Notre Dame Journal of Law, Ethics & Public Policy

Volume 25
Issue 2 *Symposium On Health Care: Health, Ethics, & the Law*

Article 15

January 2014

Who Pays - Who Benefits - Unfairness in American Health Care

Clark C. Havighurst

Barak D. Richman

ARTICLES

WHO PAYS? WHO BENEFITS? UNFAIRNESS IN AMERICAN HEALTH CARE

CLARK C. HAVIGHURST* & BARAK D. RICHMAN†

ABSTRACT

In several ways, traditional health care financing has long been unfair to middle- and lower-income insureds. A major problem is monopoly pricing of many services and goods. Although the point is seldom recognized, American-style health insurance greatly aggravates the redistributive effects of monopoly by weakening the usual constraints on sellers' pricing freedom. Moreover, lucrative monopoly is often tolerated as an expedient instrument of public finance through which seemingly desirable spending on health care or health-related innovation is financed by the equivalent of an unfair head tax on individuals with private coverage.

Other underappreciated unfairnesses are specific to employer-sponsored health coverage and to the distorted incentives and perceptions spawned by the tax subsidy encouraging it. Because employer-sponsored coverage effectively hides premium costs from the employee-voters who ultimately bear them, middle- and lower-income employees regularly bear the unjustifiably high and uncontrolled costs of health coverage designed principally to accommodate the values and economic interests of the health care industry and other elites. These same consumers

* William Neal Reynolds Professor Emeritus of Law, Duke University School of Law.

† Professor of Law and Business Administration, Duke University; for much of the time this Article was written, he was Scholar-in-Residence and Senior Fellow, Center for Economic and Contract Organization at Columbia University Law School. The authors are especially grateful to Thomas P. Miller of the American Enterprise Institute for thoughtful and informed guidance through the complexities of the 2010 reform legislation; they accept sole responsibility, however, for any errors, imprecision, or ambiguity that inevitably remain. The authors additionally thank Jennifer Behrens and Jane Bahnson for excellent research assistance.

also appear to get less, as a group, out of their employers' health plans than their higher-income coworkers, despite bearing equivalent premium costs.

The Patient Protection and Affordable Care Act does little to alter the framework of employer-sponsored coverage and thus represents a missed opportunity to rectify its unfairness to the working class. Although the law's main purpose is to ensure that nearly all individuals either have employer coverage or procure "essential health benefits" through an Exchange, it defines the latter new entitlement in such a way as to perpetuate, not correct, the distortions engendered by the tax subsidy. In addition, the new law not only has no answer for the provider monopoly problem but is likely to increase wealth transfers from consumers to providers.

I. INTRODUCTION

As if the United States needed another reason (besides limited access, high costs, and uneven quality) to embark on fundamental reform of its health care system, here is one: By any

standard of social justice, far too much of the extraordinarily high cost of U.S. health care has long fallen on lower- and middle-income payers of private health insurance premiums.[1] One increasingly recognized problem is that health care prices are far too high,[2] reflecting market power obtained by health care providers despite decades of antitrust enforcement.[3] As this Article will particularly demonstrate, provider monopoly is especially burdensome for premium payers because of the way private insurance is designed and administered in the United States.[4]

Another serious matter is that monopoly pricing has become an accepted method of public finance in the health sector. Thus, much of what most insured Americans pay for their personal health coverage has gone, like an inequitable tax, to fund an industrial complex that, while it purports to serve public purposes, is far less accountable to the "tax-paying" public than public bodies normally are. Not only do less-than-affluent workers have no alternative—short of going without health coverage altogether—to paying this regressive "tax," but also the revenues they contribute to the system are very often spent in ways that benefit others far more than themselves.

Finally, virtually no health plans available to ordinary Americans in the marketplace are designed with their specific interests in mind. Instead, pursuant to perverse incentives, law, and custom, America's health plans embody the particular values and serve the particular interests of the health care industry and its most affluent customers. Especially in a time of widening income disparities in American society, it should be unacceptable for insured Americans with moderate incomes to bear a disproportionate share of the system's costs while also being denied health coverage suitable for their specific circumstances. The current deep recession only adds to the unfairness of making people pay for health coverage that fails to take their circumstances into account.

---

1. *See* Clark C. Havighurst & Barak D. Richman, *Foreword: Health Policy's Fourth Dimension*, 68 LAW & CONTEMP. PROBS. 1, 1–2 (2006) (suggesting that equity in the distribution of costs and benefits should be permanently added to the short list of subtopics—*i.e.*, access, cost, and quality—under which health policy is conventionally discussed).

2. Gerald F. Anderson et al., *It's the Prices, Stupid! Why the United States Is So Different from Other Countries*, 22 HEALTH AFF. 89, 89 (2003).

3. *See* Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847 (2011).

4. For further discussion of the destructive synergistic effects of monopoly and health insurance, see *id.* and Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 LAW & CONTEMP. PROBS. 7, 14–20 (2006).

While health policy commentators rarely focus on the special burdens that the health care system imposes on less-than-affluent insureds, they regularly and widely deplore the status of uninsured Americans. Yet the problems of the insured and the uninsured are two sides of the same coin, for it is mostly the high and constantly rising cost of conventional health coverage that has caused more and more working people to lose it. Indeed, given the options available, it is easy to understand why large numbers of middle-class Americans have been tempted to reject the extortion-like demand that they either pay the industry's high asking price for coverage (which amounts to about 19% of the median household's total income[5]) or put their family's health at risk. Yet industry interests and most commentators have focused their sympathy only on the uninsured, in the apparent hope that government will bring them and the lost revenues they represent back into the system. Easy financial access to health care is not, however, the only indicium of fairness.[6] There is nothing fair about the Hobson's choice that working Americans have long been forced to make between paying for overly costly health coverage and having no coverage at all. Whether denying consumers the latter option—as the Patient Protection and Affordable Care Act of 2010 ("Affordable Care Act" or "PPACA")[7] undertakes to do—will make the situation any fairer is a question reserved for later comment.

---

5. *See* U.S. DEP'T OF HOUS. & URBAN DEV., ESTIMATED MEDIAN FAMILY INCOMES FOR FISCAL YEAR 2010 (2010), www.huduser.org/datasets/il/il10/Medians2010.pdf (reporting estimated median household income in 2010 as $64,400); THE HENRY J. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2010 ANNUAL SURVEY 75 (2010), http://ehbs.kff.org/pdf/2010/8085.pdf (estimating the average annual premium for family health insurance coverage in 2010 as $13,770). We calculated the approximate percentage by adding to median household income 70% of the average premium—$9,773—which is the average of what employers contributed to a wage earner's employer-provided health insurance in 2010. *Id.*

6. For recent examples of how some commentators focus single-mindedly on how equitably health services are distributed while neglecting to consider where the cost burden falls, see JONATHAN COHN, SICK: THE UNTOLD STORY OF AMERICA'S HEALTH CARE CRISIS—AND THE PEOPLE WHO PAY THE PRICE (2007) (highlighting mostly the plight of uninsured individuals, not those who, literally, "pay the price"), and MADISON POWERS & RUTH FADEN, SOCIAL JUSTICE: THE MORAL FOUNDATIONS OF PUBLIC HEALTH AND HEALTH POLICY (2006).

7. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 25 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.) [hereinafter PPACA]. For ease of reference, PPACA as used here also includes amendments made to it by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

The main purpose of this Article is to call specific attention to the many, cumulatively important regressive features of the financing and regulatory regime that has long governed the private side of American health care. Some matters touched upon may seem old hat to many readers, but revisiting these features of health policy, both individually and collectively, to determine their cumulative distributional implications should be a sobering experience.[8] Everyone associated with the health care industry is accustomed to thinking about where its next dollars will come from. It is time to think about where *all* its dollars come from and whether both the cost burden and any offsetting benefits are fairly distributed. Although focused principally on unfairnesses in the entrenched, unreformed system, the Article briefly considers at the end how the PPACA generally stacks up in fairness terms.

II. EXCESSIVE PRICES: OVERPAYING PROVIDERS AND SUPPLIERS

Evidence that Americans pay excessive prices for health care goods and services comes from comparisons with prices paid to suppliers and providers in other developed nations[9] and with comparable payments under the Medicare and Medicaid programs.[10] Although the explanation for these differentials may be simply that government-controlled health systems regularly use their monopsony (buying) power to set prices below competitive levels (that is, marginal costs), the substantially higher prices observed in the United States' private sector also result from weak competition and unchecked monopoly or market power. Most importantly, private health insurance, at least as it operates in the United States, greatly enhances the ability of firms with market power to raise prices at the expense of consumers—specifically, payers of health insurance premiums. Inexplicably neglected in the antitrust and health economics literature, this observation has huge implications for both consumer and the general welfare.

---

8. Some of the Article's observations are not fully documented here but are supported and more fully explained elsewhere. *See generally* Havighurst & Richman, *supra* note 4; Havighurst & Richman, *supra* note 3. Other points, however, lack extensive empirical support because researchers have not focused nearly enough attention on distributional issues.

9. *See* Anderson et al., *supra* note 2, at 90–92.

10. *See* MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 54–55 (2010), http://www.medpac.gov/documents/mar10_entirereport.pdf.

A. *Monopoly and Health Insurance: A Corrosive Combination*

The economics textbook objection to monopoly is that the high price a monopolist naturally charges tends to discourage consumption of the monopolized good, thus diverting productive resources to other sectors and away from their best use. Interestingly, this general misallocative effect of monopoly is not a significant problem in health care because health insurance enables most consumers to pay even greatly inflated prices, which therefore do not have their usual consumption-discouraging effect. By the same token, however, health insurance enables monopolists to set prices far above what consumers would pay if they faced those prices themselves, rather than paying only deductibles, coinsurance, or copayments; in other words, with health insurance in the picture, a monopolist can charge far more than the theoretical "monopoly price."[11] Because insured consumers ultimately pay these higher prices in their health insurance premiums,[12] insurance has the effect of seriously aggravating monopoly's second objectionable effect: the redistribution of wealth from consumers to producers. Although economic theory cannot prove that one distribution of wealth is preferable to another, the public has long objected to unjustified monopolies precisely because of their redistributive effects.

In some ways, to be sure, private health insurers have made price competition more effective in many health care markets by acting as knowledgeable, aggressive purchasing agents for their insureds and by rewarding those providers willing to grant substantial discounts from their list prices with increased patient flow. But American insurers have little ability to confront true monopolists for the simple reason that they are not in a position (as individuals are, if only by necessity) to forgo purchasing a monopolized service or product simply because its price is too high. In the absence of a near-perfect substitute for a monopolized service or product as a treatment for certain health problems, health plan enrollees facing those problems could be expected to protest, even bring a lawsuit, if the plan would not purchase it for them. Although it is theoretically possible for a health plan to obtain contractual authority to make benefit/cost trade-offs in purchasing for the group, American health insurers

11. *See, e.g.*, Geeta Anand, *The Most Expensive Drugs: Lucrative Niches: How Drugs for Rare Diseases Became Lifeline for Companies*, WALL ST. J., Nov. 15, 2005, at A1 (quoting one drug company executive as saying, with reference to the profitability of a monopoly conferred under the Orphan Drug Act, "I never dreamed we could charge that much").

12. *See infra* note 20 and accompanying text.

have never sought such authority, perhaps fearing that neither their subscribers nor the legal system would respect any economizing judgments they might make.[13] Instead, health plans compete mainly to give consumers easy access to all "medically necessary" care, not optimal value for their health care dollars. American-style health insurance therefore enables providers and suppliers to parlay even marginally advantageous market positions into extraordinary monopoly profits earned at consumers' expense.

It is impossible to identify all the health care markets and submarkets in which health insurance facilitates extraordinary price gouging by monopoly sellers.[14] Antitrust enforcement has been relatively ineffective, however. Largely because federal judges often viewed nonprofit monopolies as relatively benign rather than as unusually costly to consumers, the antitrust agencies were unable to prevent many hospital mergers that increased already high levels of market concentration.[15] Similarly, the antitrust agencies, while suppressing most naked price fixing, have not been able to prevent the formation of large physician groups with substantial pricing freedom in local markets.[16] There are also many markets, including significant submarkets for highly specialized services, which feature significant market power that

13. *See generally* CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM (1995).

14. *See generally* Havighurst & Richman, *supra* note 3. The difficulty arises in part because hospitals do not exercise their monopoly power simply by raising the price of each individual service for which there is no close substitute (geographically or otherwise). Instead, they use their power over these unique services to resist insurers' demands for steep discounts from arbitrarily set list prices for numerous services the hospital provides. *See generally* Christopher P. Tompkins, Stuart H. Altman & Efrat Eilat, *The Precarious Pricing System for Hospital Services*, 25 HEALTH AFF. 46 (2006) (describing how hospitals usually negotiate prices not service-by-service but by agreeing to an across-the-board discount for large bundles of services). Although hard data on hospitals' monopoly profits are lacking, hospitals' revenues from private sources tend to exceed allocations of their fully distributed costs (which themselves usually exceed marginal cost, the competitive price) by substantially greater margins than their revenues from public sources (which generally use arbitrary fee schedules). *See id.* at 47.

15. *See* Fed. Trade Comm'n & U.S. Dep't of Justice, Improving Health Care: A Dose of Competition, at ch. 4 (2004), http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf; Cory S. Capps et al., *Antitrust Policy and Hospital Mergers: Recommendations for a New Approach*, 47 ANTITRUST BULL. 677 (2002); Havighurst & Richman, *supra* note 3; Barak D. Richman, *Antitrust and Nonprofit Hospital Mergers: A Return to Basics*, 156 U. PA. L. REV. 121 (2007).

16. *See* Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, 21 HEALTH AFF. 185, 190 (2002) ("[T]he federal enforcement agencies have been slow to challenge physician or other provider networks.").

is uncontestable legally because it arises from regulation, patents, technological causes, natural-monopoly conditions, effective product differentiation, or other market circumstances. Where a seller exercises pricing power, private health insurance—at least the kind currently found in the United States—positively facilitates its translation into a major redistribution of income to providers and suppliers. The renewal of health care cost escalation in the early 2000s, after several years of relative stability in the 1990s, resulted in part from increasing supply-side market power.[17] Prescription drugs and medical devices, both areas where patents and trade names confer valuable monopoly power, have also been important contributors to recent cost increases.

Despite its enormous impact on the prices consumers pay, few analysts have expressly recognized how American-style health insurance aggravates the redistributive effects of monopoly. For example, antitrust lawyers, courts, and economists have puzzled at length over whether nonprofit firms with market power are any less apt to charge monopoly prices than their for-profit counterparts. Yet this question fades to insignificance once one appreciates the extraordinary pricing freedom enjoyed by any firm selling a unique or especially desirable good or service covered by insurance.[18] The harm to consumers' pocketbooks from the interaction of monopoly and American-style health insurance warrants a fundamental rethinking and strengthening of competition policy in the health sector.

B. *Monopoly as an Instrument of Public Finance*

One explanation for public toleration of widespread monopoly in the hospital sector is that most of the extraordinary profits that health insurance enables nonprofit hospitals to earn in particular lines of business appear to be put to good uses in cross-subsidizing hospital activities that the market would not otherwise support. Indeed, many such institutions do not appear to be earning excess profits at all because their revenues are so promptly diverted to other uses. Yet much of the high cost of health care in the United States reflects activities and capital spending that industry members are able to undertake only

17. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 57 (2005), http://www.medpac.gov/documents/Mar05_EntireReport.pdf (noting that insurers' use of selective contracting "has been limited by both hospital consolidation and consumers' reluctance to accept limitations on their choice of providers"); *see also* Robert A. Berenson, Paul B. Ginsburg & Nicole Kemper, *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFF. 699 (2010).

18. *See generally* Richman, *supra* note 15.

because of the way in which health insurance facilitates monopoly pricing.

One kind of cost that hospitals regularly cover out of monopoly surpluses arises when the institution's costs of providing services under Medicare or a state Medicaid program exceed its revenue from that program. In addition, some legal and regulatory requirements force providers to incur costs (for example, in emergency departments) that cannot be charged directly to (or recovered in full from) some payer. Moreover, virtually all major medical centers voluntarily engage extensively in professional education or medical research, much of it not remunerative. Finally, despite subventions from various levels of government, hospitals bear substantial uncompensated costs in caring for patients without health coverage.[19]

Many have found it easy to approve nonprofit monopolies because, even though the surpluses they generate may be substantial, they go to defray health-related costs having some social utility and supporting an important safety net. Presumably, however, there is a limit to the amount of resources that should be entrusted to wealthy institutions that are essentially unaccountable to the public, either politically or in the marketplace. There is no assurance, after all, that easily gained revenues will not be squandered in low-priority activities, in overpaying for inputs, or simply through managerial slack. To be sure, tax-exempt monopolists in health care markets are committed by their corporate charters, state law, and the tax code to pursuing only "charitable" purposes (generously defined) and precluded from conferring any but incidental benefits (broadly defined) on private interests. Among other things, however, this means that the large surpluses they generate in their profitable lines of business

19. *See* Stuart Altman, David Shactman & Efrat Eilat, *Could U.S. Hospitals Go the Way of U.S. Airlines?*, 25 HEALTH AFF. 11, 14 (2006) ("[G]eneral hospitals provide a sizable amount of uncompensated care—an average of 5.5 percent of total general hospital costs, or about $25 billion, in 2003."); *see also* Bruce Vladeck, *Paying for Hospitals' Community Service*, 25 HEALTH AFF. 34, 37 (2006) (estimating that hospitals incurred "community service costs" totaling $80–95 billion in 2003). To the extent that some of these costs are recompensed through the Medicare program (and thus do not have to be financed out of monopoly profits earned at premium payers' expense), the burden still falls excessively on working Americans through a somewhat regressive payroll tax. *See* Havighurst & Richman, *supra* note 4, at 8 n.1. Most notably, of course, the Affordable Care Act promises that thirty-plus million more individuals will soon carry generous insurance coverage that will not only reduce hospitals' uncompensated-care burdens but will also make hospitals with market power even more profitable (at premium payers' expense). *See infra* Part V. For a more extensive discussion of hospital monopolies, see Havighurst & Richman, *supra* note 3.

are trapped in the health sector and unavailable for use elsewhere in the economy. Indeed, federal, state, and local tax exemptions and the conditions therefor, combined with the profit-enhancing effects of American-style health insurance, have permitted hospitals over time to suck very large amounts of cash out of the economy either to support ongoing health-related activities or to create new health facilities or new health-sector monopolies. This one-way flow of capital into the health sector has built enormous enterprises that can legally use their untaxed income and assets only for health-related activities, whatever the economy's (or premium-paying individuals') other needs.

All of this points to the need to think of nonprofit monopoly in the health care sector as an instrument of public finance, administered by private institutions that are accountable to the public in only limited ways. Although community-based governing boards, states' attorneys general, and the Internal Revenue Service provide some oversight, none of these is likely to constrain nonprofit hospitals' use of their power to charge near-profit-maximizing prices to health insurers. Nor can they provide much assurance that hospitals' money is well spent.

C. *Financing by a Regressive "Head Tax"*

Although American health insurers make it possible for health care monopolists to earn extraordinary monopoly profits, the resulting heavy costs do not fall finally on the insurers themselves. Instead, they are reflected in higher premiums, which, although paid in the first instance by employers, come ultimately from the wages of the subset of working Americans who enjoy employer-provided health coverage.[20] In this way, a myriad of health-related activities, many of uncertain value as objects of public finance, are paid for through what amounts to a hidden "head tax." True to the regressive nature of such a tax, the burden is distributed more or less equally across all premium payers, irrespective of their income, wealth, or ability to pay.[21] Few

20. Economic theory predicts, and evidence confirms, that employees ultimately bear the cost of their employer-purchased insurance, mostly in the form of reduced wages. *See* Jonathan Gruber, *Health Insurance and the Labor Market* 51–62 (Nat'l Bureau of Econ. Research, Working Paper No. 6562, 1998).

21. Later discussion, *infra* Part V.C., observes how subsidies provided in the PPACA will cap the exposure of many consumers purchasing through Exchanges to premium costs above a fixed amount, leaving government itself to pick up marginal charges such as those we here characterize as a head tax. Employees in employer-sponsored plans, however, will continue to bear indirectly the cost of arguably public goods financed through provider monopolists' overcharges.

methods of taxation are as regressive as this. Because the burden thus imposed on lower- and middle-income premium payers is so large, this regressivity should be a matter of explicit public concern.

Viewing the extraordinary profits that health care monopolists can earn at the expense of premium payers as a kind of tax is helpful in appreciating not only the distributive injustice but also the potential for resource misallocation inherent in this method of financing projects for the public good. In particular, the analogy invites consideration of the accountability of those imposing the burden and spending the resulting revenue. Unlike public taxing authorities, health industry monopolists are relatively free to set their own prices and to decide how to use the surpluses they generate. The ironic result is that, while American-style health insurance obviates the usual concern that monopoly will misallocate resources by causing monopolized goods or services to be underproduced, it combines with the peculiar incentives and circumstances of nonprofit, tax-exempt monopolists to generate allocative inefficiency of precisely the opposite kind—too *much* of a good thing.

The extraordinary profitability of nonprofit hospitals with market power has created large pools of corporate wealth that can be spent or invested only to support each institution's parochial purposes whatever the larger society's priorities may be. In the current deep recession, individual premium payers could undoubtedly find better (that is, more efficient) uses for those resources. But in the absence of any certain way to restore competition limiting the pricing freedom of powerful institutions,[22] policy makers should give serious attention to revoking the valuable tax exemptions these ownerless corporations currently enjoy. Revenue from income, property, and sales taxes imposed on these huge reservoirs of wealth not only would enable governments at all levels to reduce looming budget deficits but would also improve the efficiency with which society allocates its newly scarcer resources.

D. *Who Bears the Costs (Enjoys the Benefits) of Innovation?*

Opportunities for regressive redistribution and resource misallocation also arise from the interaction of *for*-profit monopoly and American-style private health insurance. Once again, insurance puts health industry monopolists in a position to capture more than ordinary monopoly profits. Particularly (though

22. For some suggestions, however, see Havighurst & Richman, *supra* note 3, at 871–83.

not exclusively) in the case of for-profit firms, the prospect of such extraordinary profits may induce equally extraordinary efforts to gain and keep such monopolies. Obviously, some efforts to gain monopoly power are socially beneficial, particularly those yielding technological or other innovations. But the prospect of earning very large economic rents can also induce a great deal of spending that has little or no social value. For example, firms can pursue or enhance market power by uninformative advertising, meaningless product differentiation, lobbying for restrictive legislation, erecting entry barriers of other kinds, and engaging in preemptive, duplicative, or inconsequential research and development (R&D). Indeed, it has been persuasively argued that, even as a general matter, monopoly's most serious misallocative effect is likely to be, not underproduction induced by monopoly prices, but excessive investments in seeking, gaining, holding, and increasing market power.[23] And in fact there is no assurance that would-be and actual monopolists will not dissipate a high proportion of (and perhaps even more than) their prospective rents in such endeavors. The likelihood of wasteful expenditures in pursuit or defense of market power is even greater in the health sector, where health insurance dramatically increases the lure of monopoly profits.

To be sure, one can argue that strong incentives for health care R&D are bound to pay large social dividends. Indeed, such analysts as David Cutler and Frank Lichtenberg have produced evidence that the aggregate benefits of innovation in health care far outweigh its aggregate costs,[24] and it is generally agreed that incentives for innovation tend to be substantially suboptimal in virtually all markets. Moreover, Darius Lackdawalla and Neeraj Sood have shown that, at least in theory, health insurance can

23. RICHARD A. POSNER, ANTITRUST LAW 13–18 (2d ed. 2001).

24. Unfortunately, they have far less to say about *marginal* costs and benefits, especially as consumers in different income categories (rather than economists employing assumptions about social priorities) might perceive them. *See, e.g.*, DAVID M. CUTLER, YOUR MONEY OR YOUR LIFE: STRONG MEDICINE FOR AMERICA'S HEALTH CARE SYSTEM 63 (2004) ("On the basis of low-birth-weight-infant and cardiovascular-disease-care alone . . . , the benefits of medical care are about equal to its costs."); David M. Cutler & Mark McClellan, *Is Technological Change in Medicine Worth It?*, 20 HEALTH AFF. 11 (2001) (examining five new technologies and concluding from these examples that "medical spending as a whole is clearly worth the cost"); Frank R. Lichtenberg, *Are the Benefits of Newer Drugs Worth Their Cost? Evidence from the 1996 MEPS*, 20 HEALTH AFF. 241 (2001); Frank R. Lichtenberg, *Pharmaceutical Innovation, Mortality Reduction, and Economic Growth* 1 (Nat'l Bureau of Econ. Research, Working Paper No. 6569, 1998) (concluding that "a one-time R&D expenditure of about $15 billion subsequently saves 1.6 million life-years per year, whose annual value is about $27 billion").

create near-optimal incentives for R&D.[25] On the other hand, Alan Garber and his coauthors have suggested that health insurance, because it permits monopolists to earn profits actually in excess of the marginal social value of the monopolized good, service, or technology, may encourage excessive investments in innovation.[26] Another important body of literature argues that the lure of patent monopolies induces wasteful patent races and other unproductive spending on getting, attacking, defending, and inventing around patents, both valid and invalid.[27]

Given these complexities, this is clearly not the place to opine on the net allocative consequences of innovation incentives in health care and particularly in the pharmaceutical and medical device sectors. It is far from obvious, however, that prospects for technological innovations of even very great value to the general public (or, say, to populations of the Third World) can justify forcing lower- and middle-income American premium payers to disproportionately fund the incentives needed to realize them. *A fortiori*, because serious questions can be raised about the net effect of American-style health insurance on incentives to monopolize segments of the health care market, it is unfair to make the high costs of inducing innovation part of the price that working Americans must pay if they are to have any health coverage.

E. *Reprise*

The foregoing discussion makes several important observations. First, American-style private health insurance, by greatly weakening price elasticity of demand as a constraint on monopoly pricing by health care providers and suppliers, facilitates the latter's exercise of market power, producing profits substantially exceeding (the word *obscene* comes to mind) the usual returns to lawful monopoly. Second, such monopoly profits both fuel and

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

26. *See generally* Alan M. Garber, Charles I. Jones & Paul M. Romer, *Insurance and Incentives for Medical Innovation* (Nat'l Bureau of Econ. Research, Working Paper No. 12080, 2006).

27. *See, e.g.*, M.F. Grady & J.I. Alexander, *Patent Law and Rent Dissipation*, 78 VA. L. REV. 305 (1992) ("The defect of the system is that if multiple inventors expend resources in competition for the patent monopoly, the benefit to society of having the invention will be dissipated by the cost of numerous, redundant, development efforts."). In the health care sector, one sees extensive efforts to create and heavily promote relatively modest product improvements and to differentiate brand-name products from nearly equivalent generics by heavy investment in direct-to-consumer advertising.

prospectively induce a great deal of health-sector spending, by both nonprofit and for-profit firms, that society has neither directly nor indirectly validated as appropriate uses of its scarce resources. And, third, the burden of overpaying providers and suppliers is imposed more or less equally, like a head tax, on all Americans with private health coverage, thus regressively impacting all premium payers below the high end of the income spectrum. These observations should inspire more research and political attention to how the burden of financing American health care is distributed. Self-proclaimed progressives, in particular, should curb their infatuation with health care as a preeminent good and concern themselves with the overall welfare of those who pay for it.

III. Excessive Costs: Undercompensating for Moral Hazard

A much more widely noted effect of health insurance, more familiar by far than its facilitation of providers' and suppliers' exercise of market power, results from its general unleashing of moral hazard—that is, the tendency of patients and providers to spend insurers' money more freely than the patient's own. To be sure, some higher costs are unavoidable in any pooling of financial risks and are therefore, in themselves, not a sign of inefficiency. But third-party-financed spending on health care could be seriously welfare-reducing if payers are artificially inhibited or precluded from taking cost-effective administrative and other steps to counter moral hazard or if health coverage is not carefully designed to strike an appropriate balance between financial protection and moral hazard's potentially heavy costs. Unfortunately, health insurance in the United States generates inefficiency on both scores because custom, law, and regulation are all systematically rigged to give moral hazard nearly full sway. Indeed, U.S. health policy appears to be premised on the notion that health coverage, where it exists, must entitle each insured, subject only to cost-sharing requirements, to unlimited access to any arguably beneficial health service that a physician is willing to prescribe. Thus, working Americans, if they are to have any health coverage at all, must buy a variety of it that, having been designed according the values and interests of the health care industry and other elite groups, allows no serious consideration of benefit/cost tradeoffs.

The total cost burden on premium payers resulting from overly rich entitlements is no doubt substantially larger than the burden they bear by virtue of the regressive head tax described

above. Here, however, an insured consumer receives services and goods of some value in return for his extra outlay, making the exploitation of premium payers less obvious. Moreover, trust in the health care system and admiration for all the good it does make it hard for many people to imagine that a systematic rip-off may be in progress. Yet if one can accept that many might be better off taking modest statistical risks with their family's health in order to make mortgage payments, pay energy bills, educate their children, or save for an uncertain retirement, then forcing working people to pay for health care of speculative or only marginal value can reasonably be viewed as unfair.[28] The actual magnitude of the unfairness depends, of course, on valuations that only individuals can make. But ordinary Americans are currently forced to sacrifice far too much for the privilege of having health coverage. Only in some respects, noted below, may the Affordable Care Act make their situation appreciably better.

A. *Conceding the Benefit/Cost No Man's Land*

This is not the place to explore the complex reasons why American health plans have never had, nor even seriously sought, the *de facto* and *de jure* authority necessary to efficiently counteract moral hazard.[29] But their resulting inability to withhold (that is, ration) coverage of any prescribed service on benefit/cost grounds explains not only the special power that private monopolists can exercise in health care markets (itself a consequence of unchecked moral hazard) but also the general overutilization of health services and the proliferation of extremely costly technologies, many of only slight marginal value. Even during the ascendancy of managed health care, health plans were not truly in the business of administering coverage to give subsets of premium payers good value for what they wanted to spend. Whereas that endeavor would have required establishing and administering mutually agreed-upon, cost-sensitive limits on individuals' freedom to draw on the common pool of premiums, U.S. health plans have generally adhered to the convention

28. A noted economist and physician team apparently have unexamined moral compunctions about allowing consumers significant freedom of choice in purchasing coverage that might entail some rationing of financing (not care itself, it should be noted)—even with public subsidies and numerous agents available to protect them against serious mistakes. *See* HENRY J. AARON & WILLIAM B. SCHWARTZ, CAN WE SAY NO?: THE CHALLENGE OF RATIONING HEALTH CARE (2005). *But see* Daniel Shapiro, *Why Even Egalitarians Should Favor Market Health Insurance*, 15 SOC. PHIL. & POL'Y 84 (1998).

29. *See generally* Clark C. Havighurst, *How the Health Care Revolution Fell Short*, 65 LAW & CONTEMP. PROBS. 55 (2002).

requiring them to finance all care that medical professionals deem "medically necessary." Thus, the only issues in most coverage disputes were efficacy and cost-effectiveness (in comparison with other measures of equal efficacy). Any rationing of arguably beneficial care occurred behind the scenes without the insureds' consent, usually as a consequence of insurers' use of financial incentives to induce providers to economize. Particularly since managed health care suddenly fell out of political and consumer favor in the late 1990s, U.S. health plans have conceded virtually the entire no man's land of benefit/cost tradeoffs to the moral-hazard enemy.

It is impossible to know the actual extent of inefficient utilization resulting from uncontrolled moral hazard in American health plans.[30] It has been suggested that the United States does not greatly overuse resources because its utilization rates for many services are comparable to those in other nations.[31] That comparison means little, however, without some reason to believe that foreign systems handle the moral-hazard problem well. (In any event, the only relevant comparison, for present purposes at least, would be between foreign utilization rates and consumption by *insured* Americans alone.) On the other hand, numerous studies reveal heavy spending that is wasteful even by professional standards. To be sure, such studies arguably constitute only anecdotal evidence of inefficiency because they take no account of administrative costs that would have to be incurred to achieve a more efficient result. But one widely noted feature of the American system provides a rock-solid basis for believing that current U.S. spending on health care, at least for the insured

30. Amy Finkelstein estimates that the spread of health insurance from 1950 to 1990 (including the implementation of Medicare and Medicaid) accounted for at least 40% of the dramatic increase in per capita health spending during that period. *See* Amy Finkelstein, *The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare* (Nat'l Bureau of Econ. Research, Working Paper No. 11619, 2005). Not all of this added spending was inefficient, of course, because public and private insurance provided both valuable financial security and subsidized access to essential health services. Nevertheless, the moral-hazard effect detected by Finkelstein appears substantially greater than economists had previously detected in studies of individual behavior under various insurance arrangements (for example, the RAND Health Insurance Experiment). In contrast to the earlier studies, Finkelstein's extended time horizon enables her to detect long-term market-wide effects induced by the substantially reduced price resistance (*i.e.*, steeper demand curves) that sellers increasingly faced as generous health insurance spread. These effects include greatly altered styles of medical practice and strong incentives to create and use technologies that would fail most people's benefit/cost test.

31. *See, e.g.*, Anderson et al., *supra* note 2.

population, is seriously inefficient: the federal tax subsidy for employer-purchased health coverage.[32]

B. *How the Tax Subsidy Helps the Rich (It's Not How You May Think)*

By excluding premiums for employer-sponsored health coverage from employee income subject to federal and state income and payroll taxes, the tax subsidy has long induced employers not to worry about efficiency in designing their employees' health coverage. To the contrary, their principal goal became the exploitation of a large tax loophole by making as many health care bills as possible payable with pre-tax dollars.[33] Thus, in place of taxable wages, they bought their employees generous, comprehensive coverage with minimal cost sharing. This overinsurance, amplified by uncontrolled moral hazard, could only exacerbate the health system's misallocation of the nation's resources.

Among the tax subsidy's many critics, a common objection is its greater apparent value to higher-bracket taxpayers.[34] The regressivity these critics discern is only apparent, not real, however, because the government must sooner or later replace any revenue it loses through such tax expenditures;[35] this presumably requires taxing other income at higher progressive rates, thus

---

32. *See* CHARLES E. PHELPS, HEALTH ECONOMICS 354–55 (2003) (estimating, based on empirical estimates of demand for insurance, that "employer-group health insurance premiums would be only about 55 percent as large today if the tax subsidy were not in effect"; "it seems possible that the health sector would be at least 10 to 20 percent smaller without the tax subsidy for health insurance").

33. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 extended favorable tax treatment to the funding of so-called "health savings accounts" (HSAs) if coupled with high-deductible coverage, thus significantly leveling the playing field of health insurance choices. Pub. L. No. 109-173, §§ 1201–03, 117 Stat. 2066, 2469–80 (codified as amended at various provisions of 26 U.S.C.). Unfortunately, the popularity of HSAs was due less to their benefits in purchasing health care than to their value as a new tax shelter for the rich (since income taxes on HSA earnings were deferred until paid out as retirement income and payroll taxes were escaped altogether). Although with some tweaking HSAs might in due course have caused a shift toward more efficient health coverage, *see* Mark A. Hall & Clark C. Havighurst, *Reviving Managed Health Care with Health Savings Accounts*, 24 HEALTH AFF. 1490 (2005), they are unlikely to yield health policy benefits under the 2010 legislation.

34. *See, e.g.*, POWERS & FADEN, *supra* note 6, at 132–33.

35. *See* EMPLOYEE BENEFIT RESEARCH INST., TAX EXPENDITURES AND EMPLOYEE BENEFITS: ESTIMATES FROM THE FY 2011 BUDGET 1 (2010), http://www.ebri.org/pdf/publications/facts/FS-209_Mar10_Bens-Rev-Loss.pdf (estimating cost of the tax expenditure to be almost $177 billion in 2011).

making the net tax effect on high-bracket taxpayers negligible. There are, however, some indirect ways in which the tax subsidy does substantially benefit economic elites, usually at some cost to the less affluent. A particularly important effect has been to make employers—rather than individual consumers or other, more homogeneous groups—responsible for designing or selecting most private health coverage. Although employers can usefully serve as sophisticated purchasing agents for their employees, they have interests of their own and will inevitably make choices that benefit some employees (usually higher-income ones) more than others. One way in which the greater value of the tax subsidy to higher-income workers has regressive distributional consequences is by inducing employers to prefer coverage costlier than the average subsidized worker would choose for himself.

An even more subtle and pernicious effect of the tax subsidy is to make employees with health coverage far less cost-conscious, both as consumers and as voters, than they would be if they paid for their coverage directly. Under the illusion that their employers bear any cost of coverage that is not visibly deducted from their wages, employees are inclined to demand generous coverage even when their true interests would be served by economizing.[36] Similarly, the inability of consumers to see the connection between their own pocketbooks and the macro health care choices that others make on their behalf has consequences in political arenas. Thus, those who make legislative and regulatory policy can take political credit for measures ensuring seemingly higher-quality care or more generous coverage without having to account to consumer-voters for the cost consequences.

The tax subsidy thus provides a solid foundation both for the health-care sector's dominant ideology and for a political economy that works systematically against the interests of lower- and middle-income premium payers.[37] Ideologically, both industry practice and regulatory policy are governed by a strong preference for more and better health care with little or no regard for how much it costs or who bears the cost burden. Consumers

36. Only 19% of employers that offer a choice of health plans require the employee to pay the full amount by which the cost of the choice made exceeds the lowest-cost option. THE HENRY J. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2004 ANNUAL SURVEY 63 (2004).

37. This formulation of the tax subsidy's impact and importance goes well beyond economists' far narrower focus. *See, e.g.*, Thomas M. Selden & Bradley M. Gray, *Tax Subsidies for Employment-Related Health Insurance: Estimates for 2006*, 25 HEALTH AFF. 1568 (2006).

of health care, seeing no reason to question this preference, have generally embraced it in the marketplace. Likewise, in the political process, hiding the true cost of health coverage and health services from the consumer-voters who ultimately bear them has made it relatively easy for elite interests to have their preferences honored by the government. Although special interests flex their political muscles here as elsewhere, they are less likely to meet resistance from consumer-voters when the regulatory choices affect only private costs. Thus, for example, the public generally applauds regulatory limits on the ability of health plans to ration financing even though such regulation inevitably increases insurance premiums. Whereas government regulation is regularly justified on the ground that consumers are too ignorant to be good choosers, few have acknowledged the consequences for political choices when the electorate, having been deliberately kept in ignorance about the costs they pay, fail to recognize that health care is an economic good.

The principal beneficiaries of policies and practices that err consistently on the side of costlier care and uncontrolled moral hazard are, of course, the health care industry and the twelve million individuals it employs.[38] Less obvious beneficiaries are higher-income Americans, who especially prefer, even at high cost, both the highest quality of medical care and virtually unlimited health coverage. The result is a system rigged systematically against the true interests of the political majority. Although the amount of excessive spending cannot be estimated without knowing consumers' true preferences, it is certain to be substantial. American-style health coverage thus contributes once again to a serious overallocation of resources to the health care enterprise.

IV. WHO CONSUMES WHAT ALL HAVE PAID FOR?

However one may feel about affluent Americans' routinely enjoying somewhat more and better health care than everyone else, it would certainly be unfair if consumption patterns varied significantly and positively with income (rather than with health needs alone) in situations where everyone pays the same premium for the same health coverage. Although evidence is scarce,[39] there are reasons to believe that, in American health

38. *See* Uwe E. Reinhardt, *Resource Allocation in Health Care: The Allocation of Lifestyles to Providers*, 65 MILBANK Q. 153 (1987) (emphasizing extent to which consumer savings from enhanced price competition and economizing choices would come at the direct expense of industry stakeholders).

39. *But see* Barak D. Richman, *Insurance Expansions: Do They Hurt Those They Are Designed to Help?*, 26 HEALTH AFF. 1345, 1351 (2007) (finding that even when insurance benefits and access are constant, white and high-income indi-

plans, higher-income employees make greater use of their coverage, demanding and receiving more and costlier services at plan expense than their lower-income coworkers. Even if things more or less even out because lower-income persons have generally poorer health and greater health care needs, there is good reason to question the general assumption that, in employee health plans, the healthy and wealthy subsidize the less fortunate. In fact, the subsidies may run in the opposite direction.[40]

One factor that could cause consumption patterns to be correlated positively with income within the same health plan is cost sharing. Most studies of cost sharing focus only on whether it discourages consumption of assorted health services by less affluent patients.[41] A different question is the extent to which conditioning eligibility for insurance coverage on patients' willingness to make out-of-pocket payments causes lower-income participants in employee health plans to get disproportionately fewer benefits for the premiums they pay. Intuitively, it seems likely that the winners, once again, are those who are better able to pay up-front fees.[42] Time, transportation costs, and child-care needs are additional greater barriers for the lower-income insured seeking care.

Income-correlated disparities in the volume and quality of health services received by participants in a single health plan might also result if there are class differences in patient attitudes toward certain kinds of care[43] or if physicians take different attitudes or approaches in treating different patients.[44] For example, perceiving that more-educated patients have especially high

viduals consume more of certain health services covered by insurance than their non-white and lower income coworkers).

40. Some economists' faith in market forces is such that they might expect income-correlated differences in utilization of the same health benefits to be compensated for in other benefits or take-home pay. *See, e.g.*, Mark V. Pauly, *The Tax Subsidy to Employment-based Insurance and the Distribution of Well-Being*, 69 LAW & CONTEMP. PROBS. 83, 83 (2006). But no one has shown the labor market to be this efficient.

41. *See, e.g.*, JOSEPH NEWHOUSE ET AL., FREE FOR ALL: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT (1993).

42. *See id.* at 46 (showing in a table that in a controlled setting, cost sharing had noticeably greater effects on middle-income consumers than on higher-income ones).

43. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY 28–30 (2001) (revealing that higher levels of perceived stigma associated with mental-health illness is one reason fewer African Americans seek mental health care).

44. LINNEA CAPPS, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedley et al. eds., 2003) (detailing persistent patterns of racial disparities in the delivery of medical services).

expectations concerning their health care, physicians might strive to accommodate those expectations, providing somewhat more or better services without regard to the patient's nominal entitlement. Likewise, insured individuals who are more articulate, demanding, or adept at searching the Internet may frequently get their physicians to prescribe more or better services for them than other patients normally receive.

Although equity in employer-sponsored health plans has received little attention from researchers, the vast body of evidence on racial and income disparities in the overall distribution of health care is at least consistent with, and sometimes appears to support, the hypothesis that lower-income workers tend to get less out of their health plans than they pay for. Similarly, socioeconomic status appears to correlate positively with consumption of many plan-covered services in nations with national health programs under which everyone has the same nominal entitlement.[45]

The potential for regressive redistribution in employer-sponsored health plans could be minimized, it would seem, if employers generally offered their employees different plans—each designed for a specific income group—so that each subgroup would bear only costs reflecting its own consumption, priorities, and circumstances. It does not appear that this regularly occurs. Indeed, employers may pool their nonunionized employees for purposes of health coverage precisely because the unwitting contributions of lower-income workers make it cheaper for the employer to provide the costly benefits that high-income employees particularly desire. If employee health plans do indeed operate regressively, the tax subsidy is ultimately to blame, since it both empowers employers to make the crucial choices and hides the true cost of coverage from the rank and file.

45. *E.g.*, Max Exworthy et al., *Evidence into Policy and Practice? Measuring the Progress of U.S. and U.K. Policies to Tackle Disparities and Inequalities in U.S. and U.K. Health and Health Care*, 84 MILBANK Q. 75, 79 tbl.1 (2006); Norman Frohlich et al., *Health Service Use in the Winnipeg Regional Health Authority: Variations Across Areas in Relation to Health and Socioeconomic Status*, 15 HEALTHCARE MGMT. F. 9, 9 (2002); Anthony Scott et al., *Is General Practitioner Decision Making Associated with Patient Socio-Economic Status?*, 42 SOC. SCI. & MED. 35, 35–46 (1996). Although wealthier beneficiaries also consume many covered services at higher annual rates in the U.S. Medicare program, this evidence is inconclusive in the present context because of these beneficiaries' greater access to Medigap and retiree coverage.

V. DOES THE AFFORDABLE CARE ACT RECTIFY HEALTH CARE'S UNFAIRNESS TO ORDINARY AMERICANS?

In seeking to eliminate inequality in financial access to medical care in the United States, the sponsors of the Affordable Care Act presumably thought they were improving the welfare of middle- and lower-income Americans. In some important respects, however, they left key features of the existing system largely untouched and thereby missed a rare opportunity to ameliorate the systematic unfairness to the working class that this Article shows to be a longstanding, though generally unacknowledged, characteristic of health care financing in the United States. For a large portion of the population, the new law retains essentially the same framework for fostering employer-sponsored health coverage that, by hiding premium costs from those who bear them, has long enabled industry interests and elite consumers to benefit at the expense of ordinary Americans. It is an ironic testimony to the misconceptions embedded in consumers' minds as a result of past policy mistakes that, despite the many ways in which employer-based coverage fails to serve their true interests, consumer-voters seemed to attach great importance to preserving it in the PPACA. It should be less surprising that large employers, labor unions, health industry interest groups, and many elite consumers favored preserving the traditional financing system.

The main purpose of health reform was, of course, to provide coverage for the uninsured. Under the scheme enacted for this purpose, many individuals and families will soon obtain their private coverage not through their employers but through government-sponsored "Exchanges." For these consumers, the PPACA creates an entitlement to "essential health benefits." In one demonstrable way, this new legal entitlement is fundamentally ill conceived and likely to prove very costly to the nation, unless some of the vaguely defined tools and plans for innovation optimistically included in the legislation can effectively counteract hitherto inexorable cost drivers.[46] In this case, to be sure,

46. Among the provisions in the PPACA designed to achieve cost savings are section 3022, which directs the Secretary of Health and Human Services to implement the "Medicare Shared Savings Program," using Accountable Care Organizations (ACOs). PPACA, Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395–99 (2010). ACOs, in theory, are designed to reduce fragmentation in the delivery system, thus eliminating some costs of duplication and lack of coordination. The Congressional Budget Office has estimated the program will save $4.9 billion between 2013–2019, but experience with ACOs is extremely limited and any such projection of savings is highly speculative. *See* DAVID NEWMAN, CONG. RESEARCH SERV., ACCOUNTABLE CARE ORGANIZATIONS AND THE MEDICARE

most of the excessive costs will not fall on premium payers, as they do in privately designed plans, but will be borne instead by government, which has committed itself to paying large subsidies to ensure that, for the majority of the population purchasing through Exchanges, premiums will not exceed some stated percentage of their income.[47] But, even if the new subsidies, to be funded in some measure by progressive taxation, redistribute excessive health care costs more fairly than they have been distributed in the past, the failure to reform the market for employer-sponsored coverage could leave many working Americans no better, and probably worse, off.

The number of rank-and-file workers who will retain employer-sponsored coverage after the PPACA becomes operative in 2014 is uncertain because employers will have the option of paying a modest penalty for not insuring their employees and letting them purchase subsidized coverage through an Exchange.[48] Since generous health benefits are popular with workers, many employers dropping coverage might find it both difficult and costly to adjust compensation levels to reflect the lost benefits. Larger employers, including those with unionized work forces,[49] are thus likely to choose to carry on as before, providing coverage themselves. Nevertheless, to the extent that employers do shift their lower-paid employees to the publicly subsidized plan, the latter might experience a net improvement

---

SHARED SAVINGS PROGRAM 18 (2010), https://www.aamc.org/download/161172/data/crs_acos.pdf.

Other PPACA efforts to curb health care costs are an excise tax on high-cost plans, *see infra* note 51, an Independent Payment Advisory Board, which would recommend Medicare spending reductions when Medicare cost growth exceeds the CPI, *see* PPACA § 3403, 124 Stat. at 489–507, and new resources to combat fraud and abuse, *see id.* §§ 6406, 6504, 6604, 124 Stat. at 769, 776, 780. These efforts are highly aspirational, however, since (among other hopes) they assume that Congress and other officials will fulfill pledges to remove traditional sources of cost inflation. *See generally,* STEPHEN ZUCKERMAN, ROBERT WOOD JOHNSON FOUND., WHAT ARE THE PROVISIONS IN THE NEW LAW FOR CONTAINING COSTS AND HOW EFFECTIVE WILL THEY BE? (2010), http://www.rwjf.org/files/research/67188costs.pdf.

47. PPACA § 1401, 124 Stat. at 213–20. *See infra* note 65 and accompanying text.

48. *Id.* §§ 1513, 10106, 124 Stat. at 253–56, 907–11.

49. Employers with a unionized work force will not be free, of course, to unilaterally drop their workers' coverage. Indeed, because of the perversities introduced by the tax subsidy, unions have often prospered by negotiating costly benefits that do not, in fact, enhance their members' welfare, and they might well insist on maintaining employer coverage even when their members might be better off purchasing subsidized coverage through Exchanges. *See infra* note 53.

in their welfare.[50] By the same token, those continuing with employer-purchased coverage will remain subject to the unfairnesses observed or hypothesized in this Article.

The following discussion considers the extent to which health care under the recent reforms is likely to remain unfair to the working class. It will also suggest the arguable unfairness of saddling the nation with a costly new entitlement at a time when it cannot meet the costs of earlier ones. It would be obviously unwise and arguably unfair to make the American people, either as consumers or as taxpayers, spend resources on questionably or marginally valuable (or extravagantly expensive) health care when they and the nation as a whole face serious economic difficulties and may have other, more important uses for those resources.

A. *Perpetuating the Unfairnesses Embedded in Employer-sponsored Coverage*

From the point of view of distributional fairness, the PPACA's most fundamental error is to leave largely in place, for anyone obtaining coverage through an employer, virtually the same tax subsidy for health coverage that has long misshaped both the design and perceptions of private health insurance, mostly for the benefit of the health care industry and other special interests and elites.[51] For individuals remaining in the traditional system, employers will continue to construct coverage mainly to take advantage of a tax loophole rather than to achieve cost-effective protection against unbearable financial risks, which is the usual objective of private insurance. Unfairness to rank-and-file employees would only be compounded if employers caused them to pay for costly benefits that their higher-income coworkers particularly insist upon, whether for tax or other reasons. The health care industry, of course, has long since learned

50. *See infra* note 65 and accompanying text. For employees with incomes below roughly 300% of the federal poverty line, the available "premium assistance credit" will be more valuable (and cost taxpayers more) than the current exclusion of employer-sponsored insurance benefits from their taxable wages.

51. The new law does, however, impose a surtax on so-called Cadillac health plans—that is, any with annual family premiums over $27,500—starting in 2013. PPACA § 9001, 124 Stat. at 847–53 (as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1401, 124 Stat. 1029, 1059–60). This provision was controversial, partly because of its potential effects on union-bargained benefits. Although the new tax will affect few plans immediately, the high premium level triggering it is not indexed for inflation or rising health care costs and therefore, if not adjusted by a future Congress, may eventually cause some benefits to be redesigned. Moreover, Congress is not prohibited from changing its mind.

to exploit the uncontrolled moral hazard that overbroad, U.S.-style health insurance inevitably entails.

Leaving employers as the primary purchasers of health coverage, as retaining the tax subsidy seems to do, also means that the full cost of coverage will remain largely hidden from the workers who actually pay for it, mostly unknowingly in reduced wages and other benefits. With consumers continuing to believe that their employers bear most of the cost of their coverage,[52] any preferences concerning health care that they appear to express—whether in the workplace, the marketplace, public-opinion polls, or the political process—will still not reliably reflect their true economic interests. Thus, employers, union leaders, insurers, and politicians will still be in a position to compete for the approval of employees, consumers, or voters, as the case may be, by making promises the cost of which their respective constituents will unwittingly pay.[53] Overly costly health care and overly rich health coverage, both mandated in many respects by state law and regulation, much of it driven by special interests and all of it paid for directly or indirectly by working Americans, are once again the predictable result.

Ironically, reforming the tax subsidy itself has proved politically impossible precisely because the subsidy has so confused consumer-voters about where their true interests lie. Indeed, as a

---

52. The new law provides that, for the first time, employees' W-2 forms will show their employer's contribution to their health coverage. *Id.* § 9002, 124 Stat. at 853–54. It is hard to believe, however, that this disclosure will affect many employees' beliefs concerning the incidence of those costs.

53. For a lengthy characterization of the tax subsidy's cost-hiding effect as "the crucial moral hazard" in health care, see Havighurst, *supra* note 29, at 77–82. "[T]he moral hazard that matters most in health care results from the insulation of consumers *qua* consumers from the cost of their health coverage, enabling employers and the political/legal system to take costly actions without having to account to employees/consumers/voters for their full costs." *Id.* at 81–82.

The design of the Affordable Care Act, with employee benefits left largely unchanged, can be explained in part by the substantial stake that labor unions, influential with the Democratic sponsors of the legislation, have in the old system despite its unfairness to the rank and file. Indeed, the tax subsidy's fortuitous effect of letting union leaders take credit for negotiating expensive health benefits ostensibly provided at employers' expense substantially diluted the labor movement's interest over the years in promoting legislation establishing national health insurance, as trade unions had successfully done in other western countries. *See* MARIE GOTTSCHALK, THE SHADOW WELFARE STATE: LABOR, BUSINESS, AND THE POLITICS OF HEALTH CARE IN THE UNITED STATES 42–44 (2000) (observing how, after World War II and the introduction of the tax subsidy, the labor movement divided its efforts between bargaining for health benefits and advocacy of national health insurance, but failing to highlight the tax subsidy as a key explanation for the movement's priorities).

presidential candidate, Barack Obama took advantage of this confusion when he promised—like so many politicians before him—not to "tax[ ] your health care benefits."[54] By the same token, however, it is unlikely that the unpopularity of the Obama-sponsored reforms seemingly revealed in recent opinion polls reflects much specific public awareness of the unfairnesses observed in this Article. Indeed, what is most regrettable about consumers' belief that health care is, for them, mostly a free lunch is that it invites political oversimplification of the issues, not to say demagoguery, and thus systematic neglect of health care's hidden costs. It is hard to imagine responsible, fairness-restoring reform of American health care without a binding cease-fire in the sound bite-driven partisan debate over sensitive health care issues.

B. *A Costly New Entitlement*

Another principal failing of the Affordable Care Act is its writing in stone, as a new legal entitlement, a benefit package that itself reflects the profound market failure brought about by the misdirected tax subsidy. Thus, in an under-scrutinized provision, the new law requires all "qualified" health plans (eligible to be offered to individuals and small businesses through an Exchange) to offer "essential health benefits," which must be "equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary [following a survey of private plans]."[55] This provision amounts to a sweeping statutory embrace of a benefit package that, although seemingly validated by consumer choice, has actually been shaped under incentives distorted by consumer ignorance about who actually pays for health coverage and how outrageously much it costs. Consumers with this new statutory entitlement will thus be locked into a system reflecting not their own preferences, values, and interests but those of the health care industry itself and its most elite customers. They will generally have no opportunity to purchase less costly coverage in order to put the available resources, either their own or society's, to what they might regard as better use. The heralded reform legislation of 2010 therefore seems certain to carry forward, not rectify, the consequences of the tax-subsidy-

54. *See* Foon Rhee, *Obama, McCain Tussle on Healthcare*, BOS. GLOBE POLITICAL INTELLIGENCE (Oct. 6, 2008, 4:56 PM), http://www.boston.com/news/politics/politicalintelligence/2008/10/obama_mccain_tu.html.

55. PPACA § 1302(b)(2)(A), 124 Stat. at 164. Qualified-plan benefits may then differ only with respect to cost-sharing requirements. *See infra* note 57.

induced market failure that has made American health care far more costly than it ought to be.

Comparisons with other developed nations suggest that excessive spending on health care in the United States already amounts to several whole percentage points of gross domestic product (GDP), probably more than half a trillion dollars a year.[56] This is obviously a very heavy burden to impose either by stealth or by statutory mandate on working families or the nation as a whole. But the PPACA's extension to millions of additional Americans of an entitlement to conventionally overgenerous health coverage opens opportunities for even more moral-hazard-driven waste.[57] To be sure, most questionable health spending yields some offsetting benefit to individuals in the form of improved health status, reassurance, and security. But many of these marginal benefits might reasonably be seen as an extravagance by even middle-class families forced to pay for them. What the new law declares to be "essential health benefits" are nothing of the kind, merely artifacts of a market long rigged to satisfy various special interests and elites.

---

56. *See, e.g.*, Uwe E. Reinhardt, Peter S. Hussey & Gerald F. Anderson, *U.S. Health Care Spending in an International Context*, 23 HEALTH AFF. 10 (2004). *See also* Havighurst & Richman, *supra* note 4, at 11–12 n.8. Excess health care spending in the United States was recently estimated to be $650 billion per year, equal to nearly 5% of GDP. ERIC JENSEN & LENNY MENDONCA, NAT'L INST. FOR HEALTH CARE MGMT. FOUND., WHY AMERICA SPENDS MORE ON HEALTH CARE (2009), http://nihcm.org/pdf/EV_JensenMendonca_FINAL.pdf.

57. Although some analysts, *see, e.g.*, Anderson et al., *supra* note 2, have cited international comparisons of utilization rates to minimize concern about overconsumption in the United States, their conclusions are largely meaningless because their numbers for the United States focused on consumption in the nation as a whole, including its very large uninsured (and presumably underserved) population. The PPACA's provision of new financial access for this population is certain to induce new overspending. The PPACA does, however, contemplate significant cost sharing, basing its means-tested subsidies for Exchange-purchased coverage, *see infra* note 65 and accompanying text, on a plan model (designated "silver") that requires cost sharing at the equivalent of a 30% rate. PPACA § 1402, 124 Stat. at 220–24. Because purchasers receiving subsidies will have no incentive to choose (costlier) plans with lower cost sharing, cost sharing seems certain to remain as a substantial constraint on the spending of insurer funds—indeed, as the only cost-containment tool certain to have a significant effect in counteracting moral hazard. On the other hand, patients in income brackets below 250% of the federal poverty line will receive means-tested relief from cost-sharing requirements, in an apparent attempt to equalize consumption-discouraging effects of cost sharing across income classes. Earlier discussion observed that cost sharing in employer-sponsored health plans may affect the ability of insureds with lower incomes to benefit from their health insurance to the same degree as their higher-income coworkers. *See supra* Part IV.

Thus, like the tax subsidy, the new statutory entitlement to a prescribed package of "essential" health insurance benefits will have the effect of hiding costs from those who ultimately pay them.[58] In this case, however, because of the subsidies to be provided, it is taxpayers, not consumers, who are kept in relative ignorance as to the resources they have at risk. Indeed, the whole point of creating an entitlement is to protect future benefits by reducing legislators' accountability to voting taxpayers (through the appropriations process) for the entitlement's ongoing costs. Thus, although Congress retains the power to modify an entitlement program, it rarely does so, even when facing near-certain fiscal calamity. Once again, the public tends to see and value health care's benefits more clearly than it sees or worries about paying its associated costs. To count on government's willingness or ability to control costs by tinkering with the new entitlement is not an obviously wise policy.[59]

C. *The New Mandate to Obtain Costly Coverage*

In 2014, the Affordable Care Act will take away most consumers' option of going without health insurance (or receiving only limited benefits) in return for higher wages. At this writing, the courts are considering the constitutionality of the new law's individual "mandate"—that is, its imposition of substantial financial penalties on anyone who does not procure the required coverage.[60] The issues in those constitutional challenges, however,

58. Among these costs are the opportunity costs of pursuing low-cost plans that might be more suitable for many of the Exchange insureds yet do not pass the regulatory muster of offering "essential" benefits. Additionally, consumers lose out on the benefits of innovative low-cost plans, whose offerings do not fit what conventional wisdom deems "essential." *See* Lesley H. Curtis & Kevin A. Schulman, *Overregulation in Health Care: Musings on Disruptive Innovation Theory*, 69 LAW & CONTEMP. PROBS. 195 (2006); *Innovation: Disruptive & Constructive?*, 27 HEALTH AFF. 1328 (2008) (introducing Health Affairs' symposium on disruptive innovation); *see also* Clark C. Havighurst, *Disruptive Innovation: The Demand Side*, 27 HEALTH AFF. 1341 (2008).

59. On the Affordable Care Act's largely untested, often conjectural, provisions aimed at controlling costs, see *supra* note 46.

60. PPACA §§ 1501–02, 10106, 124 Stat. 242–52, 907–11. As of this writing, three U.S. Courts of Appeals have held or have scheduled oral arguments to consider the constitutional challenges. *See, e.g.*, Meghan McCarthy, *Tougher Judges, but Possible Dismissal in Cincinnati Health Law Case*, NAT'L JOURNAL (May 31, 2011, 6:01 AM), http://www.nationaljournal.com/healthcare/tougher-judges-but-possible-dismissal-in-cincinnati-health-law-case-20110530. *See also* Florida ex rel. Bondi v. U.S. Dep't of Health and Human Services, No. 3:10-cv-91-RV/EMT, 2011 WL 285683, *29 (N.D. Fla. Jan. 31, 2011) (declaring PPACA unconstitutional); Virginia *ex. rel.* Cuccinelli v. Sebelius, 728 F. Supp. 2d 768, 782 (E.D. Va. 2010) (same); Liberty Univ., Inc. v. Geithner, No. 6:10-cv-00015-

are not the fairness questions raised in this Article, which are of only a policy nature.[61] But the constitutional irrelevance of fairness issues does not make them go away.

Defenders of the individual mandate argue that some insureds must be made to pay premiums that are higher than actuarially justified so insurers can afford to comply with the new law's requirements, including dropping all annual and lifetime limits on outlays for a single individual, covering subscribers' children up to the age of 26, and accepting new enrollees with preexisting conditions.[62] To these reformers, it is entirely natural (and fair) for government, first, to use its regulatory powers to convert private insurance (through which persons voluntarily pool risks with others facing similar ones) into generous social insurance (through which government forces the more fortunate to subsidize the less fortunate) and then to compel healthy, relatively wealthy subscribers to finance that social insurance by paying actuarially unfair premiums.[63] Although this maneuver converts premiums into a kind of taxation not provided for in the Constitution, it clearly benefits politicians eager to gain voters' approval by committing them to future spending without making plain what they are doing.[64]

The PPACA addresses the main fairness problem introduced by the individual mandate by providing means-tested public subsidies (as advanceable, refundable tax credits) to assist lower- and middle-income individuals' purchase of costly mandatory cover-

---

nkm, 2010 WL 4860299, *14 (W.D. Va. Nov. 30, 2010) (upholding PPACA against a constitutional challenge); Thomas More Law Center v. Obama, 720 F. Supp. 2d 882, 893–94 (E.D. Mich. 2010) (same).

61. Some defenders of the PPACA claim to find support for its constitutionality in the founders' desire to "promote the general Welfare," U.S. CONST. pmbl., and in Congress's constitutional power to "provide for the common Defense and general Welfare of the United States." U.S. CONST. art. I, § 8, cl. 1. Although the fairness questions raised in this Article suggest that the "welfare" of the working class (as well as "the general Welfare") is diminished, not promoted, by many of the legislation's features, there is no precedent for invoking welfare economics to invalidate an act of Congress.

62. PPACA §§ 1001, 1101, 124 Stat. at 131, 132, 141–43.

63. The transformation of private into social insurance is also accomplished by requiring an insurer to treat all the insureds it enrolls through an Exchange as a single risk pool. PPACA § 1312(c), 124 Stat. at 182.

64. For a report on how a government lawyer defending the individual mandate argued that health insurance is "a financing mechanism," not a product, and that government can therefore compel its purchase, see James Taranto, *Stealth Socialism*, WALL STREET JOURNAL (December 17, 2010), http://online.wsj.com/article/SB10001424052748704034804576025731120969862.html. The implied claim, which would seem to raise a new constitutional question, is that government is free to employ this "financing mechanism," instead of direct taxes, to impose its programs' costs on consumers.

age through the Exchanges. These subsidies mostly take the form of limits on the percentage of household income that individuals or families in various income categories up to 400% of the federal poverty line (FPL) will have to pay for coverage.[65] The ceilings on what various families must pay seem to be set so low as to expose government to potentially high and not easily controllable costs. For example, households with income in the 300–400% FPL bracket are protected against paying in premiums any more than 9.5% of their income. (Thus, a typical household with an income of $89,400—that is, 400% of the current FPL—would receive a "premium assistance credit" equal to the excess of its premiums over $8,493.) Because this maximum amount of exposure is unlikely to cover the full cost of many families' coverage, nearly every family entitled to some subsidy can expect the federal government to pick up its marginal premium costs, including amounts necessitated by the ill-conceived definition of "essential health benefits" and by the newly mandated social-insurance features of private coverage.

Once again, it appears, poorly designed subsidies hiding costs from consumers purchasing private coverage will ensure market failure. In this case, the Exchanges through which individuals and small businesses are to purchase coverage, although they have been represented as markets relying on consumer choice, cannot be expected to feature either effective price competition or opportunities for needed innovation. Indeed, only the minority of consumers who are ineligible for subsidies will possess the marginal cost consciousness that is necessary if any market is to operate efficiently, and, in any event, regulation will preclude most possibilities for cost-saving innovation.[66] Thus, despite the reformers' claim that the PPACA does not amount to a government "takeover" of health care, it seems inevitable that future costs will have to be controlled, if at all, by government intervention, direct or indirect. Although beyond the scope of this Article, the fairness of making unsubsidized households, many of them distinctly middle-class, bear the extra costs attributable to the mandated benefit package and the legislation's social-insurance features is at least debatable, as is the even more

65. PPACA § 1401, 124 Stat. at 213–20. The law also provides means-tested relief against burdensome cost-sharing requirements. *See supra* note 57.

66. In particular, there will be no room for so-called disruptive innovation, which would enable consumers to sacrifice some marginally valuable health benefits in return for desired premium savings. *See supra* note 57.

subjective question of the fairness to taxpayers of the reforms' built-in inefficiencies and lavish redistributive effects.[67]

D. *The Provider Monopoly Problem*

Still another basis for questioning the fairness of the 2010 legislation is the absence in it of any answer to the provider monopoly problem.[68] Indeed, the new law compounds the problem both by expanding the population of premium payers that providers with market power can readily exploit and by removing the many newly insured individuals as candidates to receive uncompensated care—the provision of which has long given many provider monopolies, especially those possessed by nonprofit hospitals, at least a plausible raison d'être. Thus, the new law will enable providers with market power to exact even greater tolls—from premium payers in the case of employer-sponsored insurance and from government in cases where it bears the marginal cost of coverage.

Wealthy providers, particularly tax-exempt hospitals, will therefore soon have even greater surpluses with which to advance their corporate objectives. No matter how socially worthwhile their spending of these surpluses may seem, hospitals' discretionary spending should not be financed either by the equivalent of a regressive head tax on consumers with employer-sponsored insurance or by open-ended taxpayer-financed entitlements for lower- and middle-income insureds. Wasteful spending is simply too likely because there are no mechanisms in place—either market or political—to ensure that hospitals' surpluses are put to society's or individuals' most highly valued uses.

The new law also limits what health plans can spend on administration,[69] even though such "administrative" costs

67. Whether or not the subsidies themselves are justified, some of their cost will be distributed in an arguably fair way through progressive taxation. A portion, however, is to be covered through special taxes on hospitals, pharmaceutical companies, and insurers, *see* PPACA §§ 9007–08, 9010, 124 Stat. at 855–62, 865–68, all of whom stand to benefit greatly from the influx of newly insured patients and may be in a position to pass their new tax burden back to employer-sponsored health plans, exacerbating existing unfairness.

68. *See generally* Berenson et al., *supra* note 17; Havighurst & Richman, *supra* note 3.

69. PPACA § 9016, 124 Stat. at 872 (providing for a minimum "medical loss ratio"). Although insurers may limit their provider networks and will therefore sometimes be in a position to bargain for lower prices, those health plans offered through Exchanges are required to "ensure a sufficient choice of providers," which might make it difficult to exclude a dominant provider of an important service. *Id.* § 1311(c)(1)(B), 124 Stat. at 174. To be sure, this requirement is explicitly not meant to require contracting with a provider that

include efforts to frustrate monopolists' price gouging and to counteract moral hazard. Moreover, providers are already using new provisions designed to foster the creation of so-called "accountable care organizations"[70] as an excuse for integrating with competitors, further weakening the ability of private payers to negotiate for lower prices.[71] Redistribution of wealth from consumers to providers, already an unrecognized scandal because of the ubiquity of provider market power and its special toxicity when combined with U.S.-style health insurance, seems likely only to worsen under the new regime.

VI. CONCLUSION: TREATING THE WORKING CLASS AND TAXPAYERS FAIRLY

Perhaps it is not too late to call policymakers' attention to the fundamental unfairness to the working class of the United States' dominant system of health care financing, to regret the opportunity missed in 2010, and to rectify this unfairness through major reform legislation. To be sure, a mandate requiring people to insure themselves (rather than exploiting the system's charitable impulses without paying a fair share of its costs) would not itself be unfair. But it is certainly unfair to maintain or create conditions that cause working people to spend their own money for health coverage that may be richer than is appropriate for their personal circumstances. These hardships for persons

---

"refuses to accept the [plan's] generally applicable payment rates." *Id.* § 1311(c)(2), 124 Stat. at 174. Nevertheless, a monopolist might be able to demand both an increase in such rates and price protection under a most-favored-nation clause. *See* Havighurst & Richman, *supra* note 3, at 856–57, 871–81 (citing reports documenting such monopolists' demands and suggesting antitrust and regulatory measures that might give competing health plans significant leverage even against providers possessing monopolies in significant submarkets).

70. PPACA §§ 3022, 10307, 124 Stat. at 395–99, 940–41.

71. *See* Robert Pear, *Health Law Provision Raises Antitrust Concerns*, N.Y. TIMES, Feb. 8, 2011, at A19. *See also* AM.'S HEALTH INS. PLANS, ACCOUNTABLE CARE ORGANIZATIONS AND MARKET POWER ISSUES (2010), http://www.americanhealthsolution.org/assets/Uploads/Blog/ACO-White-Paper.pdf; Berenson et al., *supra* note 17, at 699 (noting ACOs' "potential not only to produce higher quality at lower cost but also to exacerbate the trend toward greater provider market power"); Jeff Goldsmith, *Analyzing Shifts in Economic Risks to Providers in Proposed Payment and Delivery System Reforms*, 29 HEALTH AFF. 1299, 1304 (2010) ("Whether the savings from better care coordination for Medicare patients will be offset by much higher costs to private insurers of a seemingly inevitable . . . wave of provider consolidation remains to be seen."); Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OR. L. REV. 811 (2011); Havighurst & Richman, *supra* note 3, at 871–76.

whose incomes have for some time been steadily falling further behind the more fortunate few can only cause special pain in the current recession—which is not guaranteed to end before 2014, when the Affordable Care Act will add even more to working families' cost burdens.[72] Although the means-tested subsidies provided by the Act will mitigate some of the unfairnesses inherent in the overall system, they raise important policy questions of other kinds, even including their potential for triggering national bankruptcy.

In a perfect political world, awareness of the fairness and other issues identified in this Article would trigger a constructive bipartisan effort to replace the individual mandate with tax-system changes yielding both strong incentives for consumers to carry basic health insurance and new reasons and opportunities to economize in purchasing it.[73] Formulating such a proposal would also give even ideologically divided politicians opportunities to agree on measures to rectify other distributional unfairnesses, including those resulting from over-regulation of the health sector both by legislative and administrative measures and by the tort liability system.[74] Interestingly, if such a proposal could be drafted, it might stand a chance of actually succeeding in the 112th Congress. At the least, it would put defenders of the 2010 law—including President Obama himself if Congress were

72. Because health insurance premiums are relatively fixed and mostly get paid ahead of other household expenses, the health care industry has itself been relatively recession-proof—with the result that job insecurity for workers in the rest of the economy has been proportionally greater, thus adding yet another unrecognized unfairness to those already noted in this Article.

73. The proposal might contemplate, first, inclusion of the actuarial value of each employee's employer-paid health coverage in his income subject to income and payroll taxes and, second (to offset this new tax burden), offering a fixed, refundable tax credit to anyone having at least basic health insurance. Competing insurers should then be freed, with some regulatory oversight, to design, offer, and responsibly administer innovative coverage for consumers seeking good value for whatever they or their employers choose to spend. Ideally, insurers could come up with respectable products meeting truly essential needs while costing little or no more than the tax credit to which everyone would be potentially entitled. Requiring coverage to be portable and automatically renewable at actuarially fair prices would go far toward reducing, over time, the uninsurable population, the immediate needs of which should be met through public expenditure.

74. For a showing of "how industry practice, public policy, health care law, and government regulation are all structured at the most fundamental levels to ensure that . . . regressive allocation of benefits and costs remains the pattern in U.S. health care," see Havighurst & Richman, *supra* note 4, at 50–71 (including examples of specific unfairnesses crying out for reform). The PPACA does little to correct this "pattern" while creating new unfairnesses of its own.

to embrace the proposal—in the position of having to decide whether to accept the proffered alternative or instead to bet the ranch on both a favorable Supreme Court ruling on the law's constitutionality and the outcome of the 2012 elections.

Unfortunately, this very small window could be responsible legislators' last, best opportunity to craft a bipartisan, fundamentally fair, truly "affordable," and near-universal system of health care financing for the American people. Although regulatory tinkering and tweaking of the framework created by the PPACA may be able to ameliorate some of its problems, the more likely outcome is that the nation will shortly be left with the worst of both worlds: on the one hand, a private insurance market that lacks both the requisite incentives and legal room for competing health plans to counteract powerful cost drivers in the interest of their customers and, on the other hand, regulatory and redistributive mechanisms that are incapable of compensating effectively, sensitively, and fairly for the absence of reliable market forces. In general, it is hardly fair to the American people, particularly given their current circumstances, to force them to spend huge resources for which they have other, more immediate needs on marginally or questionably valuable, overpriced health care.