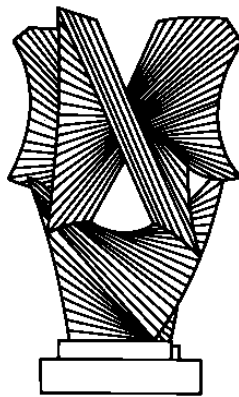


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Controlling the Costs of Medial Care: A Dose of Deregulation

Richard A. Epstein and David A. Hyman

THE LAW SCHOOL
THE UNIVERSITY OF CHICAGO

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Controlling the Cost of Medical Care: A Dose of Deregulation

Richard A. Epstein & David A. Hyman¹

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¹ Epstein is James Parker Hall Distinguished Service Professor of Law, University of Chicago, and Peter and Kirsten Bedford Senior Fellow at the Hoover Institution. Tel. 773-702-9563, Email: repstein@uchicago.edu.

Hyman is Richard & Marie Corman Professor of Law and Professor of Medicine, University of Illinois. Tel. 217-333-0061, email: dhyman@law.uiuc.edu.

Abstract:

In *Beyond Learned Helplessness*, Professor Gregg Bloche surveys the wreckage of past attempts at health care cost containment, and responds with a typical inside-the-Beltway solution: an expert independent agency. The agency will “set a national agenda for clinical outcomes research, support this research in dependable fashion, develop cost-benefit trade-off principles for medical coverage, and formulate coverage protocols based on these principles.” The resultant scheme would place “binding limits on covered services for Medicare and other federally-funded insurance programs, including extension of coverage to the uninsured. . . [and] a model for the private sector, state Medicaid programs, and state efforts to reduce the numbers of the uninsured.”

Count us doubtful. The history of expert independent agencies does not inspire optimism. Industrial policy has not succeeded in any other area in which it has been tried; price and wage controls, telecommunications, airlines, ground transportation, and agriculture all count as notable failures. If the history of administrative agencies has taught us anything, it is that expertise offers no shield against the corrosive effects of bias – particularly when government regulation is beset by the same problems with information and coordination that make markets difficult to operate.

Decentralized market actors are often better able to identify and use relevant information than a single sclerotic government agency that is beset with administrative and political problems of its own. There is little to be gained by attacking the intractable problems of modern health care policy with process-oriented solutions. A direct attack on the substantive issues is necessary.

In section I, we offer a brief critique of the system of positive rights and merit goods that underlie the case for most forms of universal health care coverage. In section II, we identify three practical problems that no working politician can wish away in the effort to implement universal health care coverage: the fundamental principle of diminishing marginal utility; the destabilizing impact of heavily subsidized government-provided coverage on the private market; and the treatment of the full range of existing regulations affecting the delivery of health care services as an exogenous given. We address each of these deficiencies in turn. In section III, we examine briefly six areas where we think massive deregulation is in order: medical malpractice, HIPAA, federal tax law, fraud and abuse, health insurance regulation, and certificate of need/scope of practice limitations.

We anticipate that our proposals will be met by howls of protest from those who benefit from the status quo and their apologists. Such complaints should be seen for what they are – a defense of rent-seeking by incumbent providers. The whole point of deregulation is to limit the opportunity and rewards of rent-seeking, thereby increasing consumer surplus. No administrative agency or committee of experts, no matter how well intentioned and knowledgeable, will be able to do a better job of meeting consumer demands than the private market. To think otherwise is to repeat the mistakes of the past, instead of learning from them.

I. Introduction: Industrial Policy Comes to Health Care

In *Beyond Learned Helplessness*, Professor Gregg Bloche surveys the wreckage of past attempts at health care cost containment. To these he responds with a typical inside-the-Beltway solution: an expert independent agency is just the ticket to solve all our problems. The agency will “set a national agenda for clinical outcomes research, support this research in dependable fashion, develop cost-benefit trade-off principles for medical coverage, and formulate coverage protocols based on these principles.” The resultant scheme would place “binding limits on covered services for Medicare and other federally-funded insurance programs, including extension of coverage to the uninsured. . . [and] a model for the private sector, state Medicaid programs, and state efforts to reduce the numbers of the uninsured.”

Count us doubtful. Although poor past performance does not guarantee future failures, the history of expert independent agencies does not inspire optimism, for it is plagued with all the difficulties of setting industrial policy from the center. We take seriously the insights of the Hayekian tradition that decentralized market actors are better able to identify and use relevant information than a single sclerotic government agency that is beset with administrative and political problems of its own. We also note that industrial policy has not succeeded in any other area in which it has been tried: price and wage controls, telecommunications, airlines, ground transportation, agriculture—count as notable failures. We see no reason why that moth-eaten approach should be able to succeed here where the problems with information and coordination that make markets difficult to operate also bedevil government regulation. Even in the best of all circumstances, the world has moved on before the ink has dried on commission reports that have been vetted by multiple times before publication. Choosing a bipartisan expert commission – to which the Council on Clinical Standards bears an uncomfortable similarity -- does not improve the prospects for centralized planning. If the history of administrative agencies has taught us anything, the insistence on expertise offers no shield against the corrosive effects of bias.

Speaking more generally, we think that there is little to be gained to attacking the intractable problems of modern health care policy with process oriented solutions. A direct attack on the substantive issues is necessary. The responsible policy analyst is duty

bound to explain which govern programs should be kept as is, which should be modified, and which should be scrapped altogether. In approaching these contentious issues, our experience is that it takes only two words to identify the major issues in health care policy: access and cost. Quality is the third contender, but we defer treatment of it to another day, and content ourselves with the simple observation that if open access is secured, market forces will go a long way to taking care of the quality issues. Returning to the main theme, unfortunately, most discussions of the twin imperatives of cost and access treat them as though they inhabited separate realms. Thus it is commonplace, especially in the context of contested Presidential elections, for all sorts of ambitious schemes to be proposed – focusing on either access or cost, with little consideration given to the connection between them. In general political discussions, the issue of access is thought to carry with it the greater salience because of the ease with which it possible to complete the sentence, “The American health care system has failed because it does not provide insurance for X million people, and supplies only inadequate insurance for an additional Y individuals.” At this point it is necessary only to fill in the blanks for both numbers, after which it is a short step to advocating a new (if not improved) government program to supply health care coverage to these additional individuals.

In order to make good on our proposals, we proceed as follows. In section I, we offer some brief critique of the system of positive rights and merit goods that underlies the case for most forms of universal health care coverage. In section II, we identify three practical problems that no working politician can wish away in the effort to implement universal health care coverage. First, is the fundamental principle of diminishing marginal utility. Second, is the destabilizing impact of heavily subsidized government-provided coverage on the private market. Third, is the treatment of the full range of existing regulations affecting the delivery of health care services as an exogenous given. We address each of these deficiencies in turn. In section III, we examine briefly six areas where we think massive deregulation is in order: medical malpractice, HIPAA, federal tax law, fraud and abuse, health insurance regulation, and certificate of need/scope of practice limitations.

Positive Rights and Merit Goods. The particular proposals that we criticize do not arise in some intellectual vacuum, but are the outgrowth of a consistent if erroneous

world view that stresses the importance of positive rights and entitlements, which in turn generates a distinctive conception of “merit goods” to which advocates of universal coverage proposals, of the sort propounded by Hillary Clinton and Barack Obama, instinctively gravitate. To set the stage for the particular inquiries that follow, we say a few words about these interrelated concepts.

The intellectual framework in which we operate is not one devoid of rights. Rather it stresses, as is common in medical-legal discussions, the principle of individual autonomy, which is in our view sufficient to allow individuals to decide to decline, or accept, medical treatment for whatever reasons they see fit, including those which other citizens and public officials find wholly unsatisfactory.² Our position is not that these individuals are always correct in their judgments. Instead, it is that they have strong incentives to gather the information necessary to make the “correct” decision in light of their own preferences – and they are likely to make fewer mistakes when they make their own decisions, compared to the mistakes that will be forced to accept if others are allowed, either in whole or in part, to arrogate decisionmaking authority. Our conception of medical autonomy is not, however, limited simply to patient choice. Instead it is an outgrowth of a larger conception of individual autonomy that applies to all persons, including those who supply health care services. They too have the right to decide whether to offer or decline to offer the services in question. The notion of individual autonomy is thus embedded in a larger classical liberal framework in which individual choice is protected against the external use or threat of force, and is augmented by the ability to contract with other persons on whatever terms and conditions are seen fit, barring fraud and duress. The notion of an entitlement or positive right to health care (i.e., a right against the state, whose payment is funded by taxation) is not part of our system, nor is part of the classical liberal tradition – even though it is central to both the Clinton and Obama health care positions.

The merit and application of this “negative rights” view of state power transcends health care services, although it admits of exceptions for network industries, common

² For a recent defense of the position, see Richard A. Epstein, *The Erosion of Individual Autonomy in Medical Decisionmaking: Of the FDA and IRBs*, 96 *Geo. L.J.* 559 (2008).

carriers, and monopolists. Those conditions apart, this system has several real advantages over any regime of positive rights – and those advantages become particularly apparent in the health care context.

The first of these is that the rules of individual autonomy and voluntary exchange are not tied to any level of social wealth or medical knowledge. The institutional arrangements make sense in societies with both primitive and advanced medical knowledge. The state therefore is relieved of the Herculean necessity of setting out the terms and conditions under which services are provided, which it must necessarily undertake in any regime of positive rights. In this voluntarist universe, the private parties know their resource limitations, and thus will not willingly make promises that they know they cannot keep. Government programs that institute positive rights, however, constantly have to make collective judgments about technical possibilities and resource availability, neither of which they can do well. Worse still, their errors are not randomly distributed, but tend to skew in the direction of promising more at lower cost than they can possibly deliver.

The combination of individual autonomy and private agreement has a second advantage. It is easily scalable. The rules of autonomy and exchange work for all levels of wealth in both large and small groups. The legal rules of the system thus remain constant regardless of the rate of medical progress and the size of new social groups. Accordingly, there is no risk in a voluntary system that government regulation will impose resource demands on private firms of social programs that they are not able to meet. In addition, all individuals have the additional assurance that their cost for health care and health insurance depends on their personal characteristics and not the members of some larger group which they are forced to join for insurance purposes. The politicking on the definition of the relevant unit for insurance, which is so important for mandated health plans, plays no role in a voluntary market that allows for lots of sorting by both the purchasers and the consumers of medical care. The voluntary market also allows for superior matching by the extensive use of various kinds of brokers and third parties. Coercive state systems simply cannot have those desirable sorting properties, nor are they readily scalable. Indeed, centrally dictated reforms are simply not intended to improve the lot of all individuals through cooperation and mutual aid; instead they use

pooling methods to redistribute wealth, often covertly, among members of the state-constructed pool.

Aggressive conceptions of positive rights are usually tied to the claim that health care constitutes a “merit” good that should not be rationed on the ability to pay, but should instead be provided on some socially constructed scale of need.³ At the outset, we note that when rightly understood, merit goods are fully compatible with markets. Assume that all individuals attend a private school in which students pay tuition and are graded for their performance. It is quite right to speak of the grade as a merit good because individual students have to earn their grade by performance in class and on examinations. They cannot simply obtain an A by offering more money for the grade than their fellow students, or paying more tuition. Merit plays the same role in athletic contests or prize competitions. People may pay to enter the competition. They cannot pay to win it, for to do so commits a fraud on third parties whose respect for the results depends critically on the processes by which they are achieved. The stress on the close connection between merit and recognition not only to private institutions, but to public ones as well. So long as institutions wish to praise or measure some form of achievement, then cannot put the relevant grades, medals or prizes up to bid. Let it be announced, or even suspected that cash payments—now called bribes—of the participants determined the outcome, then the entire enterprise flounders, with large financial and reputational repercussions to the organizations that let this happen. It is for this reason that the Motion Picture Association is so skittish about the voting for Oscars. Rigged bids spell the demise of this system of honors.

The effort to import some notion of merit goods into the health care debate has nothing to do with this coherent account of merit goods. Instead, within the framework of any system of positive rights, merit goods are defined negatively, so that they represent those goods that “we” think should not be allocated in a market system that respects consumer sovereignty. Once that step is taken, the actual basis for allocation will differ widely, but *never* on the conventional conception of a merit good. In some instances, the motivation for this second-generation of merit goods is outright paternalism, premised on

³ See generally, Richard A. Musgrave, "Merit goods," 3 *The New Palgrave: A Dictionary of Economics* 452-53 (1987).

the implausible assumption that the state can make better judgments for individuals than they can for themselves. Even if one thinks that explanation has some plausibility some of the time, it would not compel the adoption of any form of universal health care coverage unless we also assume that the large majority of the population with less than “Cadillac” coverage do not understand their own true interest.⁴

Nor can this broader account be saved by insisting an expanded definition of merit goods is necessary to counteract negative externalities. Any such claim represents a confusion of categories. Negative externalities—pollution or monopoly, for example—supply an independent potential basis for regulation wholly without regard to any false framing of the dispute over “merit goods” as that term is now used in the health care debate. No matter how described, however, this belated invocation of negative externalities is a double-edged sword. After all, one of the arguments *against* providing universal health care is the broad negative financial consequences it has on many individuals who are forced to participate in the program in order to subsidize the care received by others. It is nice to call this maneuver “social insurance” but that term conceals more than it reveals. Insurance contracts are devices for risk smoothing that leave all plan participants better off in expectation than by staying out. Social insurance is a way to pool risk but to redistribute the premiums so that some individuals are, by design, systematically left worse off than if they could purchase their insurance, or refuse to purchase insurance, in voluntary markets. The phrase then is an alluring oxymoron, not a subset of standard insurance contracts. It seeks to use the favorable connotation that insurance has in voluntary markets, and twists its meaning to disguise its redistributive agenda which, if sound, has to be defended in its own terms.

Any discussion of social insurance thus invites the third, and most pervasive explanation for calling something a merit good: the explicit defense of coercive redistribution for that good, but not for others. Yet, as with both positive rights and social insurance, the invocation of “merit goods” does little to answer the question of how much redistribution should be allowed. Surely there are approaches that allow for some public support for health care without embracing the position that health care is a

⁴ See generally Clark C. Havighurst & Barak Richman, Distributive Injustice(s) in American Health Care, 69 L. & Contemp. Probs. 7 (2006).

pure merit good that should be funded by (progressive) taxes and supplied to all equally regardless of their ability to pay, and the net social benefits that will come from its provision in question.

In fact, the use of the term merit good operates as an unfortunate show-stopper in an otherwise difficult debate. Our statute books are littered with programs in which special nonmarket arguments are said to require huge subsidies to preferred groups, wholly without regard to the distortions that are created when these explicit or implicit subsidies are introduced. How else is one to define the raft of agricultural subsidies, rent control and labor statutes that rest on claims that the market does a terrible job in supplying particular goods, without asking whether the new programs do better across all cases? Merit goods, hardly. Demerit goods seems a more appropriate description.

Nor do we have any reason to believe that any programs that sought to implement the idea of merit goods could work successfully in their own right. The most obvious point is that the level of health is only partially dependent on the level of health care that is provided under that name. Good habits, education, safe occupations, teenage birth rate, crime rates, and a thousand of other factors influence the levels of health care, and help explain why in cross-country comparison, the correlation between expenditures on health care correlate so weakly with health.⁵ These goods cannot all be “merit” goods. Some must be purchased in the market place. The upshot is that persons who are denied the ability to spend additional resources on health care will substitute other goods and services that will help them achieve their health ends. Our prediction finds support in a recent study by June and Dave O’Neill, which shows that the gradient on survival as a function of income is, if anything, steeper in the Canadian system than it is in the American system: expenses outside the health care system really matter.⁶ In view of these findings, we think it highly unlikely that we can achieve both widespread health care improvements and parity of health care across income levels simultaneously.

⁵ June E. O’Neill & Dave M. O’Neill, Health Status, Health Care and Inequality: Canada vs. the U.S., NBER, working paper 13,429, <http://www.nber.org/papers/w13429> (2007), at 3 (as accounting for the two-year greater life expectancy in Canada).

⁶ O’Neill & O’Neill, *supra*, reporting inter alia, that “more US residents than Canadians answered fully satisfied and excellent.” Id at 2.

Nonetheless, it appears that the Robert Wood Johnson Foundation is now ready to attempt squaring the circle with the formation of a non-partisan Commission, headed by Mark McClellan and Alice Rivlin, to address how these multiple social factors influence health.⁷ But there is good reason to think that this project runs serious risk of failure. The central mission of this non-partisan Commission is “to identify and recommend practical solutions to eliminate health disparities and improve health for all Americans.” The latter goal is consistent with market methods, but the only way to “eliminate health disparities” is to champion a strong view of redistribution that will likely frustrate the objective of cross-the-board improvement. The unspoken secret is that on balance there is a higher *social* rate of return from securing better health care for “productive” citizens than for “unproductive” citizens, if only to increase the resource base for the next generation.

Having said this much we freely confess—indeed insist—that, even if health *parity* regardless of wealth suffers from the incurable weakness of any radical egalitarian program, there will always be some case for a subsidy for health care among the needy; no one thinks that wealth is an adequate and complete proxy for well-being at the extremes of the income distribution. But the use of the term “merit” good, the easy invocation of positive rights to anything and everything, the demands for perfect parity all suffer from one defect: they blind us to the key questions of degree that matters so much on health care issues. Worse still, they turn our attention away from sensible pricing systems that could broaden the choices available to the very individuals that are the ostensible beneficiaries of merit-based claims.

Once again, therefore, we think that it is best to bracket any supposed merit issue, by focusing on how best to increase access and reduce costs. It may well be in the end that significant subsidies for lower-income persons might be desirable. Health care is a field where there is a near-universal sense (from all parts of the political spectrum) that the unfortunate should be taken care of. But we think that the better strategy is to start the other way around. Begin with market liberalization first and move to subsidies only

⁷ Robert Wood Johnson Foundation to Launch National Commission to Address Why So Many Americans are Sicker and Die Younger than Others: Mark McClellan, Alice Rivlin to Lead the National Effort, February 28, 2008.

once the limits of that initial approach are identified. Redistribution always increases taxes, reduces revenue, and reduces output in all relevant dimensions. The burden of justification for compelled subsidies is higher than it is for reforms that reduce costs, increase access, and reduce taxation. So we should start there.

III. The Systematic Shortfalls of Universal Care.

A. Rising Marginal Costs We are now in a position to turn to the three major structural difficulties with any universal health care system. The first of these involves the rising marginal cost as public institutions seek to make their coverage provisions more and more comprehensive. In many institutional settings, costs and problems are not distributed pro rata across populations. If anything, the problem becomes more acute as the populations become more heterogeneous along any relevant dimension—including those which are not perceived or understood by those designing the plan. Thus, it is commonplace to observe that 5% of patients are responsible for 95% of the administrative problems.

It is not necessary to impugn the character of those involved to observe that self-interest creates an incentive to game (and even defraud) any system that is set up. Yet, it is difficult to ignore the devastating consequences to system integrity that follow when any plan attempts to bring within its scope the tiny fraction of individuals that will do just that.⁸ The last five percent will on average, be individuals for whom it is substantially more costly to provide services. They are likely to be poor, to have low human capital, and, in at least some appreciable fraction of the cases, to engage in self-destructive habits on a repetitive basis. Any program with universal coverage as its goal is, by definition, unable to weed out these troublemakers – even though the failure to do so makes the system less responsive to the health care needs of the rest of the population. The result of forced inclusion of this population is the counter-productive siphoning away of resources that would otherwise be devoted to individuals with more favorable risk profiles.

Those pushing these reforms have a Pollyannaish optimism on this point, assuming that new individuals can be brought within the system without displacing or

⁸ For a recent plea to avoid covering these bad apples, see Peter Schuck & Richard Zeckhauser, *Targeting Social Programs, Avoiding Bad Bets, Removing Bad Apples* (2007).

otherwise placing at risk the health care that is now provided to persons already within the system. Yet, the history of numerous government programs provides ample reasons for skepticism that this problem can be solved – particularly given the due process limitations likely to be imposed on attempts to police such (mis)conduct. A goal of trying to address the problems of only 95% of the population may sound defeatist, but in the end it has far greater chances of success than any utopian vision of universal coverage that tries to shoehorn in the last 5%.

B. Distortions by Regulation, Taxation and Subsidy The second deficiency is ignoring the likely destabilizing influence of government-provided insurance (with its full array of regulations, taxes and subsidies) on the private market. To be sure, this problem is a sign of progress; there does not currently appear to be much enthusiasm for a one-payer system, which would make the state the sole financing party, and render illegal any action that seeks to purchase private insurance. This progress may simply be the recognition of political reality; after the demise of the (Bill) Clinton plan, we cannot see any reform that has as a necessary consequence a *reduction* in the level of access to health care that is already provided to Medicare beneficiaries and other preferred groups.

In particular, it is no accident that both the Obama and (Hillary) Clinton health plans take a quite different approach than the (Bill) Clinton health plan – announcing to all people that “if you are happy with your current health coverage, keep your health care coverage (through employer or individual coverage.)”⁹ The Obama plan seeks to convey the same basic message, with even more dizzying optimism: “If you already have health insurance, the only thing that will change for you under this plan is the amount of money you will spend on premiums. That will be less.”¹⁰ The basic theme is not taxes but “choices,” which are claimed to be greater than ever before. Under both plans, individuals may keep their current coverage; they can acquire a coverage that is good as that which Congress has for its own members; and they can get full parity for mental health coverage. With the stress on prevention, and the removal of (unspecified) hidden

9 American Health Choices Plan: Quality, Affordable Health Care for Every American.”

<http://www.hillaryclinton.com/feature/healthcareplan/americanhealthchoicesplan.pdf>

¹⁰ Healthcare: Plan for a Healthy America,
[http://www.barackobama.com/issues/healthcare/.](http://www.barackobama.com/issues/healthcare/)

taxes, the promise is that the current revenue streams will be able to cover all the additional coverages, especially when the Bush tax cuts to persons earning more than \$250,000 are repealed.

Such plans represent a sensible, but not impregnable, moral vision that some minimum level of health care is a state responsibility and additional coverage should be made available to those who are not content with their existing options. The harder question in this case is whether these plans can make good on their central promise to expand the available options, most notably, the ability to keep one's current form of insurance if that is desired. For a number of reasons, we think that this attractive slogan will be unattainable in the end. (The claim that premiums will decline by thousands of dollars is, of course, preposterous.) Both the Clinton and the Obama plan, for example, include in their coverage options the ability to enroll in the Federal Employee Health Benefit Program (FEHBP), whose benefits are estimated to be 15 percent more generous than those found currently in Medicare.¹¹ We agree with Benjamin Zycher that the political pressures on this point will be impossible to resist.¹² One obvious question is whether present Medicare participants will be able to opt-into the FEHBP. If so, they will do so in droves. It is hardly likely that the age group that today receives the most heavily subsidized form of health care will be forced to take a back seat to any Johnny-come-lately group. We think that any FEHBP-based plan will be made available to Medicare participants one way or the other.

In pricing its various health care options, the new Clinton and Obama programs make a further error in that they implicitly assume that adding more people to the covered pool lowers aggregate risk. Unfortunately, mandatory pools are not scalable. Nor do they address any of the administrative problems associated with what we are confident will be decreasing returns to scale. If the cost of providing coverage to those currently in the FEHBP is lower than doing so for new entrants, the provision of will require an upward adjustment in revenues just to cover expenses. The administrative burdens are still greater.

11 See Benjamin Zycher, *Free to Choose? Why Private Health Insurance Won't Survive Under the Clinton and Obama Health Care Plans*, Medical Progress Today.Com, February 15, 2008.

12 Id.

The difficulties do not stop here. Additional coverage will cost money – if past history is any guide, substantially more than is projected. Funding such coverage will require broad-based increases in taxes, and higher taxes will reduce the after-tax income available for privately insured individuals to pay the necessary premiums to stay in their current plan. The surge in demand will also create pressures on the cost side – particularly since the proposed reforms do not include much in the way of strategies squeezing out excessive care (i.e. care which costs more than it is worth). Accordingly, the spill-over effects from heavily subsidized increased public spending are likely to be large. The combination of less after-tax income and higher costs could easily result in a squeeze on private coverage. Private employers will be tempted to ditch plans as many employees gravitate toward the subsidized coverages supplied by government. The situation will not be eased if these national health care plans impose the rigid set of price controls that are implicit in the promised expansive coverage and low costs. The Obama plan, for example, lays its intentions bare when it states confidently:

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

Employer Contribution: Employers that do not offer or make a meaningful contribution to the cost of quality health coverage for their employees will be required to contribute a percentage of payroll toward the costs of the national plan. Small employers that meet certain revenue thresholds will be exempt.

Similarly, the Clinton program contains an explicit “guaranteed issue” component where by any person who applies for coverage must be taken in so long as they pay their premiums, which are again set by government, without the ability to vary by the risk of the insured. The requirement of automatic renewal, but not at voluntary rates, is yet another nail in the coffin. No matter how lofty the rhetoric, the bottom line is a system of price controls.

The cumulative effect of these provisions is staggering. No insurance company could survive the system of watchdog regulation that requires increased coverage mandates, imposes extensive price controls, and eliminates all underwriting discretion on key matters of coverage and extent. Profit is revenue minus costs. For these plans, the operative definition of “profit” seems to be, cost minus revenues. Even if the employers wanted to keep offering coverage in this hostile environment, in order to avoid the payroll tax, it is quite likely they could find no sellers at the administratively set prices.

In the end, these massive conditions will undermine the stability of private plans. Recall, the only promise that is being made is that the state will not *ban* one’s existing coverage – not that the employer or health care provider will choose to continue supplying the current health care plan once the basic economic conditions on both the demand and the cost side have radically changed. In time, high taxes and large subsidies will combine to drive most of these plans out of business. The rate, standards, and reporting regulations will help finish off the job. Where and when that the tipping point comes, no one can say in advance. Indeed in all likelihood the private plans that remain will tenaciously survive in the new environment. But in the end, our gloomy prediction is that a cascade will develop whereby first some plans will fail, placing greater pressures on the overall health care system, which will in turn lead other plans to fail.

For those who are skeptical of this movement, it is worthwhile to reflect on the parallel history of workers’ compensation plans.¹³ These plans began on a voluntary basis in the 1860s in England, chiefly with high-risk industries like mining and railroads. These plans flourished for about 30 years until the adoption of mandatory coverages under the 1897 Workmen’s Compensation Act, which contained a provision identical to

¹³ Richard A. Epstein, *The Historical Origins and Economic Structure of Workers' Compensation*, 16 Ga. L. Rev. 775 (1982).

that in the Obama program, requiring all private plans to provide benefits at least as generous as those in the state program.¹⁴ The voluntary plans disappeared, as they could not meet the mandates imposed upon them.

We think that the massive amounts of redistribution associated with these plans are, in the long run, wholly inconsistent with the maintenance of a competitive market. If one of these plans is adopted, in time there will be only one source of funding for health care in the US – meaning that we will have gotten a one-payer system after several small steps, instead of one big step. Stated differently, the operation of a private market is dependent on the larger economic and social framework of which it is a part. Under any system with universal aspirations, private plans are always at risk – even if they are grudgingly allowed to formally remain in business.

C. The forgotten alternative: deregulation. The third global defect associated with the political preoccupation with access is that all existing regulations on the provision of health care are treated as an exogenous given. There is no effort to rethink the way in which these systems operate, and whether they are consistent with any long-term and systematic effort to provide high quality health care at low prices. We make no secret of our antipathy to much of the current regulatory framework, which increases costs and reduces choices. We are therefore especially concerned about any strategy that treats the current framework of health care delivery as being off limits — at least until such time as universal health care is put into place, at which point we will be further locked into the current dysfunctional state of affairs. Instead our view is that we should systematically deregulate on a number of fronts in ways that will help increase the quality and reduce the cost of health care.

Once that happens, the access and quality problems will start to take care of themselves. As costs are reduced and choices are increased, some individuals who are now priced out (or opt out) of the health care system will have an incentive to come back in. Unlike the access-first approach that raises taxes and imposes other hidden burdens, our approach will raise revenues (through higher profits) and human satisfaction (through the provision of better health care services). Those who are the “best bets” for benefiting from health care will filter back into the system – expanding coverage without running

¹⁴ Workmen’s Compensation Act, 1897, 60 & 61 Vict., Ch. 37, § .

into the steep marginal cost curves that otherwise dominate the analysis of any universal health care system.

The obvious question is the magnitude of these effects. Pure theory does not provide an answer to such questions – but given the current degree of over-regulation of the health care delivery marketplace, it seems likely that that a system of regulatory liberalization will have major effects, at least so long as the major targets of opportunity are addressed.

We stress that there is no single magic bullet that is able to respond to the problems we face. The question of increased costs always takes place along separate and multiple margins, which tend to interact with one another in unfortunate ways. Deregulation should exhibit the same interconnections, only now, happily, in reverse: we expect synergistic effects as multiple regulatory regimes are cut back or dismantled simultaneously. Unlike the promises of presidential hopefuls, there is no single grand solution that will dig us out of the regulatory mess that we have created for ourselves. Instead, a series of systematic efforts will change conditions at the margin.

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

We now turn to a short list of “low hanging fruit” that should be high on the list of any deregulatory agenda. Most of the low hanging fruit is based on the presumption that health care is provided more or less through the channels that are common today, with individual physicians or physician groups playing a dominant role in the provision of health care services. The last reform, which may well be the most important at all, is also the most sweeping: we should open the provision of basic health care services to para-professionals, working alone or in concert with vendors from other large retail and consumer service sectors of the economy. Such vendors would bring their marketing and management skills to health care – and do what American business has always been best

at doing -- reaching the bottom end of the market with no-frills service that are better than no services at all.

IV. Targets for Deregulation

Our list of targets fall into six discrete areas: medical malpractice, HIPAA, federal tax law, fraud and abuse, health insurance regulation, and Certificate of Need/scope of practice limitations. These reforms are grouped into a wide range of categories. Some of these regulate the way in which medical care should be provided, by dealing with such matters as insurance and privacy mandates. Others deal with standard business practices of physicians, including various prohibitions on physician self-dealing in connection with fraud and abuse statutes that carry with them the threat of heavy costs. Others deal with questions of liability for services rendered in connection with medical malpractice. Most important are the restrictions on licensing and the practice of medicine by non-physicians.

For all their differences these multiple state interventions are all subject to one dominant objection that surfaces in a thousand guises. The major strength of markets is that they allow for a decentralized solutions to problems that seek to balance costs with benefits. It would be foolish to insist that all markets move effortlessly to the optimal solution to any problem. Such naiveté ignores the difficulties with the mistakes in judgment that are common in complex situations. And it must make allowance for the constant change in external conditions that require constant variations in institutional response. Rather, the defense of markets is more cautious. In general, all market participants seek to enter into arrangements under which they will gain from trade. When both sides take this approach, the bargains that emerge should produce joint gains or win/win outcomes. By aligning self-interest with an accurate internalization of costs and benefits, market institutions will tend to correct errors more quickly than government planners who neither bear the direct consequences of their mistakes nor are in a position to reap a large portion of the gains from their innovations.¹⁵ In our view, the insistent incentives to self-correction constitute one great advantage to voluntary markets.

¹⁵ See, for a general discussion, David A. Hyman, *Regulating Managed Care: What's Wrong with A Patient Bill of Rights*, 73 S. Cal. L. Rev. 221, 236-37 (2000) (discussing relative costs of government and market failure).

The redundancy of market institutions, which allows the weaker firms to fall by the wayside, offers yet another advantage. All else being equal, the greater the level of market freedom, the higher the level of innovation, and the wider the range of choices. When government regulators seek to place certain arrangements out of bounds, they restrict the scope of that joint freedom. The fewer remaining options for potential trading partners means that the search for joint gains will be subject to constraints that produce two huge forms of social losses: the increased costs of public oversight, and the inferior private responses that are acceptable in light of that oversight. Of course, we do not think that these twin considerations control in all cases. There is always a reason to be concerned about contracts in restraint of trade – especially those practiced by physician groups.¹⁶ But the restrictions on the organization of health care delivery that we address do little to bolster horizontal arrangements in restraint of trade. They typically concern the types of arrangements that physicians can enter into with patients, and that physicians and patients can enter into with a range of third party intermediaries. All these restrictions are costly. In this paper, our treatment on these matters cannot be exhaustive, but we hope that the examples that we choose will prove suggestive.

Medical Malpractice The rules governing liability for medical practice have created an open wound in health care over the past thirty-plus years. It may be asked why the modern law of medical malpractice constitutes a form of government regulation when it represents “merely” the evolution of ordinary common law rules of tort liability. The response rests in the key relationship between medical malpractice and the doctrines of freedom of contract. In the pre-1950 period there was little or no effort on the part of health care providers to contract out of the tort system. The general view was that the modest doctrines that existed may not have done much good, but they also did little harm. It was always recognized that medical malpractice was a different species of tort liability from road accidents. Most road accidents are easily resolved by deciding which (or both) of two parties has complied with the rules of the road. The level of error in the application of the rules is relatively small, so that the rewards created by the system tend to reinforce the proper forms of behavior that are otherwise enforced by licensing laws before people drive and traffic fines and discipline during driving. The harms in question

¹⁶ Am. Med. Assoc. v. United States, 317 U.S. 519, 536 (1943).

are usually imposed on other individuals, so that strict tort rules have the desirable effect of reducing the overall rates of accidents.

The considerations that surround the imposition of tort liability in medical malpractice are quite different. Here the legal system must contend with obvious differences in skill levels among physicians and hospitals, across localities and in different specialties. It does no good to insist that all physicians and health care facilities meet some average standard of care, if that standard is taken to imply that the bottom half of physicians and hospitals are negligent in the routine application of their standards. Instead the historical response was to rely on customary standards generated within the profession to set the applicable standard of care.¹⁷ In addition, proof of negligence, save in extraordinary cases, generally required the plaintiff to identify the particular flaw in the defendant's treatment of the patient, and to establish the causal connection between that want of care and the injury that followed. Much effort was devoted to making it clear that physician and hospital liability did not turn on simple errors in judgment, and that physicians and hospitals could not be held liable solely because something went amiss during their efforts to serve or save patients. The entire system was backed with the presumption that conduct performed in good faith was entitled to a certain level of deference. Exceptions to that rule were exceedingly narrow—i.e. *res ipsa loquitur* was largely limited to cases where some external force injured the plaintiff in a different part of their body than the surgical site.¹⁸

The key source of trouble came in the early 1960s in the highly influential decision in *Tunkl v. Regents of the University of California*,¹⁹ when the California Supreme Court adopted its highly influential paradigm of contract domination by large firms relative to “powerless” individual patients and consumers. This approach allowed the courts to invalidate even explicit efforts by defendant-institutions to contract out of the tort system and disclaim tort liability. The reasons offered by courts and their

¹⁷ See, e.g. Clarence Morris, Custom and Negligence, 42 Colum. L. Rev. 1147-1164-1165 (1942).

¹⁸ *Ybarra v. Spangard*, 154 P.2d 687 (Cal. 1944)

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

academic supporters in support of this position seem to us to be most unpersuasive.²⁰ We readily concede—indeed we insist—that the provision of health care is a service of great importance to members of the public. But it is a non sequitur to insist that the current levels of care will necessarily be improved through government regulation. And it hardly follows because hospitals open their doors to all comers that they should thereby surrender their ability to determine the terms and conditions on which they provide service. Quite the opposite. The heterogeneous nature of the patient base suggests that the administration of health care system will be better if contracts are allowed to standardize risk so that difficult patients—that pesky tail again—do not drive up the cost of health care services for anyone else. Yet *Tunkl* did not see standardization as a positive force against adverse selection and moral hazard, but only as form of adhesion that deprived consumers of meaningful choice.

The correct analysis of this situation starts with a question that neither *Tunkl* nor its progeny bother to ask: why did these exculpation clauses come into being around 1960, in both product liability and medical malpractice cases? Our answer does not depend on, and in fact repudiates, theories of unequal bargaining power, which we think highly unlikely in the face of intense competition in the health care sector both before and after that time. Rather, we think that the key change in the legal environment was that private institutions sensed that the drift in the tort law doctrines on malpractice had moved away from rules that were close to a contractual optimum. The newer and more expansive rules on liability were rightly perceived as imposing standards of care and liability that was too costly and too unreliable. Before 1960, any imperfections of the tort law were sufficiently small that it was not worth anyone's effort to contract out from them. After that time, as the substantive bases of liability started to expand, the costs of contracting out were perceived to be far lower than those of staying with the system.

Why? The basic truth of all forms of contractual liability is that the expected costs of settlement, verdicts and litigation must all come out of the fees that are generated from the patients to whom service is provided. If that constraint is not met, the firm will have to trim its patient or procedure list, alter its price structure or close its doors.

²⁰ See, e.g., Glen O. Robinson, Rethinking the Allocation of Medical Malpractice Risks between Patients and Providers, 49 *Law & Contemp. Probs.* 172 (1986).

Different organizations will opt for different strategies. Even the best of these strategies will only mitigate the social losses (i.e. the sum of consumer and producer surplus) relative to the first-best contractual solution. The slow ratcheting up of tort liability did not stem from any single cause: rules on custom became a bit more favorable to plaintiffs; rules on *res ipsa loquitur* were more aggressively applied; inferences of causation were subject to a greater degree of jury control; and damages continued to move smartly upward.

Each of these changes in the decided cases took place independently, without considering their synergistic interaction. Assume an oversimplified model in which each of these four variables—standard of care, use of *res ipsa loquitur*, causation, and damages—moves in favor of the plaintiff by 25 percent. This impact of the combined shift suggests that liability will increase by $1.25^4 = 2.441$ – or a near two and half fold increase in liability in any given case, driving a corresponding increase in administrative costs. Let them double — a more realistic estimate — and the number becomes 2^4 , or 16—a real sea change. The higher rates of potential return will induce more cases to be filed, with results varying depending on the application of those rules by juries that sit in different counties. Although the overwhelming majority of cases are settled, settlement terms are set in the shadow of the jury – and there is wide variation in the application of a given set of rules within different regions and counties in a single state, let alone across states.²¹ The ability of plaintiffs to handpick venue means that plaintiffs can pick those places where the local judges and juries are most favorable to their cause.

The expansion of liability was driven by judges who thought that they were correcting market imperfections, not creating them. Given their optimistic view of their own handiwork, they saw little if any reason to increase the levels of judicial scrutiny to guard against the risk of error. Quite the opposite, an increased deference to juries and a decline in legal rules couched in terms of “reasonableness” heralded the arrival of a new era. The expansion in liability plus the increase in overall expenses likely resulted in at least some defensive medicine, although the precise magnitude has been exceedingly

²¹ Richard A. Epstein, Contractual Principle versus Legislative Fixes: Coming to Closure on the Unending Travails of Medical Malpractice, 54 DePaul L. Rev. 503 (2005).

difficult to pin down. The decision of the California Board of Regents—a public body, one might add—to restrict liability by contract was not casually made. Instead, it was done in anticipation of the rough waters ahead once liability outpaced the ability for various patients (and their third party payers) to cover the risk.

The decision to knock out these “adhesive” contracts eliminated all possibility of private self-correction of judicial error in setting the rules on malpractice liability. Under *Tunkl* and similar cases, all the relevant parameters in medical malpractice cases were determined by judges and juries who had little or no understanding of the institutional constraints that had led to such remarkable medical progress before the major expansion of tort liability through judicial regulation. Judges did not understand that employers and insurers have influence over the selection of health care providers; that hospitals have internal review boards that check the systematic levels of performance of physicians and other health care providers with a level of technical expertise that a jury cannot bring to bear in making difficult judgment on individual cases — and doing so with a sample size of one. Stated in a sentence, these decisions proceeded on the assumption that only judicial expansion of the rules of liability stood between the individual patient and major medical risk. The role of intermediate institutions in controlling or curtailing risk was never discussed or considered.

But the evidence is now clear. What good has the malpractice system done? Not much, and not nearly enough in light of its costs. The best empirical evidence suggests that there are no significant differences in the rate of medical error in the Canadian system in which medical malpractice liability is about a tenth of our own.²² The American medical malpractice system massively under-deters potential tort-feasors, and it massively under-compensates injured patients.²³ The simple point here is that underclaiming and overclaiming, compounded by high error rates and high costs of

²² Donald Dewees & Michael Trebilcock, *The Efficacy of the Tort System and Its Alternatives: A Review of the Empirical Evidence*, 30 *Osgoode Hall L.J.* 57 (1992).

²³ See generally David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 *Vand. L. Rev.* 1085 (2006) (finding limited evidence the tort system deters medical errors); Patricia Danzon, *Liability for Medical Malpractice*, *Handbook of Health Economics* (A.J. Culyer & J.P. Newhouse (2000) (same); Michelle M. Mello, & Troyen A Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 *Texas L. Rev.* 1595 (2002) (same).

running the system give it insufficient deterrent effect. Physicians and hospitals do not know how to alter conduct in response to a set of signals that say “take better care,” without providing clearer guidance as to what should be done next. Yet interest in allowing contractual freedom back into the system remains tepid at best.²⁴

The saga of medical malpractice liability is not just a tale of good intentions and bad outcomes. It also helps explain some of the cost and access problems that dog the health care system. The high cost of medical malpractice and malpractice insurance can close down emergency rooms, place intolerable burdens on rural clinics serving poor populations, stifle various forms of innovation because of more or less well-founded fear that adverse consequences will generate crushing liability, and in some instances, it can lead physicians to exit high risk specialties and high-risk jurisdictions.²⁵ Reversing the decision in *Tunkl* should lead to a renewed competition among hospitals and physicians in the provision of alternatives to the existing liability system, and in the range of medical care offering. It could induce third party intermediaries to take more active steps to shape liability rules and dispute resolution processes in ways that lower costs. At this point no one can say for sure what the new contractual provisions would require; one cannot even be confident that they would be the same for all procedures and all specialties in all locations. Indeed, it is equally plausible that they will vary in accordance with the needs and circumstances of particular institutions, counties, states specialties, and practices. Deregulation allows us to harness the private information that is available to health care providers and the large institutions with which they do business. We cannot predict how much would be saved, except to say that we do not think it would be trivial. Regardless of the actual magnitude of savings, moving from tort to contract represents an important and necessary step in our general program of increasing access by reducing costs.

Privacy Reform The second topic of reform involves the use of government regulation to protect the privacy interests of patients. The key statute on this front is the

²⁴ See, e.g., Frank A. Sloan & Lindsey M. Chepke, *Medical Malpractice* 131-132 (2008).

²⁵ See, for the Illinois illustration, Christi Parsons, *Illinois Doctors Press for a Malpractice Limit*, Chi. Trib., July 9, 2004, § 3, at 1.

Health Insurance Portability and Accountability Act, or HIPAA.²⁶ The title of the statute references its original goals: portability (enhancing the ability of employees and their dependents to have uninterrupted health insurance coverage when they change jobs) and accountability (fraud control). HIPAA also contained a single paragraph, instructing HHS to prepare regulations to ensure patient privacy if Congress was unable to pass legislation on the subject within a two year period.

In due course, HIPAA regulations were issued by HHS on the eve of the Clinton Administration's departure from office. The regulations take a divided attitude on consent. Information can be released without the consent of patients for a wide variety of purposes, including billing and government oversight. But in many other instances, patient privacy is protected by insisting patients must give individual consent to the dissemination and use of all relevant information about them within standard medical settings. HIPAA thus created a huge pre-clearance apparatus, and displaced the previous ex post system which supplied various tort actions against physicians who flouted well-established privacy norms.²⁷

The central question about HIPAA is whether an ex ante pre-clearance system is justified given the absence of evidence that the prior system of ex post remedies was inadequate. In our view the answer to that question is a resounding no. There is no cost-justified reason to impose highly restrictive regulations on ordinary human interactions to deal with a set of problems that have already been effectively controlled by clear social norms and institutional practices, backed up in rare instances by legal action. Why incur costs in 100 percent of social interactions when the ex post system (which is still available) needs to be invoked only in an infinitesimal number of situations?

We can think of no good answer to these questions. There is every reason why no groundswell of public support coalesced around the HIPAA regulations, most of which

²⁶ See Richard A Epstein, *HIPAA on Privacy: Its Unintended and Intended Consequences*, 22 *Cato J.* 13 (2002).

²⁷ The traditional tools of litigation included obvious actions for breach of fiduciary duty, invasion of privacy, intentional infliction of emotional distress, medical malpractice, and defamation—along with various actions for breach of civil and criminal statutes. R.J. Moses, "Privacy Actions and HIPAA: Using The Health Insurance Portability Accountability Act to Protect Patient Privacy." Practising Law Institution (PLI Order NO B0-00RFW) (November) 526-533 (2000).

met with resistance or disbelief from the public at large. It did not take HIPAA to make every health care provider acutely aware of the huge damage to good will that follows from any breach in the security surrounding sensitive information. We are confident that voluntary markets were already taking simple, common-sense, cost-justified steps to deal with these issues, and did at a cost far less than that associated with HIPAA.²⁸ Consider a simple example: the typical psychiatrist's office does not have a waiting room populated with nervous patients waiting to see their analysts. Everyone understands that seeing someone else in the waiting room is itself viewed as a serious invasion of privacy. The typical office has incoming patients arriving at staggered intervals, and outgoing patients exit through another door. Not foolproof to be sure, but clearly sensible. Similarly, most employers have figured out that they will not be able to encourage their workers to get counseling for alcohol, eating or substance abuse if the results of these sessions are recorded in personnel files for all persons within the firm to see. So services of this sort are farmed out to third persons under pledges of confidentiality whereby the results of those sessions never make it into the personnel file of the particular employees. We suspect that similar institutional accommodations can be multiplied a thousand-fold by persons who are closer to the issue than we are.

So just what does HIPAA do to add to the mix? A quick inspection of the massive government website reveals just how intrusive HIPAA has become in regulating patient behavior in the name of protecting patient autonomy. HIPAA's frequently asked questions (FAQs) reveal that a doctor can call a patient's wife to tell her that he has been in a car accident, or a husband that his wife is about to deliver, or one roommate about the injury of another, or in an emergency situation that a father has suffered a stroke. For these insights, do we need government approval and thousands of pages of regulations and interpretations? There is no indication that individual physicians and practices could

²⁸ Alan Newberger, A pilot with the Cleveland Clinic for health information access <http://googleblog.blogspot.com/2008/02/pilot-with-cleveland-clinic-for-health.html>, February 21, 2008: [O]ur health efforts will help you access, store and communicate *your* health information. Above all, health data will remain yours -- private and confidential. Only you have control over when to share it with family members and health providers."

not tackle this issue, taking account of obvious and not so obvious variations in the types of treatment and patient population.

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

Insurance Mandates. It is striking that growth in the overall economy has been associated with growth in both the number of insurance mandates and the number of uninsured. Some mandates regulate the relationship between insurance companies and health care providers, by requiring that the insurance plan include “any willing provider,” and cover services rendered by chiropractors (46 states), psychologists (44 states) and optometrists (43 states).²⁹ Others require insurance companies to issue benefits to various types of coverage to their patients. These include coverage of newborns (50 states), alcoholism treatment (45 states) diabetic supplies (47 states), breast

²⁹ Council for Affordable Health Insurance (“CAHI”), Health Insurance Mandates in the States: 2006, available at http://www.cahi.org/cahi_contents/resources/pdf/MandatePub2006.pdf.

reconstruction after mastectomy (48 states), and mammograms (50 states).³⁰ What impresses us is that the rise of mandates tracks the decline in the percentage of individuals in covered plans at a time when greater individual wealth should leave more funds for health care. In our view, mandates are part of the explanation. Mandates require persons either to purchase more insurance than they want or to exit the market. They constrain competition in the financing and delivery of health care services. And then tend to take money from the poor and working class, and giving to the upper middle class, who provide (and disproportionately receive) the mandated services.³¹ The McCarran-Ferguson Act, by creating state-specific monopolies in health insurance regulation, makes these problems particularly acute. The absence of a national market raises the cost of insurance in local markets, thereby reducing the overall fraction of the population that is able to purchase this insurance.³² The removal of this prohibition has no direct budgetary costs, and huge social benefits. We see no reason why this kind of restriction cannot be eliminated immediately. If states want to regulate inefficiently, they should bear the costs of their inefficiency, and not impose it on other states with more prudent policies. Similarly, if states want to engage in redistribution, let jurisdictional competition forces them to confront squarely the costs of their largesse. Any rigorous program of reform should eliminate needless roadblocks to greater coverage.

Similar objections can be made about any system of community rating, which seeks to equalize the rates charged to individuals for health care insurance. Building in the dubious notion that health insurance is a merit good, the program in effect requires low-risk individuals to purchase insurance at the community rate, if they wish to purchase it at all. Sometimes the prohibition is directed various forms of discrimination, such as that based on genetic condition, as in rules that make it set premiums without taking into account the differential costs of AIDS or various genetic disabilities.³³ The net effect is

³⁰ Id. at 4.

³¹ Barak D. Richman, Insurance Expansions: Do They Hurt Those They Are Designed to Help? 26 Health Aff. 1345 (2007).

³² David A. Hyman, Health Insurance: Government Failure or Market Failure? Ct. Ins. L. J. (forthcoming, 2008).

³³ For a more extended critique of these programs, see Richard A. Epstein, The Legal Regulation of Genetic Discrimination: Old Responses to New Technology, 74 Bost. U. L. Rev. 1 (1994).

drive low-risk persons from voluntary plans. In response the state can coerce all individuals to purchase health insurance at state-determined rates, creating covert wealth transfers. In still other situations, the nondiscrimination norm may be invoked under HIPAA in order to prevent employers from offering lower rates of insurance to workers who take steps to improve their health,³⁴ thereby reducing the overall health of the population. This incident is one amongst many which indicates the transformation of the antidiscrimination principle in health care politics. At its core, that principle was intended to prevent the redistribution of wealth across multiple users of a public utility. The principle thus required the same payments for persons who imposed the same burdens on the common system. But individuals that imposed greater costs on the system had to pay higher rates. Now it is inverted. Nondiscrimination thus requires that only equal charges be imposed on individuals regardless of the differential burdens they impose on the system. This new version of the principle thus mandates cross subsidies from healthy to unhealthy persons, reducing the returns to good health and increasing the returns to bad habits. The revised nondiscrimination principle thus undermines the very health that the various systems of regulation seek to create. Every version of “social insurance” of social insurance will have precisely this deleterious effect. We see no reason why either federal or state regulation should frustrate the efforts of private persons to reduce health care costs.

Taxation. Federal tax law provides a substantial subsidy for employment-based health insurance, as the premiums are deductible to the employer but not taxable as income to the employee.³⁵ This tax subsidy is the source of considerable inequities and allocative inefficiency.³⁶ The inequities arise in part because employees (or at least some employees) receive a subsidy that is denied to others. The allocative waste arises because the subsidy for health care leads to its overconsumption relative to other goods.

³⁴ Victoria E. Knight, *Wellness Programs May Face Legal Tests: Plans that Penalize Unhealthy Workers Could Get Tighter Rules*, Wall Street Journal

³⁵ I.R.C. § 106 (1986) (“Gross income does not include contributions by the employer to accident or health plans for compensation (through insurance or otherwise) to his employees for personal injuries or sickness.”).

³⁶ David A. Hyman & Mark Hall, *Two Cheers For Employment-Based Health Insurance*, 2 *Yale J. Health Pol’y, L. & Ethics* 23 (2001); Havighurst & Richman, *supra* note 4.

There is no shortage of proposals on the best way to fix the problem.³⁷ The first best solution is to repeal the federal tax break for these premiums, which removes both problems. We think that it is decidedly a second-best solution to extend the deduction of health care premiums to other form of payments, as it is generally unwise to expend political capital to solve one problem (inequities) at the cost of exacerbating the second problem (overconsumption of health care). In a normative paper, we do not choose to engage in political squabbles of the choice of the least grotesque compromise position.

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

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

Next, the self-referral provisions prohibit physicians from referring Medicare and Medicaid patients to ancillary providers in which they or their family members hold a

³⁷ David A. Hyman, Getting the Haves to Come Out Behind: Fixing The Distributive Injustices of American Health Care, 69 L. Contemp. Probs. 265, 274 (2006): The reform options include “repealing the exclusion outright; continuing to exclude it from income, but capping its value and allowing it to erode over time; converting the exclusion to a tax credit; leaving the existing exclusion alone, but adding tax credits as a subsidy for the poor; making the exclusion more universal. . . excluding all out-of-pocket spending on health care; and, so on.”

financial interest, and prohibit ancillary providers for billing for services that result from such referrals. The provisions are treated as creating strict liability offenses, punishable by program exclusion and civil monetary penalties.

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

As one of us (Hyman) noted in an earlier article, the state regulation of fraud and abuse raises substantial problems with statutory over-inclusiveness and under-inclusiveness. These system design errors are compounded by overzealous enforcement, and excessive investment in compliance programs. The self-referral provisions have utterly failed in their attempt to provide clear guidance, and the false claims act has created a significant risk of blackmail settlements.³⁸ We suggest outright repeal of the self-referral provisions, and modification of the false claims act to minimize the risk of misuse.

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

³⁸ David A. Hyman, *Health Care Fraud and Abuse: Market Change, Social Norms, and “the Trust Reposed in the Workmen,”* 30 *J. Legal Studies* 531 (2001); David A. Hyman, *HIPAA and Health Care Fraud: An Empirical Perspective,* 22 *Cato J.* 151 (2002).

Free Entry for all: Eliminating Limitations on Scope of Practice The history of health care in the United States is marked by consistent and effective attempts by physicians to limit competition from less expensive alternative providers. The American Medical Association's (AMA) basic position on health matters is that all interested parties had to accept "the private physician's monopoly control of the medical market and complete authority over all aspects of medical institutions."³⁹ Professors Havighurst & King concisely describe the standard playbook employed by the AMA and its allies:

[O]utbreaks of . . . competition were ruthlessly suppressed, with the result that the hegemony of the dominant ideology was seldom challenged. Under the banners of "medical science," "quality of care," and "professional prerogative," the medical profession was able to repel most attacks along its borders, to force many of its antagonists into alliances, and to confine other would-be invaders to narrow enclaves.⁴⁰

³⁹ PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 300 (1982).

⁴⁰ Clark C. Havighurst & Nancy M.P. King, *Private Credentialing of Health Care Personnel: An Antitrust Perspective—Part Two*, 9 AM. J.L. & MED. 263, 291 (1983).

In the past half-century, antitrust enforcement has placed substantial limits on the ability of the medical profession to engage in such conduct. However, the rise of managed care brought forth new strategies, including unionization, “Astroturf” campaigns targeting specific managed care practices, and disciplinary proceedings against medical directors of managed care organizations. Such conduct is not limited to physicians; hospitals have engaged in similar battles with physician owned ambulatory surgery centers and single specialty hospitals. Hospitals have used certificate of need statutes to delay and deter entry by new competitors, and limit the ability of existing competitors to broaden their range of services and improve their infrastructure. Hospitals also lobbied aggressively for stricter regulatory requirements for specialty hospitals, and even secured an 18 month moratorium on Medicare reimbursement of such institutions.

The latest delivery-side innovation is the opening of outpatient clinics in retail outlets. Such facilities offer a restricted range of services, focusing on those necessary to help patients “get well” and “stay well.”⁴¹ Most are staffed by nurse-practitioners or physician assistants, backed up by extensive use of standardized protocols, computerized decision support tools, and electronic medical records. Pricing is completely transparent, hours are long, and parking is free and freely available. The available evidence suggests that quality of care is at least as high as in traditional health care delivery channels – and in many instances higher.⁴²

⁴¹ William M. Sage, *The Wal-Martization of Health Care*, 28 *J. Legal Medicine* 503 (2007).

⁴² *Id.*

The response of the medical profession to retail clinics is largely déjà vu all over again, with the standard set condemnations involving quality and continuity of care – along with an occasional candid admission that physicians are concerned about loss of revenue and market power.⁴³ As expected, retail clinics have been condemned by professional societies, including the AMA and the American Academy of Pediatrics.⁴⁴

We have no brief for any given health care delivery system or system reform. But we do insist on one general point. New entry is the single most powerful force for restructuring a dysfunctional industry, like health care.. Those entering will deviate from the established methods within the field – often by unbundling or rebundling the mix of goods and services that are on offer, or de-skilling the provision of services. Many of these innovations will fail, at some social cost. But the minority of innovations that “take” can easily produce gains that dwarf the losses from failed experiments. Although these initiatives face opposition from incumbent providers, no one has a property right in doing business the way they prefer. We take this position for every trade and profession, including our own. The alternative is to accept inefficient feather-bedding and long-term stagnation, To be sure, new entry presents real difficulties in health care, given the problems of quality control. We do not suggest that a market offering only “snake oil” to the uninformed is desirable. But it is a mistake to assume that informational deficits do not also affect public regulators. Indeed, our view is that markets are usually better able to collect and disseminate information and coordinate behavior than alternative institutional arrangements.

The great advantage of free entry is that no one at the center has to have the foggiest notion of why one program of innovation works when other fails. There are ruthless but honest checks on behavior, coupled with constant innovation, and rapid dissemination of successes.

⁴³ Richard Bohmer, *The Rise of In-Store Clinics—Threat or Opportunity?*, 356 NEW ENG. J. MED. 765, 765, 767 (2007).

⁴⁴ See Bruce Japsen, *Doctors, Retailers Square Off: AMA to Seek Probe of In-Store Clinics*, CHI. TRIB., June 26, 2007, sec. 3, at 1; Jay E. Berkelhamer, *Retail Health Clinics Are a Return to an Earlier Form of Medical Care*, WALL ST. J., May 19-20, 2007, at A7 (noting the American Academy of Pediatrics’ opposition to retail clinics because they undermine continuity of care).

To us, these recent developments promise greater access through lower costs. But we can offer no guarantee of that result. All we can do is to insist with all the vehemence we can muster that on matters as these the market—the individual preferences of countless consumers — should be the judge of what consumers do and don't want to receive. Deregulation helps ensure that consumers – and not some providers backed by the force of the state – determine that issue. Were we writing on a blank slate, we would support certification instead of licensure as the basic model for certifying competence. Failing that, we support dramatically loosening the prohibitions on scope of practice that currently complicate the ability of retail clinics to use nurse-practitioners and physician assistants.

III. Conclusion

We anticipate that our proposals will be met by howls of protest from those who benefit from the status quo and their apologists. Such complaints should be seen for what they are – a defense of rent-seeking by incumbent providers. The whole point of deregulation is to limit the opportunity and rewards of rent-seeking, thereby increasing consumer surplus. No administrative agency or committee of experts, no matter how well-intentioned and knowledgeable, will be able to do a better job of meeting consumer demands than the private market. To think otherwise is to repeat the mistakes of the past, instead of learning from them.