¹ To oversimplify, this group includes two classes of individuals: those who have played within the rules and have had a run of bad medical needs, and those who have abused the system and imposed heavy burdens because of their antisocial behavior. One difficulty in running any health care system is the need to respond differently to these two classes of individuals, who are difficult to separate in practice.

It also does not impugn the character of anyone involved in the health care systems to observe that self-interest creates an incentive to game (and even defraud) any system that is set up. Yet it is difficult to ignore the devastating consequences to system integrity that a tiny fraction of individuals pose to the system as a whole.³² Those who doubt this proposition should either Google “emergency room frequent flyers” or spend the weekend in a big city emergency room.

The last few percent of the newly covered population under PPACA will, on average, consist of individuals for whom it is substantially more costly to provide services. These individuals are more likely to receive coverage through Medicaid than through the exchanges, and to have low physiological and human capital. A significant fraction consists of the victims of tragedies that are in no sense of their own making. But others engage in self-destructive habits, such as alcohol and drug abuse, on a repetitive basis. Any program with universal coverage as its goal is, by definition, unable

31. See Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures, Revisited*, 20 HEALTH AFFAIRS 9, 12–13 (2001), available at <http://content.healthaffairs.org/content/20/2/9.full.pdf+html> (finding that the top 10% of the population accounts for 69% of health expenditures, and the bottom 50% of the population accounts for 3% of health expenditures). Indeed, it is the fact that such expenses are highly concentrated that creates a demand for voluntary insurance in this and other markets.

32. For a recent plea to avoid covering these bad apples, see generally PETER SCHUCK & RICHARD ZECKHAUSER, *TARGETING IN SOCIAL PROGRAMS, AVOIDING BAD BETS, REMOVING BAD APPLES* (2006).

to weed out these high-risk insureds—even though the failure to do so makes the system less responsive to the health care needs of the rest of the population. The forced inclusion of this population siphons away resources that would otherwise yield higher value if devoted to individuals with more favorable risk profiles.³³ Put otherwise, the decision to expand coverage to these individuals is a social choice that requires extensive cross-subsidies, and creates significant dislocations. Not surprisingly, the effort to control one social problem creates another.

The debate here is not over ends, but over means. No one thinks that it is a good thing for some people to go without health insurance, any more than it is a good thing for them to go without food, clothing, or shelter—the three most basic needs. Rather, the question is over means: can this program pay for itself, or will it degenerate into a system where health care rights against the state are formally guaranteed, even as systematic shortages compromise the level of health care benefits that can be provided in practice? The Obama Administration has repeatedly demonstrated a Pollyannaish optimism on this point, by insisting that new individuals can be brought into the system without compromising the health care now routinely provided to persons already in the system. Yet the history of numerous government programs provides ample reason for skepticism on this point, particularly in light of the many constitutional and administrative limitations that are likely to impede attempts to police such (mis)conduct. An effort to address the problems of “only” 95% of the population may sound defeatist, but it actually has far greater chances of success than any utopian vision of universal coverage.³⁴ We believe that the reason why the Democrats’ health care reform proposals have met such fierce resistance is, in part, because their efforts to help the bottom tail will necessarily reduce the level of health care available for the vast majority of Americans now covered by some portion of the health care system—including the elderly, who consistently vote in high numbers

33. In the formulation of Schuck & Zeckhauser, such individuals are both “bad apples” and “bad bets.” *Id.*

34. See Mark Ramseyer, *Not-So-Ordinary Judges in Ordinary Courts: Teaching Jordan v. Duff & Phelps*, 120 HARV. L. REV. 1119, 1208 (2007) (“In a second-best world, the right legal rule is not one that tries to get the ‘right result’ every time. It is the rule Richard Epstein . . . attributes to . . . Walter Blum: a simple, easily implementable rule that gets the right result 95 percent of the time. In fact, of course, even that approach may overestimate the abilities of real world courts. In our badly flawed legal system, perhaps the right legal rule is not one that tries to get the right result 95 percent of the time. Perhaps it is a rule that leaves courts satisfied with a decent result 60 or 70 percent of the time.”).

in both primary and general elections.³⁵ The median voter perceives that he will be made far worse off by Obamacare relative to the status quo, just as the median voter had the same concerns about the Clinton health reform plan. (Whether the status quo was sustainable is, to be sure, a different matter.)

These factors lay bare the preposterous claim that Obamacare will reduce costs by \$2,500 per family.³⁶ Additional coverage always costs money—if history is any guide, substantially more than is projected. In all fairness, PPACA funded a host of pilot projects and demonstration projects intended to lower costs. But at present there is no evidence that any of them will work—and even if they do work, there is no evidence they are scalable. More broadly, the primary focus of PPACA is expanding coverage, and funding such coverage will require broad-based increases in taxes. Higher taxes in turn will reduce the after-tax income available for privately insured individuals to pay the necessary premiums to stay in their current plans. The surge in subsidized demand will also create pressures on the cost side—particularly since the proposed reforms offer few, if any, strategies for squeezing out excessive care (i.e., care which costs more than it is worth). The situation will become more precarious because higher taxes are in the offing to fund other entitlement programs, without any real awareness that the same (shrinking) pool of wealth from the rich cannot be put simultaneously to multiple purposes. Accordingly, the spill-over effects from increased public spending are likely to further impair the private market.

B. Taking the Existing Regulations as a Given

It takes only three words to identify the major issues in health care policy: access, cost, and quality. It is commonplace, especially in the context of contested presidential elections and heated political struggles, for all sorts of ambitious schemes to be proposed to deal with inadequacies in one or more of these three. Historically, access has dominated the debate, in part because it is easy to frame the issue. All one has to do is complete the sentence “the American health care system has failed because it does not provide insurance

35. The Obama Administration’s attempts to discredit Representative Paul Ryan’s Medicare reform proposals have been far less successful than was expected, in no small part because PPACA cut Medicare spending by a comparable amount.

36. For a recent attempt to do some damage control on this particular prediction, see Ezra Klein, *Obama Guesses His Way to Trillions in Health Savings*, BLOOMBERG VIEW, June 6, 2013, <http://www.bloomberg.com/news/2013-06-12/obama-guesses-his-way-to-trillions-in-health-savings.html>.

for X million people and supplies only inadequate insurance for an additional Y million individuals.” Once the blanks are filled in, it is only a short step to advocating a new (if not necessarily improved) government program to supply health care coverage to these unfortunate individuals.

This approach to health reform unwisely treats all existing regulations as an exogenous given, morally wise, and economically sound. We do not go so far to say that reform proponents actually believe in their heart of hearts that this is true. But even if we stipulate that reform proponents have serious doubts about the wisdom of existing regulations, they should be judged by their actions (and inactions). Reform proponents have made no real effort to rethink how these regulatory systems operate and whether they work to provide high quality health care at low prices. Notwithstanding its panoply of pilot programs, PPACA is built on the existing regulatory infrastructure, with little consideration given to its basic soundness. As we detail in the next section, every licensing and entry restriction on physicians, hospitals, and other health care providers, both actual and potential, is treated as part of the fixed environment, either because it is regarded as desirable or because of its entrenched political support. Stated differently, reformers never acknowledge the possibility that the current regulatory framework is part of the problem. Instead, they use the current arrangements as the foundation for further regulatory interventions into a market that is dysfunctional, at least in part, because of those same regulations.

V.

DEREGULATION: THE BETTER ALTERNATIVE

A. *General Recommendation*

We make no secret of our antipathy to much of the current regulatory framework, which increases costs and reduces choices without providing much in the way of offsetting benefits. It makes little sense to treat the current framework of regulation of health care delivery as being effectively off limits—at least until such time as universal health care is put into place, at which point we will be further locked into the current dysfunctional state of affairs. Instead our view is that we should systematically deregulate on a number of fronts in ways that will increase quality and reduce the cost of health care.

Once that happens, the access and quality problems will start to take care of themselves. As costs are reduced and choices are increased, some individuals who are now priced out (or opt out) of

the health care system will have an incentive to come back in. Unlike the access-first approach that raises taxes and imposes other hidden burdens, our approach will raise revenues (through higher profits) and human satisfaction (through the provision of better health care services). Those individuals who are the “best bets” for benefiting from health care will filter back into the system, expanding coverage without running into the steep marginal cost curves that otherwise plague any universal health care system.

The obvious concern centers on the magnitude of these deregulatory effects. Pure theory does not provide an answer, but given the current degree of over-regulation of the health care delivery marketplace, we think it highly likely that regulatory liberalization will lead to major improvements, if allowed to remain in place long enough for private actors to have confidence to make long-term investments.

We stress that no single magic bullet is able to respond to the many-faceted problems created by past regulatory efforts. The question of increased costs plays out along separate and multiple margins, which tend to interact with one another in unfortunate ways. Deregulation should exhibit the same interconnections, only now, happily, in reverse. We expect synergistic effects as multiple regulatory regimes are cut back or dismantled simultaneously. Contrary to the promises of presidential candidates and congressional committees, no single grand solution can dig us out of our self-inflicted regulatory morass. But a series of systematic efforts would improve conditions along multiple, often unknown, margins.

The elimination of inefficient regulation should be congenial to persons on all sides of the political spectrum. After all, even a one-payer government-run system would work better if the state could provide health care efficiently. Whatever one’s sentiment toward one-payer systems, it is hard to explain why more regulation on the delivery side of the health care market is desirable when measured against either of the relevant parameters (cost and access).

B. Specific Areas Where Massive Deregulation is in Order

We now turn to a short list of “low hanging fruit” that should be high on any deregulatory agenda. This list reflects the presumption that health care will be provided more or less through the channels that are common today, with individual physicians or physician groups playing a dominant role in the provision of clinical services. The last reform, which may well be the most important of all, is also the most sweeping: we should open the provision of basic

health care services to para-professionals, working alone or in concert with vendors from other large retail and consumer service sectors of the economy. Such vendors would bring their marketing and management skills to health care and do what American business has always been best at doing—reaching the bottom end of the market with no-frills services that are better than no services at all.

We focus on six areas where we think massive deregulation is in order: medical malpractice, the Health Insurance Portability and Accountability Act (“HIPAA”) enforcement, health insurance regulation, federal tax law, fraud and abuse, and certificate of need/scope of practice limitations. The reforms we propose fit into a wide range of categories. Some address the way in which medical care should be provided on matters such as insurance and privacy mandates. Others deal with standard business practices of physicians, including various prohibitions on physician self-dealing (in connection with fraud and abuse statutes) that impose heavy costs. Others deal with questions of tort and contract liability for services rendered, including medical malpractice. Restrictions on licensing and the practice of medicine by non-physicians deserve special attention.

For all their differences, these multiple regulatory and statutory interventions are met with one dominant objection that surfaces in a thousand guises. The major strength of markets is that they allow for decentralized solutions to the full array of difficult constantly changing problems that require a bewildering cast of characters to balance costs against benefits separately and simultaneously. But it would be foolish to insist that all markets move effortlessly to the optimal solution to any problem. Such naiveté ignores the mistakes in judgment that are common in complex situations. And we must make allowances for the constant changes in external conditions that require ongoing adaptations in institutional response.

Rather, our reliance on markets is based on the recognition that markets (even deeply flawed ones) are still likely to outperform more rigid government plans that are always subject to regulatory capture and limitations on local knowledge. In general, market participants seek to enter into arrangements under which they will gain from trade. When both sides take this approach, the bargains that emerge should produce joint gains or win-win outcomes. By aligning self-interest with an accurate internalization of costs and benefits, market institutions will tend to correct errors more quickly than government planners who neither bear the direct consequences of their mistakes nor are in a position to reap a large por-

tion of the gains from their own useful innovations.³⁷ In our view, the insistent drive to self-correction constitutes one great advantage to voluntary markets, for producers and consumers alike.

The redundancy of market institutions, which allows weaker firms to fall by the wayside, offers yet another advantage. All else being equal, the greater the level of market freedom, the higher the level of innovation and the wider the range of choices will be. When government regulators seek to place certain arrangements out of bounds, they restrict the scope of this inventive behavior. The fewer remaining options for potential trading partners means that the search for joint gains will be subject to constraints that produce two kinds of large social losses: (i) increased costs of public oversight, and (ii) inferiority of the private responses that are acceptable in light of that oversight. Of course, we do not think that these twin considerations control in all cases. There is always reason to be concerned about contracts in restraint of trade, especially those employed by physician groups.³⁸ But the legal restrictions on the organization of health care delivery that we address do little to undermine horizontal arrangements in restraint of trade. These restrictions typically concern the types of arrangements that physicians can enter into with patients and that physicians and patients can enter into with a range of third-party intermediaries. All these restrictions are costly. Our treatment of these matters in this section cannot be exhaustive, but we hope that the examples that we have chosen will prove suggestive.

One final note: it may well be the case that significant subsidies for lower-income persons turn out to be necessary, even after a comprehensive strategy of deregulation is adopted. This would not be surprising; health care is a field in which there is a near-universal sense across the entirety of the political spectrum that deserving indigents should be taken care of, even if there is less agreement on who is “deserving.” But we think that the better strategy is to start

37. See generally David A. Hyman, *Regulating Managed Care: What's Wrong with a Patient Bill of Rights*, 73 S. CAL. L. REV. 221, 236-37 (2000) (discussing relative costs of government and market failure).

38. *Am. Med. Assoc. v. United States*, 317 U.S. 519, 536 (1943) (sustaining a criminal conviction on the Sherman Act for contracts in restraint of trade). The FTC has also made a cottage industry out of bringing antitrust cases against physician groups. See Health Care Division, Bureau of Competition, Federal Trade Commission, *Overview of FTC Antitrust Actions in Health Care Services and Products* (Mar. 2012), available at <http://www.ftc.gov/bc/healthcare/antitrust/hcupdate.pdf>; see also *supra* note 16.

the other way around, adopting a program of “redistribution last.”³⁹ Begin with market liberalization, then move to subsidies only once the limits of this first approach are identified. Redistribution always increases taxes, reduces revenue, and reduces output in all relevant dimensions. The burden of justification for compelled subsidies is higher than it is for reforms that reduce costs, increase access, and reduce taxation. So we should start there. With that, we turn to the six areas we believe are ripe for deregulation.

1. Medical Malpractice

The rules governing liability for medical malpractice have created an open wound in health care over the past forty years. The modern law of medical malpractice is often defended on the ground that it is “merely” the latest stage in the continuous evolution of ordinary common law rules of tort liability. Our response rests on the key relationship between medical malpractice and the doctrines of freedom of contract. In the pre-1950 period there was little or no effort on the part of health care providers to contract out of the tort system. The general view was that the modest tort doctrines of the time may not have done much good, but they also did little harm. It was always recognized that medical malpractice was a different species of tort liability than, say, road accidents. Most road accidents are easily resolved by deciding which of two parties has complied with the rules of the road. Error in the application of the rules is relatively small, so the damage payments through the tort system tend to reinforce the proper forms of behavior as defined by licensing laws and traffic fines. The harms in question are usually imposed on other individuals, so that strict tort rules have the desirable effect of reducing the overall rates of accidents.

The role of tort liability in medical settings is quite different. Here the legal system must contend with obvious differences in skill levels among physicians and hospitals, across localities, and in different specialties. It does no good to insist that all physicians and health care facilities meet some average standard of care if that standard implies that the bottom half of physicians and hospitals by definition are negligent in their routine clinical work. Instead the historical response was to rely on customary standards generated within the profession to set the applicable standard of care.⁴⁰ In

39. Richard A. Epstein, *Decentralized Responses to Good Fortune and Bad Luck*, 9 THEORETICAL INQUIRIES IN LAW 309 (2008), available at <http://bepress.com/cgi/viewcontent.cgi?article=1179&context=til>.

40. See, e.g., Clarence Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1163–65 (1942).

addition, proof of negligence, save in extraordinary cases, required the plaintiff to identify the particular flaw in the defendant's treatment of the patient, after which he was required to establish the causal connection between that want of care and the ensuing injury. Much effort was devoted to excluding physician or hospital liability for simple errors in judgment and to blocking the liability of physicians and hospitals solely because something went amiss during their efforts to serve or save patients. The presumption that conduct performed in good faith was entitled to a certain level of deference backs the entire system. Exceptions to that rule were exceedingly narrow—for example, *res ipsa loquitur* was largely limited to cases where some external force injured the plaintiff in a different part of the body than the surgical site.⁴¹

The key source of trouble came in the early 1960s in *Tunkl v. Regents of the University of California*,⁴² when the California Supreme Court adopted its highly influential paradigm of contract domination by large firms relative to “powerless” individual patients and consumers. This approach allowed courts to invalidate even explicit efforts by defendant-institutions to contract out of the tort system and disclaim tort liability. The reasons offered by courts and their academic allies in support of this position seem to us to be most unpersuasive.⁴³ We readily concede—indeed we insist—that the provision of health care is a service of great importance to members of the public. But it is a non sequitur to insist that the current levels of care will necessarily be improved through government regulation. It hardly follows that the hospitals that open their doors to all should be made to surrender the right to determine the terms and conditions on which they provide service—quite the opposite. The heterogeneous nature of the patient base suggests that administration of our health care system will be better if contracts are allowed to control risk so that difficult patients do not drive up everyone else's medical costs. Yet the court in *Tunkl* did not see contract standards as a positive force against adverse selection and moral hazard, but only as a form of adhesion that deprived consumers of meaningful choice.

The correct analysis of this situation starts with a question that neither *Tunkl* nor its progeny bothered to ask: Why did these excul-

41. See, e.g., *Ybarra v. Spangard*, 154 P.2d 687 (Cal. 1944).

42. 383 P.2d 441 (Cal. 1963). It is no accident that a similar hostility to freedom of contract in that same year ushered in the huge expansion of product liability. See *Greenman v. Yuba Power Products, Inc.*, 377 P.2d 897 (Cal. 1963).

43. See, e.g., Glen O. Robinson, *Rethinking the Allocation of Medical Malpractice Risks Between Patients and Providers*, 9 LAW & CONTEMP. PROBS. 172 (1986).

pation clauses come into being around 1960, in both product liability and medical malpractice cases? Our answer does not depend on, and in fact repudiates, theories of unequal bargaining power, which we think wholly implausible in the face of intense competition in the health care sector both before and after that watershed moment. Rather, we think the key change in the legal environment was that private institutions sensed that malpractice law doctrines had moved away from rules that they were willing to accept.

The slow but inexorable ratcheting up of tort liability did not stem from any single cause: the defense of medical custom became more frayed at the edges, *res ipsa loquitur* was more frequently applied, inferences on causation were subject to a greater degree of jury control, and damages continued to move smartly upward.⁴⁴ The newer and more expansive rules on liability were rightly perceived as imposing standards of care that were both too costly and too unpredictable. Before 1960 any imperfections of the tort law were sufficiently small that it was not worth anyone's effort to contract out of them. After that time, as the substantive bases of liability started to expand, the costs of contracting out were perceived to be far lower than those of staying within the preset judicial rules.

Why? The basic truth of all forms of contractual liability is that the expected costs of settlement, verdicts, and litigation (including the costs of defending suits that do not ultimately result in a payout) must all come out of the fees that are generated from the patients to whom service is provided. If that constraint is not met, the firm will have to trim its patient or procedure list, alter its price structure, or close its doors. Different organizations will opt for different strategies. Even the best of these responses to regulation will only mitigate the social losses relative to the first-best contractual solution. They never do as well as the original system.

Each of the changes to tort liability in the decided cases took place independently, without consideration of their synergistic in-

44. We use the pre-*Tunkl* era as our baseline. In other work, one of us found that the frequency of paid medical malpractice claims per physician has been dropping steadily for almost twenty years, and is now less than half the level it was in 1992. Payouts per physician have also been dropping since 2003, and are now 46% below their 1992 level. The decline is largest in states that recently capped total or non-economic damages, but there are also large and sustained declines in states with older damage caps and states with no damage caps. Myungho Paik, Bernard Black & David A. Hyman, *The Receding Tide of Medical Malpractice Litigation*, J. Empirical Legal Stud. (forthcoming 2013), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2109679. Unfortunately national data is not available prior to 1990, so it is impossible to quantify the impact of *Tunkl* on claim frequency.

teraction. Assume an oversimplified model in which each of these four variables—standard of care, use of *res ipsa loquitur*, causation, and damages—moves independently of the others in favor of the plaintiff by 25%. The impact of these combined shifts is, in theory, an increase in liability by $1.25^4 = 2.441$: a near two-and-half-fold increase in prospects for liability in any given case, driving a corresponding increase in administrative costs. Let them double—a more realistic estimate—and the number becomes $2^4 = 16$: a dramatic change. The higher rates of potential return will induce more cases to be filed, seeking new forms of damages, with outcomes varying depending on the application of the rules by juries that sit in different counties. Although the overwhelming majority of cases are settled, settlement terms are set in the shadow of anticipated jury awards and there is wide variation within different regions and counties in a single state, let alone across states.⁴⁵ Plaintiffs' ability to handpick venue causes them to gravitate to those places where local judges and juries are most favorable to their cause.⁴⁶

Judges, who thought that they were correcting market imperfections, not creating them, drove the expansion of liability. Given their optimistic view of their own handiwork, judges saw little, if any, reason to increase the levels of judicial scrutiny of jury verdicts to guard against the risk of passion, prejudice, or even error. Quite the opposite, their increased deference to juries and a concomitant decline in legal rules, which allowed juries to make judgments couched in terms of "reasonableness," heralded the arrival of a new era. The expansion in liability plus the increase in overall expenses likely resulted in at least some defensive medicine, although its precise magnitude has been exceedingly difficult to pin down.⁴⁷ The levels surely vary by specialty, location, and probably other variables as well. With this in mind, it becomes clear that the decision of the

45. Richard A. Epstein, *Contractual Principle Versus Legislative Fixes: Coming to Closure on the Unending Travails of Medical Malpractice*, 54 DEPAUL L. REV. 503, 515–18 (2005). In practice, coverage limits act as a limit on the amounts recoverable from individual physicians. This means for cases likely to result in above-limits damages, the jury has a more significant impact on determining liability than on determining damages.

46. It is not an accident that tort reform advocates have pushed for restrictions on forum shopping.

47. Research on this issue has found mixed evidence, but most researchers believe the effect is modest. In other work, one of us found no evidence that dramatic restrictions on tort liability affected health care spending levels or trends. Myungho Paik et al., *Will Tort Reform Bend the Cost Curve? Evidence from Texas*, 9 J. EMPIRICAL LEGAL STUD. 173 (2012) ("In sum, we find no evidence that Texas's tort reforms bent the cost curve downward.").

California Board of Regents—a public body, one might add—to restrict liability by contract was not casually made. It was done in anticipation of the rough waters ahead once it became clear that the potential medical malpractice liabilities would require funding levels in excess of the ability of patients (and their third-party payers) to pay.

The decision to knock out these “adhesive” contracts eliminated all possibility of private self-correction of judicial error in setting the rules on malpractice liability. Under *Tunkl* and similar cases, all the relevant parameters in medical malpractice cases were determined by judges and juries, with little or no understanding of the institutional constraints that led to such remarkable medical progress before the major expansion of tort liability. Judges did not understand that employers and insurers have influence over the selection of health care providers and that hospitals maintain internal review boards that check the performance of physicians and other health care providers. These professional checks are not useless ornaments designed to shield hospitals from the prying eyes of outsiders. These bodies employ a level of technical expertise that no jury, with a sample size of one, can bring to bear when making difficult fact-laden judgments about individual cases. Stated in a sentence, the judicial decisions of the 1960s proceeded on the assumption that only judicial expansion of the rules of liability stood between the individual patient and disaster. The role of intermediate institutions in controlling or curtailing risk was never discussed or considered.

But the evidence is now clear. What good has the malpractice system done? Not much, and not nearly enough in light of its costs. The best empirical evidence suggests that there are no significant differences in the rate of medical error in the Canadian system, in which medical malpractice liability is about a tenth of our own.⁴⁸ The American medical malpractice system massively under-deters potential tortfeasors and massively under-compensates injured patients.⁴⁹ The simple point here is that under-claiming and over-claiming, compounded by high error rates and high costs of run-

48. Donald Dewees & Michael Trebilcock, *The Efficacy of the Tort System and Its Alternatives: A Review of the Empirical Evidence*, 30 OSGOODE HALL L.J. 57, 83 (1992).

49. See generally Patricia Danzon, *Liability for Medical Malpractice*, in HANDBOOK OF HEALTH ECON. VOL. 1B 1339 (Anthony J. Culyer & Joseph P. Newhouse, eds., 2000) (finding limited evidence that the tort system deters medical errors); David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085 (2006) (same); Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX L. REV. 1595 (2002) (same). See also David A. Hyman & Charles

ning the system, largely neutralize any deterrent effect. Physicians and hospitals do not know how to alter conduct in response to a set of signals that says “take better care,” without providing clearer guidance as to what should be done next. Yet in the face of demonstrated regulatory failure, the interest in allowing contractual freedom back into the system remains tepid at best. Obamacare offered nothing on this issue.

The saga of medical malpractice liability is not just a tale of good intentions and bad outcomes. It also helps explain some of the cost and access problems that dog the health care system. The high cost of medical malpractice and malpractice insurance can close down emergency rooms, place intolerable burdens on rural clinics serving poor populations, and stifle various forms of innovation because of the more or less well-founded fear that adverse consequences from novel procedures will generate crushing liability. In some instances, it can lead physicians to exit high-risk specialties and high-risk jurisdictions.⁵⁰ Reversing the decision in *Tunkl* should lead to renewed competition among hospitals and physicians in the provision of alternatives to the existing liability system and in the range of medical care offered. It could induce third-party intermediaries to take more active steps to shape liability rules and dispute resolution processes in ways that lower costs. At this point, no one can say for sure what the new contractual provisions would require; one cannot even be confident that they would be the same for all procedures and all specialties in all locations. It is equally plausible that they will vary in accordance with the needs and circumstances of particular institutions, counties, states, specialties, and practices. Deregulation allows us to harness the private information that is available to health care providers and the large institutions with which they do business. We cannot predict how much would be saved, except to say that we do not think it would be trivial. Regardless of the actual magnitude of savings, moving from tort to contract represents an important and necessary step in our general program of increasing access by reducing costs.

Silver, *Five Myths of Medical Malpractice*, 143 CHEST 222 (2013) (reviewing empirical evidence on the performance of the medical malpractice system).

50. See, e.g., Christi Parsons, *Illinois Doctors Press for a Malpractice Limit*, CHI. TRIB., July 9, 2004, § 3, at 2, available at http://articles.chicagotribune.com/2004-07-09/business/0407090349_1_medical-malpractice-malpractice-insurance-malpractice-limit/2 (giving the Illinois illustration). It is a different issue whether damages caps actually attract physicians. See David A. Hyman et al., *Does Tort Reform Affect Physician Supply? Evidence From Texas*, 20–23 (University of Illinois Law, Behavioral and Soc. Sci. Research Papers Series, Working Paper No. LBSS12-12, 2012), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2047433.

2. Privacy Reform

The second topic of reform involves the use of government regulation to protect patients' privacy interests. The key statute on this front is the Health Insurance Portability and Accountability Act ("HIPAA").⁵¹ The title of the statute references its original goals: portability (enhancing the ability of employees and their dependents to have uninterrupted health insurance coverage when they change jobs) and accountability (fraud control). HIPAA also contains a single paragraph instructing HHS to prepare regulations to ensure patient privacy if Congress is unable to pass legislation on the subject within a two year period.

In due course, HHS issued HIPAA regulations on the eve of the Clinton Administration's departure from office. The regulations take a divided approach to consent. Information can be released without the consent of patients for a wide variety of purposes, including billing and government oversight. But in many other instances, patient privacy is protected by insisting that patients give individual consent to the dissemination and use of all their relevant information to the many parties—doctors, pharmacies, billing agencies—within standard medical settings. HIPAA thus created a huge pre-clearance apparatus, displacing the prior ex post system that included tort liability, only rarely needed, for physicians who flouted well-established privacy norms.⁵²

The central question about HIPAA is whether an ex ante pre-clearance system is justified, given the absence of evidence that the prior system of ex post remedies was inadequate. In our view, the answer to that question is a resounding no. There is no cost-justified reason to impose highly restrictive regulations on ordinary human interactions to deal with a set of problems that have already been effectively controlled by clear social norms and stable institutional practices, backed up in rare instances by legal action. HIPAA, at the very least, imposes administrative costs, technical security costs, and physical security costs dealing with patient privacy.⁵³

51. See Richard A. Epstein, *HIPAA on Privacy: Its Unintended and Intended Consequences*, 22 CATO J. 13 (2002).

52. The traditional tools of litigation included obvious actions for breach of fiduciary duty, invasion of privacy, intentional infliction of emotional distress, medical malpractice, and defamation—along with various actions for breach of civil and criminal statutes. Robert J. Moses, *Privacy Actions and HIPAA: Using the Health Insurance Portability Accountability Act to Protect Patient Privacy*, in CORP. LAW & PRACTICE 2000, at 526–32 (PLI Corp. Law & Practice, Course Handbook Ser. No. B0-00RW, 2000), available at Westlaw 1216 PLI/Corp 513.

53. For this typology, see Richa Arora & Mark Pimentel, *Cost of Privacy: A HIPAA Perspective* (Dec. 9, 2005) (unpublished manuscript) Carnegie Mellon

These specific costs, moreover, understate the total burden because they do not include the system-wide loss in efficiency that includes a slow-down in institutional operations and the learning and compliance costs of patients, their families and other persons outside the health care system who necessarily interact with it. Why incur the very hefty costs of running a pre-clearance system in 100% of social interactions when the ex post system (which is still available) needs to be invoked only in exceptional situations?

We can think of no good answer to these questions. There is every reason why no groundswell of public support ever coalesced around the HIPAA regulations, most of which met with stout resistance or stunned disbelief from the public. It did not take HIPAA to make every health care provider acutely aware of the huge damage to goodwill that follows from any breach in the security surrounding sensitive information. Voluntary markets were already taking simple, common-sense, cost-justified steps to deal with these issues, and did so at a cost far less than that associated with HIPAA.⁵⁴ Consider a simple example: the typical psychoanalyst's office does not have a waiting room populated with nervous patients waiting to see their therapists. Everyone understands that seeing someone else in the waiting room is itself viewed as a serious invasion of privacy. Thus the typical office has incoming patients arriving at staggered intervals and outgoing patients exiting through another door. Not foolproof to be sure, but clearly sensible. Similarly most employers have figured out that they will not be able to encourage their workers to get counseling for eating disorders or alcohol and substance abuse if the results of these sessions are recorded in personnel files open to all persons within the firm. So services of this sort are farmed out to third parties under pledges of confidentiality, ensuring that the results of those sessions never make it into the particular employee's personnel file. We suspect that similar institutional accommodations can be multiplied a thousand-fold by persons who are closer to the issue than we are.

So just what does HIPAA add to the mix? A quick inspection of the massive federal HIPAA website reveals just how intrusive HIPAA

University, available at <http://lorrie.cranor.org/courses/fa05/mpimenterichaa.pdf>.

54. See Alan Newberger, *A Pilot with the Cleveland Clinic for Health Information Access*, GOOGLE OFFICIAL BLOG (Feb. 21, 2008), <http://googleblog.blogspot.com/2008/02/pilot-with-cleveland-clinic-for-health.html> (“[O]ur health efforts will help you access, store and communicate your health information. Above all, health data will remain yours—private and confidential. Only you have control over when to share it with family members and health providers.”).

has become in regulating patient behavior in the name of protecting patient autonomy. HIPAA's frequently asked questions ("FAQs") reveal that a doctor can call a patient's wife to tell her that he has been in a car accident, or a husband to tell him that his wife is about to deliver, or one roommate to report on an injury to another, or in an emergency situation to tell a child that a father has suffered a stroke. For these insights, do we need government approval and thousands of pages of regulations and interpretations? There is no indication that individual physicians and practices could not tackle this issue, taking account of obvious and not so obvious variations in the types of treatment and patient population.

The regulations also steadfastly refuse to take advantage of the three most important words in any regulatory framework that aims to harness private information in the face of diverse circumstances: "unless otherwise agreed." Instead of creating a default framework that autonomous and competent patients can contract around, the HIPAA framework, with its carefully crafted list of examples, exceptions, and repeated use of the word "may" (but never "must") raises many more questions than it answers. Physicians go to medical school, but the HIPAA framework is built around law school hypotheticals. The law allows a doctor to speak to a patient's wife about minor injuries, but how should that doctor behave with single or divorced people, or unmarried couples living together? Does one illustration imply that other types of calls should be regarded as invasions of privacy? Or should similar cases be treated in similar ways? May a doctor tell the unmarried father that his pregnant partner is about to give birth? And may friends who are not roommates be told about injuries? These petty examples raise as many questions as they answer and cast a pall over common sense in day-to-day administration, at least for people who do not keep a copy of the Federal Register at their bedside. Scrap the confidentiality provisions in HIPAA, and any type of health care system, from single-payer to fee-for-service, will perform better.

3. Insurance Mandates

It is striking that growth in the overall economy has been associated with growth in both the number of insurance mandates and the number of uninsured people. Some mandates regulate the relationship between insurance companies and health care providers by requiring that the insurance plan include "any willing provider" and cover services rendered by chiropractors (forty-six states), psy-

chologists (forty-four states), and optometrists (forty-three states).⁵⁵ Others require insurance companies to cover particular services. These include care of newborns (fifty states), alcoholism treatment (forty-five states), diabetic supplies (forty-seven states), breast reconstruction after mastectomy (forty-eight states), and mammograms (fifty states).⁵⁶ What impresses us is that the rise of mandates tracks the decline in the percentage of individuals, including employees, who retain medical coverage when greater individual wealth has generated additional funds for health care for a larger fraction of the population. In our view mandates are part of the explanation. Mandates require persons either to purchase more insurance than they want or to exit the state-regulated market.⁵⁷ They constrain competition in the financing and delivery of health care services. And they tend to take money from the poor and working class and give it to the upper middle class, who knows how to game the system so as to receive a disproportionately large fraction of the mandated services.⁵⁸

The McCarran-Ferguson Act makes these problems particularly acute by creating state-specific monopolies in health insurance regulation. The absence of a national market raises the cost of insurance in local markets, thereby reducing the overall fraction of the population that is able to purchase this insurance.⁵⁹ The removal of this prohibition has no direct budgetary costs and huge social benefits. We see no reason why this restriction cannot be eliminated immediately. If states want to regulate inefficiently they should bear the costs of their inefficiency and not impose it on other states with more prudent policies. Similarly, if states want to engage in redistribution, let jurisdictional competition force them to confront squarely the costs of their largesse. Any rigorous program of reform

55. VICTORIA CRAIG BUNCE ET. AL., COUNCIL FOR AFFORDABLE HEALTH INS., HEALTH INSURANCE MANDATES IN THE STATES: 2006, 6 (2006), available at <http://cdm16064.contentdm.oclc.org/cdm/ref/collection/p266901coll4/id/3758>.

56. *Id.* at 4.

57. When the mandate is imposed by the state, exit can take the form of becoming uninsured, or finding employment (and insurance) from an employer that is self-funded, and hence not subject to state mandates. If Congress passes such mandates, the only option for exit is to become uninsured, or emigration.

58. Barak D. Richman, *Insurance Expansions: Do They Hurt Those They Are Designed to Help?*, 26 HEALTH AFF. 1345 (2007). Such reverse Robin Hood schemes are not unique to mandates. See DAVID A. HYMAN, MEDICARE MEETS MEPHISTOPHELES (2006).

59. See generally David A. Hyman, *Health Insurance: Government Failure or Market Failure?*, 14 CONN. INS. L.J. 307 (2008).

should eliminate needless roadblocks to greater coverage and competition.

Similar objections can be made about any system of community rating, which seeks to equalize the rates charged to individuals for health care insurance. Building in the dubious notion that health insurance is a merit good—in the specific sense of a good that should not be bought and sold—the program in effect requires low-risk individuals to purchase insurance at the community rate, if they wish to purchase it at all.⁶⁰ The net effect of such provisions is to drive low-risk persons from voluntary plans. The predictable regulatory response is not to roll back community rating, but instead to coerce all individuals to purchase health insurance at state-determined differentiated rates that nevertheless create covert wealth transfers.⁶¹ In still other situations, the nondiscrimination norm may be invoked under the Employment Retirement Income Security Act (“ERISA”) in order to prevent employers from offering lower rates of insurance to workers who take steps to improve their health, thereby reducing the incentive for workers to become healthier.

Community rating is one of many instances of the transformation of the anti-discrimination principle in health care politics. At its core the regulatory foundation of an anti-discrimination principle, properly conceived, was to prevent the redistribution of wealth among multiple users of a public utility. The principle thus required that persons who imposed the same burdens on the common system pay the same amount, and individuals that imposed greater costs pay higher rates. Now the principle is inverted, with low-cost users required to pay higher rates and high-cost users allowed to pay lower rates. The new principle of nondiscrimination thus mandates cross subsidies from healthy to unhealthy persons, reducing the returns to good health and increasing the returns to bad habits, and undermining the very health that the various systems of regulation seek to create. Every version of “social insurance” will have precisely this deleterious effect. We see no reason

60. Concerns about genetic discrimination in health insurance underwriting resulted in federal legislation, but states have limited or eliminated the discretion of insurers to price risk across a broad array of conditions. For an extended critique of these efforts with regard to genetic discrimination, see Richard A. Epstein, *The Legal Regulation of Genetic Discrimination: Old Responses to New Technology*, 74 B.U. L. REV. 1 (1994).

61. Although PPACA does not embrace full-blown community rating, the statutory limitations on rate variation by age and gender create compression, resulting in the same cross-subsidies. *See supra* note 7.

why either federal or state regulation should frustrate the efforts of private persons to reduce their own health care costs.

4. Taxation

As noted previously, federal tax law provides a subsidy for employment-based health insurance, as the premiums are deductible to the employer but not taxable as income to the employee.⁶² This tax subsidy is the source of considerable inequities and allocative inefficiency.⁶³ The inequities arise in part because employees, or at least some employees, receive a subsidy that is denied to others. The allocative waste arises because the subsidy for health care leads to its overconsumption relative to other goods. There is no shortage of proposals on the best way to fix the problem.⁶⁴

The first-best solution is to repeal the federal tax break for these premiums, which removes both problems. We think that it is decidedly a second-best solution to extend the deduction of health care premiums to other forms of payments, as it is generally unwise to expend political capital to solve one problem (inequities) at the cost of exacerbating the second problem (overconsumption of health care). We do not think it is useful to engage in political squabbles over the least grotesque compromise position.

Similar reasoning applies to the tax-exemption of non-profit hospitals. Decades of scholarship have failed to provide a persuasive rationale for the status quo, let alone evidence that we are getting our money's worth from the foregone tax revenues.⁶⁵ It is time to end the charade that an undifferentiated subsidy tied to status can outperform a graduated subsidy tied to quantifiable, objective measures of performance.

62. I.R.C. § 106 (2006) (“[G]ross income of an employee does not include employer-provided coverage under an accident or health plan.”).

63. David A. Hyman & Mark Hall, *Two Cheers For Employment-Based Health Insurance*, 2 YALE J. HEALTH POL’Y L. & ETHICS 23, 25 (2001).

64. See David A. Hyman, *Getting the Haves to Come Out Behind: Fixing The Distributive Injustices of American Health Care*, 69 L. CONTEMP. PROBS. 265, 274 (2006) (The reform options 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. . . excluding all out-of-pocket spending on health care; and, so on.”).

65. See David A. Hyman & William M. Sage, *Subsidizing Health Care Providers Through The Tax Code: Status or Conduct?*, HEALTH AFFAIRS, June 20, 2006, at W312-13, available at <http://content.healthaffairs.org/content/25/4/W312.full> (citing past scholarship attempting to rationalize the status quo and suggesting that these explanations fail to answer the more difficult policy questions).

5. Fraud and Abuse Statutes

The question of fraud and abuse is a subspecies of the larger question of conflicts of interest and self-dealing that pervade the health care arena. In many cases, one individual will enter into transactions with a related company. A physician, for example, may choose to have lab work done by a firm in which he has a partial interest. In some circumstances, this self-dealing could lead to unnecessary charges. In other cases, the close connection between the two firms could result in cooperation that lowers costs. In our view, it is difficult in the abstract to decide whether the efficiencies involved in these cases outweigh the dangers of abuse.

Under our present legal system, however, the law uniformly takes a grim view of these arrangements among related firms. Three different statutes provide the basic framework for addressing fraud and abuse in health care. The anti-kickback statute broadly criminalizes the solicitation or receipt of remuneration in connection with items or services for which payment can be made by Medicare or Medicaid. There are various statutory exceptions, administrative regulations creating safe harbors, and advisory opinions covering a range of ill-defined circumstances. Prosecutions have been rare and have focused on the most egregious fact patterns, even though the statutory language and precedent sweep much more broadly.

Next, the self-referral provisions prohibit physicians from referring Medicare and Medicaid patients to ancillary providers in which they or their family members hold a financial interest. Further, they prohibit ancillary providers from billing for services that result from such referrals. The provisions are treated as creating strict liability offenses, punishable by program exclusion and civil monetary penalties.

Finally, the False Claims Act creates a cause of action against those who knowingly present a false claim to the government. Violations are punishable by substantial statutory penalties per claim, plus a fine of three times any overpayments.

These measures simultaneously raise substantial problems with statutory over-inclusiveness and under-inclusiveness.⁶⁶ These system-design errors are compounded by overzealous enforcement and excessive investment in compliance programs. The self-referral provisions have utterly failed in their attempt to provide clear gui-

66. David A. Hyman, *HIPAA and Health Care Fraud: An Empirical Perspective*, 22 CATO J. 151 (2002); David A. Hyman, *Health Care Fraud and Abuse: Market Change, Social Norms, and "the Trust Reposed in the Workmen,"* 30 J. LEGAL STUD. 531 (2001).

dance and the False Claims Act has created a significant risk of “blackmail” settlements, in which defendants pay because the stakes are too high for them to risk a trial. We suggest outright repeal of the self-referral provisions and modification of the False Claims Act to minimize the risk of misuse.

We do not suggest repeal of the anti-kickback statute. Although we believe those responsible at HHS should create more safe harbors and be more flexible in their interpretation of the statute in advisory opinions, the statute is an important guardian of the fiscal integrity of the Medicare program, given that the overwhelming majority of Medicare beneficiaries are still in the traditional (fee-for-service) part of the program, where kickbacks pose an obvious incentive for overutilization.

To be sure this list is not exhaustive; Medicare has experienced significant fraud-control problems because it systematically underinvests in administrative oversight and fraud prevention. Many reformers brag about Medicare’s low administrative costs, but we doubt that is a useful measure for assessing system performance when far more is lost to fraud than is saved by under-investing in administration and fraud control.⁶⁷ Our call for deregulation should not be viewed as a license to commit fraud or abuse, although we doubt whether off-label promotion should be treated as either.

6. Limitations on Scope of Practice

The history of health care in the United States is the history of repeated, and usually effective, attempts by physicians to limit competition from less expensive alternative providers. The American Medical Association’s (“AMA”) basic position on health matters has long been that all interested parties had to accept “the private physician’s monopoly control of the medical market and complete authority over all aspects of medical institutions.”⁶⁸ Clark Havighurst and Nancy King concisely describe the standard playbook employed by the AMA and its allies:

[O]utbreaks of . . . competition were ruthlessly suppressed, with the result that the hegemony of the dominant ideology was seldom challenged. Under the banners of “medical sci-

67. To be sure, there are other problems with this measure as well. For example, the costs incurred by other federal entities are simply ignored in the calculation (the IRS collects most of the money, Social Security keeps the books, and Congress and its staff act as a board of directors).

68. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 300 (1982) (discussing the principles of the AMA in the 1930s).

ence,” “quality of care,” and “professional prerogative,” the medical profession was able to repel most attacks along its borders, to force many of its antagonists into alliances, and to confine other would-be invaders to narrow enclaves.⁶⁹

In the past half-century, antitrust enforcement has placed substantial limits on the ability of the medical profession to engage in such conduct. However, the rise of managed care brought forth new strategies, including unionization, “Astroturf” campaigns⁷⁰ of disruptive public protests targeting specific managed care practices,⁷¹ and disciplinary proceedings against medical directors of managed care organizations. Such conduct is not limited to physicians; hospitals have engaged in similar battles with physician-owned ambulatory surgery centers and single-specialty hospitals. Hospitals have used certificate-of-need statutes to delay and deter entry by new competitors and to limit the ability of existing competitors to improve infrastructure and broaden their range of services. Community hospitals also lobbied aggressively for stricter regulatory requirements for specialty hospitals and even secured a provision in PPACA imposing a moratorium on Medicare payments to such institutions, unless they have a provider agreement with Medicare as of December 31, 2010.

The latest delivery-side innovation is the opening of outpatient clinics in retail outlets. Such facilities offer a restricted range of services, focusing on those necessary to help patients “get well” and “stay well.”⁷² Most are staffed by nurse practitioners or physician assistants and are backed up by extensive use of standardized protocols, computerized decision support tools, and electronic medical records. Pricing is completely transparent, the facilities are open for long hours, and parking is free and freely available. The available evidence suggests that the quality of care is at least as high as in traditional health care delivery channels and in many instances higher.⁷³

The response of the medical profession to retail clinics is déjà vu all over again, with the standard condemnations involving qual-

69. Clark C. Havighurst & Nancy M. P. King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective—Part Two*, 9 AM. J.L. & MED. 263, 291 (1983).

70. “Astroturf” campaigns refer to “ginned up” campaigns of artificial indignation, rather than genuine “grassroots” campaigns.

71. See, e.g., Lachlan Markay, *SEIU Stages Astroturf ‘Flash Mob’ in DC to Criticize Romney*, BREITBART (Aug. 9 2009), <http://www.breitbart.com/Big-Government/2012/08/09/SEIU-Stages-Astroturf-Flash-Mob-in-D-C-to-Criticize-Romney>.

72. William M. Sage, *The Wal-Martization of Health Care*, 28 J. LEGAL MED. 503, 505 (2007).

73. See *id.*

ity and continuity of care and the occasional candid admission that physicians are concerned about loss of revenue and market power.⁷⁴ As expected, retail clinics have been condemned by professional societies, including the AMA and the American Academy of Pediatrics.⁷⁵ We harbor no particular preference for any given health care delivery system or system reform. But we do insist that the inability of anyone to know in advance what system works best leads to a simple but powerful general conclusion: new entry is the single most powerful force for restructuring a dysfunctional industry like health care. Those entering will deviate from the established methods within the field, often by unbundling or rebundling the available mix of goods and services. In all cases they seek to develop standard protocols whereby persons with lower skills can make better decisions than high-paid physicians relying on some combination of hunch and experience. Many of these innovations will fail, at some social cost. But the minority of innovations that “take” can easily produce gains that dwarf the losses from failed experiments.

Although these initiatives face opposition from incumbent providers, no one has a property right in doing business the way they prefer. We take this position for every trade and profession, including our own. The alternative is to accept inefficient feather bedding and long-term stagnation. To be sure, new entry presents real difficulties in health care, given the problems of quality control. But quality control also poses challenges to well-entrenched institutions. We do not suggest that a market offering only “snake oil” to the uninformed is desirable. But it is a mistake to assume that informational deficits, and other institutional pathologies, do not also affect public regulators.

Our view is that markets are usually better able to collect and disseminate information regarding quality than centralized institutional arrangements. Consider the fact that many more people obtain information on pharmaceuticals from intermediate physician organizations than from the FDA, whose major preoccupation lies in limiting the ways in which information about off-label drugs can be disseminated to the physicians and patients who need it. Similarly, food manufacturers and other intermediaries are an impor-

74. Richard Bohmer, *The Rise of In-Store Clinics—Threat or Opportunity?*, 356 *NEW ENG. J. MED.* 765, 767 (2007).

75. See Bruce Japsen, *Doctors, Retailers Square Off: AMA to Seek Probe of In-Store Clinics*, *CHI. TRIB.*, June 26, 2007, § 3, at 1; Jay E. Berkelhamer, Letter to the Editor, *Retail Health Clinics Are a Return to an Earlier Form of Medical Care*, *WALL ST. J.*, May 19, 2007, at A7 (noting the American Academy of Pediatrics’ opposition to retail clinics because they undermine continuity of care).

tant source of nutritional information, so long as government regulation does not chill these sources by discouraging truthful health claims.⁷⁶

The great advantage of free entry is that no one at the center needs to have the foggiest notion of why any given innovation works. There are ruthless but honest checks on behavior, coupled with constant innovation and rapid dissemination of successes. To us, these recent developments promise greater access through lower costs. But we offer no guarantees of that result. All we can do is to insist, with all the vehemence we can muster, that on matters such as these, the market—the individual preferences of countless consumers—should be the judge of what consumers do and do not want to receive. Deregulation helps ensure that consumers—not some providers or do-gooders backed by the force of the state—determine the direction of medical practice. Were we writing on a blank slate, we would support private certification instead of public licensure as the basic model for signaling competence. Failing that, we support dramatically loosening the prohibitions on scope of practice that currently complicate the ability of retail clinics to use nurse practitioners and physician assistants.

CONCLUSION

High goals often lead to government overreaching, not to industry efficiencies. The rate regulations imposed by PPACA stem from the belief that regulation can root out inefficiencies that markets cannot touch. The point is improbable as a matter of general theory for it assumes that firms in competitive markets are unable to equate costs and benefits at the margin. The inability to understand how markets work leads to massive regulation, which is likely to prove catastrophic.

Deregulation offers this nation the greatest opportunity to increase competition and choice. It offers the only chance we can see of simultaneously increasing performance on cost, access, and quality. In the first instance, deregulation necessarily reduces costs, both private and social. This creates lower costs for services and, with a reduction in taxation, higher income levels to purchase the services in question. The result should be an improvement in access, so that the number of uninsured individuals falls. And fewer barriers to

76. *See, e.g.*, Press Release, Federal Trade Commission, FTC Staff Weighs in on Food Labels and Obesity (Dec. 15, 2003), *available at* <http://www.ftc.gov/opa/2003/12/fdaobesity.shtm>.

entry will encourage new suppliers of medical services to enter the market, thereby increasing the quality.

We anticipate that our proposals will be met by howls of protest from those who benefit from the status quo and their academic apologists. Such complaints should be seen for what they mostly are—a defense of rent-seeking by incumbent providers on the one hand, and an effort by new players to sup at the public trough on the other. Some have more principled objections, but they still serve, willingly or not, as the “Baptists” in an unsavory coalition of “Bootleggers and Baptists.”⁷⁷ The whole point of deregulation is to limit the opportunity and rewards of such rent-seeking, thereby increasing consumer surplus. No administrative agency or committee of experts, no matter how well intentioned and highly credentialed, will be able to do a better job of meeting consumer demands than the private market. To think otherwise is to repeat the mistakes of the past, instead of learning from them.

77. See Bruce Yandle, *Bootleggers and Baptists in Retrospect*, 22 REGULATION 3 (1999), available at <http://object.cato.org/sites/cato.org/files/serials/files/regulation/1999/10/bootleggers.pdf> (“[D]urable social regulation evolves when it is demanded by both of two distinctly different groups. ‘Baptists’ point to the moral high ground and give vital and vocal endorsement of laudable public benefits promised by a desired regulation ‘Bootleggers’ who expect to profit from the very regulatory restrictions desired by Baptists, grease the political machinery with some of the expected proceeds.”).

