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Adam, Martin and John: Iconography, Infrastructure, and America's Pathological Inconsistency About Medical Insurance

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INTRODUCTION

Following the ongoing health care and insurance debate, which has once again moved toward center stage in American politics, one might
understandably get the impression that the most important names in the area are politicians such as Hillary Clinton, Barack Obama, John Edwards, John McCain, or Mitt Romney. Similarly, public intellectuals and pundits

1. All of these persons are, of course, presidential candidates who have each proposed various solutions for the perceived deficiencies of American health care and medical insurance. Democrats Clinton, Obama and Edwards have suggested quite similar plans modeled to some degree upon the mandated private coverage plan adopted by Massachusetts in 2006. Republicans McCain and Romney, have proposed less regulatory and government interventionist models relying primarily on tax credits and incentives. See Farhana Hossain, Where The Democrats Stand/Where the Republicans Stand, NEW YORK TIMES, Sun., Dec. 30, 2007 at 14-15. See, e.g., John Edwards, Building one America - through tax-funded health care, LAS VEGAS REVIEW, Jan. 18, 2008, at 9B, col. 1. None of the major candidates has proposed a single payer plan, in spite of earlier predictions to the contrary. See, e.g., Fred Bannister, November Is Coming And Single-Payer Proposals Could Follow, NAT'L UNDERWRITER (Life & Health ed.), June 5, 2006, 27. As discussed herein, this is largely a reflection of the success with which market-based ideology favoring private insurers has dominated the public policy debate. See Cynthia Crossen, Before WWI Began, Universal Health Care Seemed a Sure Thing, WALL ST. J., April 30, 2007, B1, col. 1

Ironically, Romney as Governor of Massachusetts supported that state’s plan, which is quite similar to the major Democratic initiatives, albeit after opposing some provisions sought by the legislature, which overrode his veto before he signed the final bill into law. See Sally C. Pipes, Intensive Care for RomneyCare, WALL ST. J., Feb. 26, 2007, A19, col. 3 (CEO of conservative policy institute critical of Massachusetts plan identified with Romney); Steve LeBlanc, Mass. House Overrides Gov. Romney Veto of Health Care Fee, INS. J., April 26, 2006, available at www.insurancejournal.com/news/east/2006/04/26/67613.htm (describing peculiar circumstances and limited nature of veto as well as Romney’s overall support for and advocacy of the law); Edit., Romney Care, WALL ST. J., April 12, 2006, A14, col. 1 (identifying Romney as proponent of plan, which Journal criticized as failing to “measure up to the political and media hosannas.”).

See also, David Leonhardt, A Health Fix That Is Not a Fantasy, N.Y. TIMES, April 12, 2006, at C1, col. 1 (praising Massachusetts plan as prudent compromise between Canadian-style system and status quo in U.S.); see also Steve Piontek, O Massachusetts!, NAT’L UNDERWRITER (Life & Health ed.), April 10, 2006 at 4;

such as David Broder, David Brooks, Paul Krugman (or at least the \textit{New York Times} and \textit{Wall Street Journal} editorial pages) come to mind.\textsuperscript{2} Alternatively, health care scholars such as the instant Symposium participants or other health policy scholars such as Uwe Reinhardt, Troyen Brennan or Theodore Marmor, although not quite household words in most of the United States, are well known to even the casual traveler in the region and might be advanced as important figures in the debate.\textsuperscript{3}

But these people, however accomplished, important or wise they may be, arguably have less to do with the ongoing health insurance status quo in American than two dead men. The arguably most important people, at least iconographically, for American Health Care are John Wayne and Adam Smith.\textsuperscript{4} More precisely, the characteristics they have come to

\textit{See also} Leonhardt, supra, at C1, col. 1 ("To a lot of thoughtful people, the only way to fix the health insurance crisis is to get the federal government to cover everyone. Britain, Canada, Japan and a number of other rich countries do so, and they each spend less many on health care than this country does. They also don't have major companies, like General Motors, flirting with bankruptcy in large part because of the cost of health benefits. It is a pretty good argument, but it has an undeniable flaw. There is almost no chance of universal coverage happening anytime in the foreseeable future. Health insurers made $100 billion in profits last year, and industries of that size are just not legislated out of business.").

2. Broder, Brooks, and Krugman are all syndicated columnists and authors who frequently write on public policy and health care issues. \textit{See}, e.g., David S. Broder, Health-care hybrid connects with officials, SACRAMENTO BEE, May 1, 2006, available at www.sacbee.com/content/opinion/story (specifically commenting on Romney's role in Massachusetts). Although faceless, the editorial pages of the \textit{Times} and the \textit{Journal}, as well as those of other major American newspapers, arguably are the leading public intellectuals in the health care debate and politics generally.


4. Other now-dead men, many of them largely anonymous, have of course also played a key role because of past decisions that shaped the current health care status quo. \textit{See} Timothy Stolzfus Jost, \textit{Is Health Insurance a Bad Idea? The Consumer-Driven Perspective}, 14.2 \textit{Conn. Ins. L.J.} 377 (2008) (hereinafter Jost, \textit{Bad Idea?}) (noting tax
embody and personify in the historical and public mind drive much of the reflexive thinking about American health care and medical insurance—largely in unfruitful directions. A third long-deceased icon personifies a different vision, but one that has never taken center stage in the medical insurance debate.

John Wayne needs little introduction, even to the members of Generations X & Y. His movies, most of them westerns, continue to populate cable movie channels. More than thirty years after his death, he continues to be the paradigmatic representation of the myth of American rugged individualism and self-sufficiency. Under the Wayne model, the individual is both charged with controlling his own destiny and expected to succeed in doing so, in spite of long odds, with little or no help from others (save or a possible gunslinging sidekick or two). This archetype is expected to engage in effective self-help without hesitation (or guilt)(what’s a few dead bodies in the service of a greater cause?), complaint, or self-pity. Even things like being shot are only minor setbacks to this archetype. Certainly, acute or chronic illness would not break his stride and he would not expect government to provide him any health care safety net.

Adam Smith, who needs perhaps even less introduction to readers of a scholarly journal, was the Eighteenth Century Scottish philosopher and economist who persuasively argued that largely unregulated private


5. Typically, Wayne portrayed a strong, silent type good guy who when pressed would fight (with quite deadly force) for his rights and those of anyone oppressed by the bad guys de jour in his movies, who where most often ordinary criminals or business thugs along with the occasional Indian (Wayne would never have used the words “native American”) renegade (e.g., *The Comancheros*). In occasional forays outside the Western movie genre (e.g., *The Quiet Man*), Wayne largely portrayed the same character, albeit unarmed and less prone to violence.
markets were the key to economic growth and prosperity. According to
Smith, the pursuit of private gain by individuals and entities throughout
society would, as if guided by an "invisible hand," lead to the optimal
allocation of goods and services. This, in turn, would create an optimally
efficient state of affairs and maximum aggregate wealth for society.\(^6\)

Implicit in Smith’s assessment, but underemphasized relative to wealth,
was the inevitability that some market participants would fare better than
others. A tacitly paid price for greater overall wealth and economic growth
was relative poverty and failure for some. During much of post-Smith
history, the “fallout” from his market-oriented approach, which was largely
accepted in Europe and North America, was treated as a necessary evil
required to obtain the benefits of a vibrant mercantile system.

During the Twentieth Century, politics and government moved to
soften the edges of inequality through social welfare programs and
infrastructure designed to foster greater equality of opportunity (e.g., public
schools). In addition, it became recognized that on occasion the invisible
hand faltered and market failure or imperfection justified regulatory
correction.\(^7\) Thus, notwithstanding the demi-god status of Smith (to the
intellectual public) and Wayne (to the general public), there is a strong
social justice strand in American thought that emphasized communitarian
norms such as equal access, solidarity against life’s greatest threats, and
assistance to the less fortunate. Arguably, no particular person epitomizes
this school of American thought to the degree Wayne embodies rugged
individualism and Smith market efficiency. As this article argues, that’s
part of the problem: the iconic status of rugged individualism and market
efficiency is so firmly established in the American psyche that it works to
the occasionally unfortunate detriment of social justice and communitarian


\(^7\) This revision to the pure laissez faire or invisible hand ideology that dominated
the U.S during the late 19th Century is most associated with Franklin Delano Roosevelt’s
“New Deal,” which established significant regulatory infrastructure for many business
activities. However, the administrations of predecessor Presidents Theodore Roosevelt and
Woodrow Wilson had also made considerable strides in this direction, as had Congress.
After Republican challenges by Wendell Willkie and Thomas Dewey to Franklin Roosevelt
and Harry Truman, respectively failed, many of the basic New Deal principles and
structures were accepted, at least tacitly, by all major political actors, including Dwight
Eisenhower, who succeeded Truman as president. See PAUL KRUGMAN, A LIBERAL
CONSCIENCE Chs. 1-3 (2007); Suzzanne Bilyeu, FDR: how he changed America — and still
affects your life today; no President has had as great an impact on everyday life in America,
values. American resistance to a government-administered single-payer system of medical insurance is one of those unfortunate occasions.

Perhaps the closest thing to a Wayne or Smith-like secular icon embodying social justice and community compassion values is Martin Luther King, although others might prefer Abraham Lincoln, Franklin Delano Roosevelt, Robert Kennedy, some other progressive politician, military leader (George C. Marshall or Dwight Eisenhower would be credible candidates), or social welfare advocate (e.g., Marian Wright Edelman) as the symbol of this segment of national thought. 8

8. To (I hope) state the already known: Lincoln was President of the United States during the Civil War; Kennedy was Attorney General of the United States and U.S. Senator from New York during the 1960s; Army General Marshall was Chairman of the Joint Chiefs of Staff during World War II and the driving force behind the Marshall Plan to rebuild Europe after the War; Army General Eisenhower was Supreme Allied Commander in Europe during the War and later President; Edelman is founder of the Children’s Defense Fund (and a sufficiently iconic figure that Hillary Clinton took pains to mention her status as Clinton’s first employer after law school during the Democratic candidates’ debate in South Carolina on Jan. 21, 2008). Certainly, the author of Abraham, Martin and John saw Lincoln and Kennedy as united in common cause with King as well as by their violent death’s form assassin’s bullets. See introductory note, supra.

In attempting to identify a personification of social justice and communitarian values, I am specifically overlooking religious figures. My selection of King as icon for the social justice school of American thought could be viewed as a religious figure in that King was a Protestant Minister and frequently invoked religious themes in his speeches. See Sarah Vowell, Radical love gets a holiday, N.Y. TIMES, Jan. 22, 2008, A19, col. 1 (noting King’s use of biblical themes and comparison of his speeches, particularly “I Have a Dream” speech, to Jesus’s Sermon on the Mount). See, e.g., Martin Luther King, Jr., Letter From Birmingham City Jail (April 12, 1963) (making repeated religious references to Jesus Christ and other religious figures in writing to addressees “as a fellow clergyman and a Christian brother” hoping to find them “strong in the faith”), reprinted in JAMES M. WASHINGTON (ED.), A TESTAMENT OF HOPE: THE ESSENTIAL WRITINGS AND SPEECHES OF MARTIN LUTHER KING, JR., 289 (1986) and (perhaps more accessible to the legal profession) STEPHEN N. SUBRIN, MARTHA L. MINOW, MARK S. BRODIN & THOMAS O. MAIN, CIVIL PROCEDURE: DOCTRINE, PRACTICE AND CONTEXT 149 (2d ed. 2004). See also Walker v. City of Birmingham, 388 U.S. 307 (1967) (reprinting as Appendix King’s speech in connection with efforts to stage protest march) (“We believe in a system of law based on justice and morality.”).

In spite of this, I view King as primarily a socially secular figure. Certainly, he tried hard to be inclusive and non-denominational even as he invoked religious themes. For example, his Letter from a Birmingham Jail takes plain to include reference to his “Christian and Jewish brothers” and he specifically discusses the Jewish philosopher Martin Buber.

More important, King’s legacy today is a secular one of racial and social justice founded on rational concepts of fair treatment of individuals and retains little of its once more overtly religious air or rhetoric. As testament, I am writing this on the national King holiday (Monday, Jan. 22, 2008), one widely observed in an overwhelmingly secular
In addition, there is a "professionalism" paradigm for conceiving health care that competes with an economic/market competition model, a social justice/rights-based model, and an institutional model. Peter Jacobson has characterized the field as reflecting "an ongoing struggle between market proponents (a consumer-driven health care system), proponents of a social justice model (largely governmentally determined), and medical professionals" with the social justice model in at least temporary ebb while "the real struggle for doctrinal supremacy in health law is between the market and professional models."

Interestingly and ironically, Adam Smith can perform double duty on as a representative of the professionalism model as well. Smith supported professional self-regulation (and substantial remuneration for manner. In a widely televised CNN Democratic presidential earlier in the day, there was considerable reference to King, including a concluding Wolf Blitzer question regarding which candidate King would endorse were he still alive (and not assassinated on April 4, 1967 in Memphis, Tennessee, an event noted in the 1983 U2 song Pride in the Name of Love), further testament to King's place in secular popular culture. All of the discussion was secular and did not mention King's religious roots or rhetoric. See also Martin Luther King, III and John Edwards, email from Edwards for President campaign, Jan. 21, 2008 (Democratic presidential candidate attempts to use favorable comments by King's eldest son to win votes and contributions in secular manner).

Perhaps the ultimate proof of King's secular status, albeit kitschy and perhaps offensive to veterans of the civil rights movement, is an email I received on January 21, 2008 announcing a "Martin Luther King Day Special" on continuing legal education through which an attorney could pay "only $199 to fulfill your California MCLE" as part of the vendor's desire to "celebrate [King's impact on American life]." See Martin Luther King Day Special: Only $199 to Fulfill Your Entire California MCLE, Law.com CLE Center, Jan. 21, 2008. Just as George Washington and Abraham Lincoln became associated with winter furniture sales, King's legacy has been appropriated, in at least some part, by commercial interests. Once again, the Smith/Wayne iconography of market and individual consumerism exhibits an imperialism that attempts to impose itself on social justice and professionalism.


professionals) in order to achieve high professional standards and quality that would in turn redound to the benefit of society. In effect, a good part of the current health care debate can be characterized as one waged by the ghosts of the Market Smith and the Professionalism Smith.

Regarding the competing paradigms outlined by Jacobson, I am arguably adding rugged individualism and personal responsibility to the list rather than treating it solely as a subset of the economic/market model. On the issue of institutional competence, I accept Jacobson's assessment that this is an important framing device in debating health policy, one that (as discussed later in this article) weighs in favor of a greater government role in providing medical coverage. But institutional competence as a school of thought is less prominent in the American psyche. No particular icon of institutional competence emerges in national folklore, although it is perhaps personified to an extent by FDR, who popularized government as a competent institution to respond to economic and social concerns and to provide a safety net and springboard for the citizenry. Perhaps a better human representation of the institutional aspect of health policy debate would be Lyndon Johnson, whose political skill and electoral power in the wake of his 1964 landslide over Barry Goldwater brought about Medicare.

The trio of Smith, Wayne and King, of course, played no direct role in the development of health care and medical insurance policy. But the perceptions and attitudes they represent have driven much of American

11. See Smith, supra note 6, at 111.

We trust our health to the physician; our fortune and sometimes our life and reputation to the lawyer and attorney. Such confidence could not safely be reposed in people of a very mean or low condition. Their reward must be such, therefore, as may give them that rank in the society which so important a trust requires. The long time and the great expence which must be laid out in their education, when combined with this circumstance, necessarily enhance still further the price of their labour.

Id. (spelling in original).

opinion that does directly affect the long-running debate and attitudes toward the status quo and proposed alternatives. Because of Waynian rugged individualism, there is resistance to communal insurance programs, even to the point where the old bogeyman of “socialized medicine” remains a standard part of the stump speeches of at least Republican presidential candidates (at least during the primary season when preaching to the faithful). This strand of the American character has also given much rhetorical force to terms like “consumer-driven,” “ownership society,” “freedom,” and “choice.” Working in tandem with the rugged individualism ethos of “freedom,” Smithian fidelity to private markets makes even Democrats flinch from advocating a single-payer, government administered medical insurance system, although this is largely the norm in

13. See Mary Anne Bobinski, The Health Insurance Debate in Canada: Lessons for the United States?, 14.2 CONN. INS. L.J. 341 (2008) (“The very terms of the debate [in the U.S.] – ‘socialized medicine’ and ‘government bureaucrats’ – reveal more about the signposts of American political discourse than they do about the reality of the [Canadian] system they seek to describe”) (footnote omitted). Mitt Romney, in particular, has used the phrase as a criticism of the proposals of Democratic candidates notwithstanding his support for significant government intervention in the medical care market when he was governor of Massachusetts. See Broder supra note 2.


As illustrated in Furrow’s article, there is often a substantial tension between the goals of personal autonomy and the quality and availability of medical coverage. Furrow’s primary target in that piece is Hyman, who provided the pony metaphor of choice-versus-health safety net in a cartoon published in an issue of the Journal of Health Policy, Politics and the Law focusing on the FTC’s Report on Health Care and Competition for which Hyman was a primary author. Id. at 414. (characterizing market choice position on health care, including HSAs as “plausible in the abstract but flawed for too many Americans who need health care, yet still appealing to those ideologically blinded to the costs of the market in health care and the human waste generated by ideology ungrounded in complex reality”). In this Symposium, Jost and Mariner are not as directly in focused combat with Hyman (a role that perhaps falls to me) but they reflect a perspective akin to Furrow’s. See also Timothy Stoltzfus Jost, The Massachusetts Health Plan: Public Insurance for the Poor, Private Insurance for the Wealthy, Self-Insurance for the Rest, 55 KAN. L. REV. 1091, 1092 (2007) (writing from perspective similar to Jost, Bad Idea?, supra note 4 (manuscript at 2-3)); David A. Hyman, The Massachusetts Health Plan: The Good, the Bad, and the Ugly, 55 KAN. L. REV. 1103 (2007) (writing from perspective similar to Hyman, Government Failure, supra note 4) (and apparently preferring Clint Eastwood to John Wayne as an icon of rugged individualism).
Canada and the Western European societies most analogous to the U.S.,

Pushing back, with mixed success, against these social and psychological forces (that also have great political and financial support from special interests such as private insurers and drug manufacturers) are the professionalism strand of Smith and King's social justice perspective. These push in largely the opposite direction, seeking universal, community-wide medical coverage and greater government involvement to achieve this goal.\textsuperscript{16}

The iconic pull of market and individualism notions and personas is so strong that it has prevented full progression of health coverage in the U.S. and today supports a strong counter-revolution in the form of Health Savings Accounts (HSAs) and other types of allegedly "consumer-driven" health coverage as part of an "ownership" society.\textsuperscript{17} Despite increasing

\textsuperscript{15} In the field of eight Democratic hopefuls (Clinton, Obama, Edwards, Biden, Dodd, Richardson, Gravel and Kucinich) prior to the January 2008 Iowa caucuses, only Kucinich backed a government-administered single payer system. See Molly Ball, \textit{Meet the Candidates: 10th in a Series}, LAS VEGAS REV.-J., Jan. 1, 2008, at B1.

\textsuperscript{16} As Hyman would undoubtedly note, the professionalism perspective receives substantial special interest support from doctors and to some extent from other medical providers. See, e.g., David A. Hyman & Charles Silver, \textit{The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?}, 90 CORNELL L. REV. 893 (2005). But unlike Hyman (at least as I read his work), I do not see physicians and other medical providers (hospitals, labs, diagnostic services, equipment makers) as uniformly in lockstep in their drive (strongly emphasized by Hyman) to extract more money from the pockets of patients or payers (be they government or private insurers). The relative interests and preferences of medical providers may well diverge. For example, hospitals might rationally conclude that they will do better under a private insurance regime than a government single payer regime of medical insurance. As discussed below (TAN 65-75, \textit{infra}), I have a strong suspicion that this is the case given the degree to which private insurance has not in my view done as much to tamp down hospital charges as it has done to extract discounts from physicians.

evidence that America would be better off moving toward a single payer system similar to the Canadian-European models, political reality continues to serve up either market-based or hybrid systems that at best provide only halting progress and at worst resemble a private-public bureaucracy seemingly designed by Franz Kafka and Rube Goldberg.


18. Studies consistently show that countries with government-administered national medical insurance have per capita health care costs of approximately half those in the United States and that by almost all measure, their populations are at least as healthy as Americans. See PAUL KRUGMAN, CONSCIENCE OF A LIBERAL 218 (2007) (2004 per capita health care spending in U.S. is $6,102, as compared to $3,165 in Canada, $3,150 in France, $3,043 in Germany, $2,508 in Great Britain); Jost, Bad Idea?, supra note 4; Justin Lahart, Rethinking Health Care and the GDP, WALL ST. J., Jan. 25, 2007, at Cl (U.S. spends 16 percent of its gross domestic product on health care, as compared to much lower proportions for Germany (10.6 percent of GDP), France (10.5 percent), Canada (9.9 Percent), Italy (8.8 percent), the U.K. (8.4 percent), and Japan (8.0 percent) but “Americans don’t seem to be getting much for the money. In both France and Japan, the average life expectancy is higher than in the U.S., and the infant mortality rate is lower. This is true in most other [developed] countries . . . .”). Accord, Uwe E. Reinhardt, Peter S. Hussey & Gerard F. Anderson, U.S. Health Care Spending In An International Context, 23 HEALTH AFFAIRS 10, 11 (2004); Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey & Varduhi Petrosyan, It’s the Prices, Stupid: Why the United States Is So Different From Other Countries, 22 HEALTH AFFAIRS 89 (2003) (contending that “[h]igher health spending but lower use of health services adds up to much higher prices in the United States than in any other [Organization for Economic Cooperation and Development] OECD [a/k/a/ developed] country.”) But see Bobinski, supra note 13 (manuscript at 7-8). (Canadian expenses recently rising more rapidly than in the past, reaching $4,548 per capita and 10.3 percent of GNP in 2006); Patricia M. Danzon, Hidden Overhead Costs: Is Canada’s System Really Less Expensive?, 11 HEALTH AFFAIRS 21, 22 (1992). See also Troyen Brennan, Transcribed Speech of Troyen Brennan, 15 ANNALS HEALTH L. 339, Appendices B, C (2006) (U.S. health insurance premiums nearly doubled between 1999 and 2005, far outpacing both medical inflation and overall inflation).

19. The 1993 proposal of the Clinton Administration (dubbed “Hillarycare” by critics) provides perhaps the best example. Diagramming the plan resembled a Jackson Pollock painting. But other popular proposals such as the Massachusetts plan and those of the
This comment addresses the legacy of what I term the Wayne-Smith (market) mindset and its effect on the modern medical coverage debate, focusing in particular on several misconceptions, overstatements, and cognitive errors that have prevented the U.S. from embracing a modern, government-administered universal medical coverage along the lines of the Canadian-European model. These concepts too greatly dominate American views on the issue, obstructing progress toward a Canadian or European model that would dramatically improve the overall cost and quality of American medical care. A government-administered single-payer system more consistent with the Smith (professionalism) and King social justice models would provide more productive templates for expanding, improving, and streamlining United States medical care.20

The legacy of uncritical acceptance of the Wayne-like individualism and Smithian world of omniscient markets include: the legal fictions that individuals consistently best know their own interests and can effectively shop for insurance coverage and medical care;21 the legal friction or tension

leading Democratic presidential candidates also contain considerable complexity. See SUsAN ESTRICH, THE CASE FOR HILLARY CLINTON 104 (2005).

20. I use the term “single-payer” both literally (I would prefer a program more like that of France or an expanded version of Medicare) and as a short-hand reference meaning a national government mandated system of public medical insurance even if in distribution multiple loci of payment are used. See Jost, supra note 14, at 1091 (“This model is often characterized as a single-payer model, although universal public coverage does not, of course, require a single payer. Many of the world’s social insurance programs in fact have multiple payers”).

Considering costs and benefits in totality, I operate with the premise that the quality of care increases if, on the whole, a higher quantum of competent medical service is provided throughout society. Thus, I would consider a system “better” if it served all people with B+ level care and eliminated noncoverage and reduced substandard care even if some persons who formerly received A+ or gold-plated care with shorter waiting times would have preferred the current system. Taking this broad view, there is almost no question that the Canadian and Western European systems are “better” than that of the U.S. See Bobinski, supra note 13, (“In the aggregate, the result is that Canadians fare better than Americans” and noting that as compared to Canadians, Americans “are one third less likely to have a regular medical doctors, one fourth more likely to have unmet health care needs, and more than twice as likely to forego necessary medicines.” (quoting Karen E. Lasser, et al., Access to Care, Health Status, and Health Disparities in the United States and Canada: Results of a Cross-National Population-Based Survey, 96 AMER. J. PUB. HEALTH 1300, 1303 (2006).

21. See TAN 27-53, infra. I realize I am using a modified version of the term “legal fiction,” which most commonly is used to describe a legal rule that, although demonstrably untrue as an empirical matter, is treated as true under the law in order to achieve a legal-social end.
between individualism and communitarian empathy;\textsuperscript{22} undue veneration of markets, failure to appreciate the current system's adverse pressures on medical professionals;\textsuperscript{23} failure to realize the degree to which the evolved status quo already severely compromises market efficiency and medical professionalism;\textsuperscript{24} and unduly credulous acceptance of the supposed efficiency of private insurance as a vehicle for fair cost control.\textsuperscript{25}

In addition, the body politic has paid insufficient attention to the manner in which private insurers have adversely impacted medical professionalism and the quality of care while at the same time failing to provide sufficient cost containment.\textsuperscript{26} Assessing these aspects of the current debate leads to rejection of the supposedly consumer-driven approach and toward support for a national, government-administered single payer program as the preferred alternative to the private insurance mandates, markets and tax incentives largely suggested as the means of reforming the American status quo.

\begin{itemize}
\item For example, the legal rule that a corporation is a "person" under the law for purposes of constitutional analysis is factually incorrect. The corporate entity is clearly not a human being. The law treats it, however, as if it was a human being for purposes of application of the Due Process Clause and other parts of the law. By contrast, the notion that people are more rational, energetic, ambitious, intelligent, consistent, and careful than they really are is a misconception of fact rather than a total rejection of the empirical world. In the real world, people are negligent more often, lazier, dumber, less rational, and more inconsistent than is assumed by defenders of the U.S. health care status quo or consumer-driven alternatives. But rather than labeling this a factual fiction, I term it a legal friction because it has become relatively hard-wired into much of the law reform and public policy discussion surrounding medical care and insurance issues and is in tension with empirical reality that would normally be more determinant of public policy outcomes.
\item See TAN 54-58, infra. This friction or tension is explored in Jost, supra note 4, and Wendy K. Mariner, Social Solidarity and Personal Responsibility in Health Reform, 14 Conn. Ins. L.J. 199 (2008). Jost refers to the divide as one of solidarity-vs-individualism while Marine speaks larges of a social solidarity-vs-personal responsibility dichotomy.
\item See TAN 84-89, infra.
\item See TAN 90-100, infra.
\item See TAN 59-76, infra.
\item See TAN 59-84, infra.
\end{itemize}
I. LEGAL FICTIONS AND LEGAL FRICTIONS

A. THE LEGAL FICTION OF THE CONSISTENTLY-RATIONAL, EMPOWERED CONSUMER

In reality, of course, the strong American values of rugged individualism and preference for private markets are often compromised, so much so that we do not even appreciate the degree to which the America’s secular church of public opinion has engaged in heretical behavior. For many Americans, there is already a largely government-run medical care system – the Veteran’s Administration system of hospitals and medical care in that arena that is not much different from the socialized medical system of Great Britain. Similarly, we notice with some alarm when insurers and their executives earn high profits even if we are hesitant to raise taxes, stop potentially anticompetitive consolidation or take regulatory action that might impinge on the profitability of health insurers or health care providers. Most prominently, through programs like Medicare and Medicaid (and the Federal Employees Insurance Program), the government has become deeply involved in medical insurance notwithstanding purported American fidelity to private markets and minimalist regulation.

In general, however, the United States has largely resisted Canadian-European style universal health care and medical insurance out of deference to the mythology of rugged individualism and efficacy of markets. In addition, these perceptions have fueled collateral norms and beliefs that have impeded any move toward a national single payer approach to health insurance. First, there is what I regard as the erroneous legal fiction that people are more discerning about their health care and insurance choices than is actually the case. In addition, we operate under a legal fiction that to some extent a large percentage of persons afflicted with medical problems are themselves responsible for their plight through personal failure. Both of these presumptions, if not completely erroneous, are at least far more problematic than acknowledged.

First, the issue of whether prospective patients really know what is best for them regarding medical care and insurance coverage. A large amount of psychological research suggests that people in general are not nearly as good at decision-making as is commonly supposed. Rather than being consistently wise, calculating, rational decisionmakers, people are subject to a host of cognitive biases that may often warp their assessments. Among
them are self-serving bias, optimism bias, status quo bias, hindsight bias, and extremeness aversion. In addition, various heuristic traits of humans govern their decisionmaking process, sometimes in ways that make for sub-optimal analysis. Among these are the availability heuristic, social influence, anchoring, and case-based decisions. Further, people sometimes make irrational decisions because of loss aversion and the “mental accounting” of excessively compartmentalizing money rather than viewing it as fungible, which impedes good cost-benefit analysis.

In general, people are only able to focus on one or two salient factors at a time when making decisions. They are rational, but only have “bounded” rationality that is shaped to a large degree by the choices presented, the manner in which the choices are presented, and the overall context of the situation requiring a decision. Thus, even under the best of circumstances, people are often not optimal decisionmakers. They are often more Britney Spears than John Wayne or Adam Smith.

This becomes particularly problematic regarding medical care and insurance because these situations seldom present optimal settings for sound decisionmaking. The process of seeking and evaluating medical care and advice is often complexity and usually unfamiliar to laypersons. Most people are not well educated about either medicine or insurance, both of which are complex. As a result, they will have inherent difficulty making assessments about competing medical care or insurance alternatives.

As Wendy Mariner has noted, there exist significant differences between ordinary consumers engaged in regular retail activity and health care patients. Consumers are active buyers while patients are often required to be more passive “recipients” of medical services (if they can afford the services). Consumer spending is more strictly limited by personal resources while patient expenditures, at least for the insured, are not strictly tied to patient wealth. Consumers tend to have something closer to bargaining equality with vendors while patients have “unequal


28. See Sunstein, supra note 27, at 5; Stempel, Coexistence, supra note 27, at 351-52.

29. See Sunstein, supra note 27, at 5; Stempel, Coexistence, supra note 27, at 353.

skill and knowledge of health care” relative to medical providers. However, medical providers have at least a quasi-fiduciary duty to the patient while vendors ordinarily have no fiduciary duty to buyers (but often do have obligations sounding in statute, regulation or tort law). Most important, a standard issue consumer makes purchases “based on voluntary choice” while the medical patient seeks care “based on need.”

Although they may have tools for mitigating the patients’ informational disadvantage relative to medical care providers and insurers (e.g., WebMD, word-of-mouth, local reputation), these hardly level the playing field for obtaining medical care. Particularly if a need for medical care arises suddenly, the consumer is effectively stripped of even the illusion of choice. In extreme cases (e.g., an auto accident that disables the consumer), the choice of medical care is made by others. Even when making conscious choices, the prospective patient is usually limited by insurance coverage and the treating physician’s hospital privileges as well as the availability of facilities. Once admitted to a hospital for care (which may take hours if arising unexpectedly, the patient is able to change venue only if he or she has picked up a few tips from watching Prison Break, Escape from Alcatraz, or similar media fare.

But the problems of shopping for doctors pale in comparison to the problems of shopping for insurance. Because many medical events are not serious, consumers have some chance to gain experience that they can deploy in obtaining medical care. For example, if the first doctor one sees is uninformed or unfriendly, the patient can go elsewhere for the next office visit (although this may be difficult in areas with a shortage of physicians

31. See Wendy K. Mariner, Theory and Practice, supra, note 17, at 495 fig.1.
32. Tools such as WebMD and a home copy of the Physician’s Desk Reference can be wonderful aides in managing one’s own medical care. But self-directed reading and study alone can of course not even approach the training and expertise of medical professionals. A consumer can become better informed about medical issues but will never be as discerning a consumer of medical services as she is of grocery stores, restaurants, or even more esoteric everyday fare such as auto repair.

Word of mouth and reputation are helpful but suffer a severe limitation in that the sources of this information usually suffer from the same limitations of expertise that make it difficult for the instant consumer. In particular, because of the complexity of medical care, consumers may evaluate medical providers by factors relatively unrelated to the quality of care. For example, a given medical provider may have an undeservedly good reputation because of friendly office staff, spacious facilities, and short waiting times even if the doctor is borderline incompetent as a diagnostician or unwilling to immediately prescribe useful treatment for fear running afoul of insurers. Conversely, a technically excellent physician may have only a so-so reputation because weak interpersonal skills or because she is a woman, member of a racial or ethnic minority, or of foreign origin.
where doctors are not taking new patients). Routine doctor visits, prescription fills, or diagnostic tests, although different than a trip to the supermarket, are not so different that the consumer can not make observations, gather experience, and adjust "buying" behavior. Where medical care is urgent, medical events infrequent, and care decisions highly complex or specialized, consumers have little real chance to perform as intelligent consumers. But in many situations, they do.

Contrast this with health insurance. First, for many working Americans, the choice of health insurer is as a practical matter severely truncated. The good news is that for workers who receive health insurance as a fringe benefit, they have health insurance that is "free" or at least heavily subsidized by the employer.33 The bad news is that they are at the


Most families, of course, do not realize that they are paying an average of $12,000 per year in insurance premiums because much of the cost is borne by the employer of at least one of the adult family members. But they "pay," of course in that the employer-funded portion of insurance is taken out of the employee's paycheck prior to receipt by the employee, as is the employee's portion of the premium payment. As market-oriented commentators are correct to point out, this has the effect of shielding the true cost of insurance from workers and consumers, with many thinking of it as a "free" perk that comes with the job. This in turn undoubtedly makes the worker/consumer less cognizant of price increases and less reactive than would be the case in a normal over-the-counter market transaction.

My point, however, is that even if the consumer was slapped in the face with these premium costs, the market for insurance would be a very imperfect one. First, as discussed in text, individual consumers are pretty ill-equipped to be intelligent and effective purchasers of medical insurance. Second, when actually feeling the pain of $1,000 a month in premiums, many consumers will be reluctant to purchase the type of medical insurance they need and will often foolishly forgo insurance altogether both because of other pressing financial needs and because the "endowment effect" of having the money in their pockets will make it more painful for them to purchase the insurance with after-tax dollars than to suffer indirectly through the largely employer-funded group health system. In addition, there is the problem of individual consumer loss of buying power when converted to
mercy of whatever group health insurer(s) or plan(s) the employer has arranged. At most, the typical employer will have arranged for one or two HMO options and one or two different preferred provider networks from which the consumer can choose. If the employee is dissatisfied with the work-related group insurance options, he can in theory go to a different insurer, but it will cost him foregone benefits (the employer subsidy is wasted) as well as substantial out-of-pocket costs in addition to significant search costs spent selecting a competing insurer. As a practical matter, then, there is no effective choice of insurers for many workers, although they are the “lucky” ones in the United States because they at least have medical insurance.

Where the individual consumer is shopping for individual medical insurance, the problems are daunting. Many insurers will simply not be interested in serving this market at all. Those that are by definition are not doing as well as they would like selling more lucrative group insurance or stop-loss policies to self-insuring employers. The insurance products offered will be complex and difficult for the average consumer to understand or obtain information regarding the proposed policy and its applications.

Consider the matter of pre-existing conditions. By now, most educated Americans have at least heard about restrictions on coverage for pre-existing conditions. But they are unlikely to know how the restriction will be applied in practice. Even a trained lawyer reading judicial opinions on purchasing individual insurance rather than participating through an employer-sponsored group plan.


35. And if the employer-provided group health plan is not sufficient for the patient’s needs, the patient or her family may face substantial uninsured medical bills. See John Carryrou, As Medical Costs Soar, The Insured Face Huge Tab: Jim Dawson Hit Cap After Hospital Padding: The $1.2 Million Bill, WALL ST. J., Nov. 29, 2007 at A1, col. 4; Chad Terhune, Covering the Uninsured, But Only up to $25,000, WALL ST. J., April 18, 2007, A1, col. 4 (describing limits of Tennessee program to provide private medical insurance to the uninsured); Milt Freudenheim, The Check is Not in the Mail: Late Payment of Medical Calims Adds to the Cost of Health Care, N.Y. TIMES, May 25, 2006 at C1, col. 2. See also Benesowitz v. Metropolitan Life Ins. Co., 870 N.E.2d 1136 (N.Y. 2007) (enforcing medical insurance coverage limitation for pre-existing conditions; rejecting insured argument of violation of state regulation).
the subject would have difficulty giving a client ironclad advice about whether his or her prior medical problems make the exclusion or restriction applicable, much less whether the insurer will force the policyholder to litigate seeking coverage under various possible scenarios.  

Contingency is of course at the heart of insurance. People buy medical insurance because of the contingent risk of developing health problems. Even with the risks of adverse selection and moral hazard (both which tend to be overstated in this context), consumers are unlikely to have any real idea of whether they will be health “winners” (who have only a few significant adverse medical events in their lives) or health “losers” (who have more than their share of health problems or injuries). They are certainly unlikely to be able to predict the cost of these events and the outcomes. A buyer of health insurance may skate through life without more than annual check-ups or may become a regular prescription user subject to several expensive operations or chronic expensive treatment. Thus, right at the outset, a prospective purchaser of insurance is at a practical loss to know what type of coverage and what amount of coverage is needed.

The consumer thus depends on the insurer to put together and market an apt product for the contingencies facing the consumer. To the extent the product is standardized, comparison shopping, at least according to premiums charged, is facilitated. But where policies differ at the margin (and medical insurance is less standardized than life, auto, and general liability insurance), comparison again becomes difficult because the differences will be hard to detect and hard to decipher when detected. Unlike large businesses, individuals are far less likely to have the services of a knowledgeable broker, independent agent, or attorney who can note and explain the differences.

Most difficult, however, for comparison purposes is that the consumer will not readily be able to predict the insurer’s behavior in the event of a claim. Among insurance insiders, certain carriers are known to be more hospitable, even magnanimous, toward claims while other insurers have a reputation for fighting many claims on technicalities and even lapsing toward bad faith too often in an effort to maximize profits at the expense of the insurer’s fiduciary-like duty to its insureds. But most consumers lack any such information. Like lambs led to the slaughter, they may joyously

march into the arms of an insurer that offers a seemingly comprehensive product at relatively low cost only to find that if a claim arises (particularly a big claim), the insurer fights it with a ferocity typically found among revolutionary guerillas.

Even for sophisticated business consumers of insurance, it is hard to predict whether the insurer will be difficult or reasonable regarding claims. Individual claims adjusters may vary. The insurer may have personnel changes at the top that convert a formerly reasonable insurer to one that fights every claim tooth and nail. The insurer may decide to outsource its claims function to a third party administrator (TPA), managing general agent (MGA), or independent adjuster. The chosen entity may be competent and reasonable or may be incompetent and excessively stingy, owing to either its low cost and lack of training/expertise or to a philosophy holding that a tough claims stance will increase insurer profit and future use of the claims entity. The situation may get better or worse depending on intervening judicial decisions. A jurisdiction that put constraints on insurer self-dealing at the beginning of a policy period may issue a new opinion giving insurers more discretion that may in turn result in more obstreperous claims stances.

Most important, the insurance contract is aleatory, no matter how sophisticated the consumer or business purchasing insurance. An aleatory contract is one in which the exchange is, unlike most contracts, not equal. The insurance policy could be anything from a great deal to an abysmal bargain for the participants. For example, if the insurer has no claims

38. See, e.g., Gallagher Bassett Services, Inc. v. Jeffcoat, 887 So.2d 777, 779-80 (Miss. 2004) (describing independent adjuster retained by insurer and its performance, which included assigning an individual adjuster to the case who was not licensed in the relevant state, had no training in matters pertinent to the claim, was unaware of relevant state law regarding “stacking” of insurance benefits until advised by claimant’s counsel, failed to obtain necessary legal opinion, misrepresented her efforts to claimant, and failed to obtain relevant coverage documentation necessary to make determination of claim; Incredibly, court deems this litany of failing mere negligence as a matter of law and insufficient evidence of gross negligence necessary to maintain claim against adjuster, overturning jury verdict finding gross negligence).

39. Regarding insurance policies as aleatory contracts, see JEFFREY W. STEMPEL, STEMPEL ON INSURANCE. CONTRACTS § 1.06 (3d ed. 2006 & Supp. 2008); EMERIC FISCHER, PETER NASH SWISHER & JEFFREY W. STEMPEL, PRINCIPALS OF INSURANCE LAW § 2.02 (Rev. 3d ed. 2006 & Supp. 2006); GEORGE E. REJDA, PRINCIPLES OF RISK MANAGEMENT AND INSURANCE 99 (9th ed. 2005) (“An aleatory contract is a contract where the values exchanged may not be equal but depend on an uncertain event. Depending on chance, one party may receive a value out of proportion to the value that is given.”) (emphasis removed); MARK DORFMAN, INTRODUCTION TO RISK MANAGEMENT AND INSURANCE 163 (8th ed. 2005)
during a policy period, the premium received is almost pure profit that earns investment income forever more. Alternatively, the insured may be severely injured the day after becoming subject to coverage. Even if the insurer behaves dishonorably in response to this type of claim, it will almost certainly pay far more in benefits and disputing costs than it ever received in premiums from the particular claimant in question. Conversely, the policyholder may in some cases receive coverage far in excess of premiums paid or in other cases pay premiums for decades and receive nothing in return. (This is not impossible even though everyone gets sick once in awhile. The insured may never be sick enough, often enough to exceed the deductible amount of the policy, which is shouldered by the insured).

In short, one does not know who wins or loses regarding an insurance purchase until years or even decades later. Contrast this to most other consumer purchases. Even where the good or service bought is complex or expensive (e.g., a car, a home), the exchange is thought to be equal, because the parties are able to make a real time comparative evaluation of value. A resident of Omaha, Nebraska may think the consumer is nuts to have paid $500,000 for a two-bedroom house in Silicon Valley, but this is the price the market has set and it may make sense in light of the consumer's objectives (e.g., a short commute to Google headquarters in which he not only works but effectively lives for twenty hours each day),

(“The aleatory feature of insurance policies differs from other [commutative] business contracts where consideration of equal value is exchanged.”) (emphasis removed).

40. But applied to its book of business as a whole, insurers may find that acting dishonorably is profitable. Although they may ultimately pay far more in benefits than was received in premiums for a particular policyholder, the insurer's war-of-attrition may succeed in getting insureds to drop meritorious claims or settle them at pennies on the dollar.

Unless the claim is sufficiently large, the insured will have trouble finding an attorney willing to take the case on a contingent fee basis (unless the insurer's position is so clearly unreasonable that it makes a bad faith suit with punitive damages likely, but caps on such damages may make a small dollar case of even egregious insurer misconduct unattractive to plaintiffs' lawyers). For most people, this means they cannot obtain legal representation because their budgets preclude them from paying counsel's normal hourly rate. In addition, the insurer's "tough" stance on claims may become sufficiently known to further discourage lawyers from becoming involved and to prompt early, "lowball" settlements with policyholders.

Perhaps most important, an insurer-wide policy of stringing out claims payments as long as possible permits the insurer to reclaim through investment income whatever underwriting loss it may have suffered in connection with individual instances of insureds who incur covered medical costs in excess of the amount of premiums paid to insurers.
which are not contingent in the manner of fortuitous health problems or other loss events. As a general rule of economics, we do not look past the observed purchasing preferences of consumers. If a thirteen-year-old thinks that a Hannah Montana album is worth $14.99, that’s its value, no matter how much one’s own taste may run in a different musical direction. The parties can value the exchange as they see fit even if third parties may question their taste or valuation.

But insurance is different—particularly for the consumer—because it is an economic transaction centered on risk and contingency. Insurers and more sophisticated business entities can mitigate the uncertainty of the aleatory contract by making actuarial calculations based on experience, comparable population data, or longitudinal studies. Most important, they pool contingent risks and through the law of large numbers can make reasonably well-calculated estimates regarding future medical care needs. By contrast, consumers will either lack access to such information or as practical matter be unable to expend the money and time necessary for such evaluations. The typical individual is simply not in a position to be a very intelligent consumer of insurance, particularly health insurance.

Currently, the private sector provides some counterweight to this imbalance of expertise through the dominance of employer-provided group medical insurance. In contrast to the individual insured, the employer has the resources, experience, and leverage to make better estimates and strike better bargains with private insurers. But this field-leveling power of the employer remains less powerful than the accumulated expertise and resources of the insurance industry.

More important, employers may not have the motivation to fully deploy their resources on behalf of insured workers. Despite its responsibilities as a benefits provider, the employer’s zeal will be diluted by a desire to keep costs down. It will be tempted to spend less for inferior coverage from a difficult insurer so long as not hard-pressed by the workforce. Individual workers are unlikely to apply such pressure. Unions are more likely to be effective advocates for employee group insureds, but unions have declined in membership to the point where only about 15 percent of the workforce is organized. Employer-provided insurance as a whole has declined in recent years as well.

For many employers, minimalist group insurance is their optimal economic strategy. Prospective workers are looking primarily for a job rather than medical coverage (which is why the danger of adverse selection

41. See Jost, Health Insurance a Bad Idea?, supra note 4.
is overstated) and, as discussed above, have only limited expertise about medical insurance. Consequently, workers and job applicants will not exert particularly powerful leverage forcing employers to achieve optimal medical coverage for their workforces. We cannot be completely confident that employers will be faithful agents of employees concerning the purchase of medical insurance.

B. THE LEGAL FICTION OF INDIVIDUAL CONTROL OF HEALTH

The second legal fiction, which also becomes part of the legal friction between individualism and collective solidarity, is the increasing tendency to implicitly assign fault to persons experiencing adverse health events and medical costs. More important, the typical consumer will not have much if any effective control over his or her medical care needs and costs. But because of the John Wayne mythology of rugged individualism and personal responsibility, society (and analysts and policymakers who should know better) act as if the individual has some meaningful control over his or her health. For example, people frequently refer to someone “beating” cancer or “battling” illness, as though one’s failure to stay healthy or recover were solely a function of one’s efforts and abilities. In reality, good or bad health, more than economic success or emotional happiness,

42. See SUSAN SONTAG, ILLNESS AS METAPHOR (1978) (describing her struggles with breast cancer and noting social tendency to see illness and treatment as analogous to protagonist in conflict with adverse entity rather than fortuitous circumstances controlled by genetics or inexorable environmental factors). See also DAVID RIEFF, SWIMMING IN A SEA OF DEATH (2008) (Sontag’s son chronicles her myriad medical problems and attempts to overcome them).

One particular example of this tendency in popular culture sticks in my mind. During the 1970s and 1980s, sportscasters often referred to Jack Pardee, a former Los Angeles Rams coach and one-time star player (a linebacker for the Rams and the Washington Redskins) as “beating” black mole cancer, expressing some awe due to the rareness of recovery from the disease at that time.

This, of course, is an empirically ridiculous way of putting it. Pardee was a great player and a tough guy. But he did not vanquish his cancer. He recovered from it through good medical care and luck. His recovery was not a testament to any moral, mental or physical superiority just as it would not indicate deficiency in these areas had he died from the cancer. Depending on chance circumstances, the same type of virus might kill Arnold Schwarzenegger but leave Pee Wee Herman relatively unscathed. Strength, athletic ability, intelligence, and determination have little or nothing to do with whether one gets sick or recovers. But we continue to talk about illness in these misleading terms.
results far more from chance than from personal decisionmaking, conduct, discipline or effort. 43

For years, insurers have waged a semantic and psychological campaign against the notion of blameless fortuity in adverse events and at least suggested that many losses are not true accidents of chance but are to a significant degree the fault of insureds. For example, automobile mishaps are no longer labeled "accidents" by most insurance personnel. Instead, they are trained to speak of "collisions" and "crashes" that imply fault on at least someone’s part (usually the driver covered by another insurer). 44 In health insurance, this more generally takes the form of the suggestion that while the insured does not knowingly become ill, the insured’s lifestyle and negligence may have created or contributed to the health problem that now requires medical care. 45 This view, although possessed of some merit in the aggregate, is generally not a productive way to think about individual medical needs and insurance claims.

In a large enough group of persons, their lifestyles will at least in some cases ultimately show significant impact on adverse health events and consequent medical care. For example, a group of chain smokers will eventually have much higher rates of heart disease, lung cancer, emphysema, and related maladies associated with smoking while a similar group of nonsmokers will, absent other factors, have fewer such adverse health events and lower medical care costs.

In the aggregate, it therefore makes considerable sense to promote the reduction of medical risk through encouraging better lifestyles among insurers. Programs to promote exercise, healthy eating, nonsmoking, moderation in alcohol use, and avoidance of illegal drugs or unregulated

43. See Jacobi, supra note 4, at 562 (noting that ten percent of population “accounts for almost 70 percent of the health care costs, and the top 2 percent accounts for almost 40 percent of the costs.”).

44. See Richard V. Ericson, Aaron Doyle & Dean Barry, Insurance as Governance Ch. 3 (2003). For one example of the tremendous public relations resources deployed by the insurance industry, see Peter J. Howe, Firm He Hired to Buff Image is Suing Mogul; Cambridge PR Shop Says it’s Owed $2M, BOSTON GLOBE, Mar. 10, 2007 (public relations firm eSapience Ltd alleges former AIG CEO and insurance executive Maurice “Hank” Greenberg owes $2 million for services purchased when he sought to burnish his image tarnished by then-New York Attorney General and later Governor Eliot Spitzer’s investigation of AIG; bills ranged as high as $978,000 for a month’s assistance in presenting Greenberg in “best light and to assure the presence and participation of key intellectual and public figures” at events involving Greenberg, according to complaint).

45. See Mariner, Social Solidarity and Personal Responsibility in Health Reform, supra note 22.
supplements all help group members as a whole, society, the medical profession, and reduce medical care usage and costs.

Paradoxically, however, the current system of crazy-quilt private patchwork insurance does little to foster these efforts. Most insurers fail to cover many potential efforts to enhance prevention of illness through better lifestyle. Historically, private insurers have been slow to cover preventive medical care such as annual checkups. This appears to result from a combination of short-sightedness, concern about overuse of this type of benefit, and the more calculatingly disturbing but perhaps correct business decision that paying for prevention in the instant policy period simply lowers some future insurer’s cost of covered care in subsequent policy periods.46

But whatever the merits of preventive care and a health lifestyle, I find it disturbing that so much of modern health care and insurance rhetoric seems to uncritically accept the notion that much of medical need results from the insured patient’s own failings of discipline rather than the simply fortuity of genetics and luck. Although a group as a whole will reflect the benefits of healthy lifestyle, individuals within the group may or may not enjoy the benefit. For example, a non-smoker who wins marathons and has low blood pressure and cholesterol may nonetheless drop dead from a sudden heart attack. Or he may be stricken with cancer. Or rear-ended by a truck. Or infected while making a blood donation.

Conversely, the 300-pounder who stands 5’8” tall and smokes two packs a day may live to be 100. When observers conclude that because each individual within a group demonstrates the whole group’s characteristics, they make what statisticians term the “ecological” fallacy.47

For example, it would be erroneous to conclude that every union member

46. This is why also why Hyman is overly optimistic in positing medical insurers will engage in an optimal level of preventive care in the absence of government regulation. See Hyman, Health Insurance: Market Failure or Government Failure?, supra note 4. In addition, as Mariner notes, preventive care and wellness programs raise the prospect of deviating from the fortuity model of insurance and creating a situation that (like HSAs, HRAs and other consumer-driven proposals) tends to benefit the upper socioeconomic strata much more than their lower SES counterparts. See Mariner, Social Solidarity and Personal Responsibility in Health Reform, supra note 22.

voting in a Democratic primary supported John Edwards, although it is true that he enjoyed (at least during the early stages of the 2008 campaign) considerable support from that group as a whole. Non-statisticians intrinsically realize that this is incorrect but are often overly casual in stereotyping based on subconscious application of the fallacy (e.g., looking at a plumber with a lunch pail on his way to the polls and assuming he is a vote for Edwards).

Much of the rhetoric about consumer/patient responsibility in health care comes dangerously close to embracing the ecological fallacy. It suggests, at least implicitly, that people with health problems are at least partially responsible and that it is therefore unfair or unwise to pool them with people who are comparatively free of health problems or the need for expensive medical treatment. This attitude is simply not rational as applied to the serendipitous nature of health problems and the need for medical care.

Only in extreme cases (e.g., the self-destructive risk-taker, the spendthrift hypochondriac), can it legitimately be said that individual patients had a significant role in maladies that have afflicted them or the total amount and cost of treatment. Much of adverse health and medical experience results from simple bad luck. It is wrong to suggest, even indirectly, that this results from the patient’s failures and that the patient is therefore less deserving of adequate medical care and insurance coverage than those blessed with better medical fortune.48

But the rhetoric in much of the health care and insurance debate, even if not strictly inaccurate, is slanted in favor of overstating the individual’s control over her health history and the relative desert of certain individuals. For example, use of a term such as “personal responsibility” is simply overdone and misleading for many health issues.49 A person stricken by


49. But this terminology is so hard-wired into our discussions of medical issues that it pervades even scholarly treatments that do not embrace an unrealistic view of an individual’s ability to control his own health care options. See, e.g., Mariner, Social Solidarity, supra note 22; Lois Shepherd, Assuming Responsibility, 41 WAKE FOREST L. REV. 445 (2005); Carol A. Heimer, Responsibility in Health Care: Spanning the Boundary Between Law and Medicine, 41 WAKE FOREST L. REV. 465 (2005); Lois Shepherd, Face To Face: A Call for Radical Responsibility in Place of Compassion, 77 ST. JOHN’S L. REV. 445 (2003). Reading the titles of these articles alone, one might first erroneously assume that they are part of the John Wayne ethos when they are in fact written from a communitarian social justice (Mariner, Shepherd) or professionalism (Heimer) perspective. The rhetoric of market, rugged individualism, and aversion to government programs is so strong in the U.S.
cancer clearly is not at fault. A person injured in an auto accident or workplace mishap may have been negligent but this hardly amounts to personally irresponsibility. As the insurance industry well knows, everybody is negligent at times but not every instance of negligence results in damage to self or others. Although behavior may contribute to problems with diabetes, heart or lung disease, much of medical outcome is a metaphorical roll of the hereditary and biological dice. Personal responsibility rhetoric implicitly blames people more accurately described as victims and provides a subconscious salve permitting society to overlook the problem of an inadequate national approach to medical coverage.

A term like "actuarial fairness," although it may be technically accurate and useful in describing risk populations, is also rhetorically overloaded with the connotation that sick people have largely been their own worst enemies (or at least must lump their conditions). Implicitly, providing coverage to those making higher demands on the medical system is "unfair" to those at lower risk or presenting fewer current demands. This nomenclature makes it easier to avoid a sufficiently comprehensive solution because it implicitly suggests that any government efforts extending beyond a market-based solution is unfair to the bulk of society and unfairly subsidizes the medical needs of the undeserving.

The net effect of this type of discourse is to reinforce the traditional American notions of rugged individualism and the optimal efficiency of markets, creating a climate where policymakers can implicitly take the position that doing more for those who are sicker, poorer, or less skilled in navigating the world carries too high a price tag, both economically (e.g., higher taxes, higher premiums, higher medical costs) and socially (e.g., enhancement of the "nanny state" in derogation of the preferred ethos of rugged individualism).

In addition to being an unfair attack on the ill and the risky, the rhetoric of individualism and market veneration is amazingly unempathetic. John Wayne was able to achieve his goals in large part because he was never seriously injured or ill, at least not prior to accomplishing his mission.51

that the immediate connotative reaction (mine, at least) to the term "personal responsibility" is to assume the speaker is advocating a "let the chips fall" position in which the individual stands alone, protected only by contract and individual fortitude.

50. See Mariner, Social Solidarity, supra note 22 (using term throughout and also using term "personal responsibility" throughout).

51. In the 1969 movie TRUE GRIT, for which he won an Oscar, Wayne was wounded while dispatching the villain but the seriousness of the wound, which ultimately did him in, did not manifest itself until after the shooting was over. TRUE GRIT (Paramount Pictures
Today, some health insurance commentators would seemingly be unwilling to chalk up adverse health events to fortuitous chance and would instead wonder whether they had instead not brought this upon themselves through lifestyle factors (e.g., smoking, poor diet, insufficient sleep, poor hygiene). This implicit appeal to the John Wayne iconography of America is used as a selling point for certain insurance and financial products by appealing to the public through rhetoric about "consumer choice" or "freedom" or an "ownership society" when these initiatives will, for most people, be far less helpful than a government-administered single payer system.

1969). Of course, defenders of rugged individualism might suggest this simply demonstrated will power (such as in the famous Jesse Ventura line (in the movie COMMANDO, which also starred a similarly macho-iconographic Arnold Schwarzenegger) "I ain't got time to bleed" until the mission is completed). COMMANDO (SLM Production Group 1985). While the laws of biology and physics (e.g., blood escapes rapidly when one is shot in a vital organ) may be suspended in Hollywood, they very much limit the ability of ill persons to surmount their maladies through exercises of personal responsibility.


53. See Deborah Stone, Health Law Symposium: The False Promise of Consumer Choice, 51 ST. LOUIS U. L.J. 475, 475 (2007) ("In these times, the new buzzwords for market reform are 'consumer choice,' 'consumer direction,' 'consumer empowerment,' and 'ownership.' [T]he rhetorical emphasis on power and control for consumers disguises the real impact of market reforms, which is primarily to reduce the collective assistance and medical services that citizens receive."). See also Monahan, Ownership Society, supra note 17 (finding useful incentive structures in consumer-driven plans but also that consumers are not particularly adept purchasers of health care).
The Legal Fiction of the Reliable Responsibility of Individuals (and the Contradictory Legal Fiction that Individuals Are Louts Who Need Stern Market and Insurer Discipline)

In addition to the rhetoric about personal responsibility concerning illness itself, there is also the suggestion in much of the debate that persons lacking adequate insurance when illness strikes are in this pickle largely through their own failure to pay the required social toll of insurance. For example, we are frequently reminded that many who do not receive medical insurance through a job will go without insurance rather than pay premiums for an individual policy. Some may even describe this as a rational decision but one that adversely affects the nation's ability to provide medical insurance that is properly funded by those who will benefit from it. For example, younger persons who are less statistically likely to have medical problems often fail to purchase insurance. As a result, the private insurance system is deprived of their premium dollars and the insurance system as a whole is underfunded. But when a twenty-eight-year-old ruptures an appendix, he will generally be able to obtain treatment at an emergency room.

The picture painted, with considerable justification, is that people like this are freeloading on the system. In reaction, even those favoring continued substantial reliance on private medical insurance urge that such persons be required to purchase insurance and heavily penalized if they do not. This is a major underpinning of the well-publicized Massachusetts plan and the health care proposals of Hillary Clinton and John Edwards.¹⁴

This is not the place to discuss mandates at length but it should be noted that mandates tend to be far less effectual than commonly supposed.⁵⁵ Consider auto insurance, where for decades every state has

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had financial responsibility laws that require, as a condition for licensing a motor vehicle, that the owner purchase and maintain auto insurance. The required minimum amounts of such insurance are shockingly low in many states and the premiums, although non-trivial, are hardly astronomical, at least for the low policy limits minimally required. However, experience shows that a large portion of the driving public fails to maintain the required insurance.\footnote{56}

There is little reason to think that medical insurance mandates will be significantly more effective. The reason: many people, especially at the economic margin, will shirk legal obligations that cost money if they can do so without significant penalty. In response, proponents of mandated purchase of private insurance seek to use penalties to create sufficient incentive for citizens to purchase required insurance. Although like auto insurance financial responsibility laws, this will work to a degree and improve upon an unfettered free market atmosphere, there is no reason to think that it will work better overall than auto insurance.

Most likely, it will work less well. At least for a few hours on a given Tuesday, anyone wanting a license plate will need to have at least some auto insurance in force. By contrast, there is no similar mandatory event, at least not one occurring prior to when insurance is needed, which will apply to all potential policyholders. The twenty-something Starbucks worker and the impoverished family of four can more easily bypass insurance mandates than can their driving counterparts. Absent a police state-like increase in law enforcement infrastructure, they will be seriously scrutinized and “caught” in their failure to procure insurance only after they have suffered an adverse medical event.\footnote{57}

\footnote{56. See Rebecca Cathcart, California Taking Aim At Uninsured On the Roads, N. Y. TIMES, Dec. 3, 2007, at A22 (Twenty-five percent of California drivers uninsured despite longstanding requirement of insurance purchase as prerequisite for licensing car).

57. See Jost, Bad Idea?, supra note 4 (noting studies showing reduced use of medical services by uninsured and failure of younger, healthier demographic groups to purchase medical insurance).}
But we continue to think of mandated private insurance as comprehensive solution to the health insurance problem, just as we have viewed mandated auto insurance as an effective public policy tool. This is unwise. A sufficiently high number of persons will fail to purchase medical insurance and pay premiums into the system for funding expanded health care. Whether this occurs because they are irresponsible shirkers and slackers or because they are simply too poor, unsophisticated, or unorganized to make the required purchase is beside the point— or at least beside my point.

My point is that even the "progressives" or "reformers" in the area of medical insurance, driven by perceived political pragmatism if not thorough analysis, have erroneously viewed private insurance purchase mandates as a near-panacea in large part out of misplaced continued belief in the legal fiction of the effectiveness of individual personal responsibility. At a minimum, this legal fiction posits that if required to purchase insurance, individuals will do so promptly and responsibly in most all cases. But if this estimate is correct, people would also purchase medical insurance even in the absence of mandates and would place such purchases ahead of other desired goods and services. Historical and empirical evidence is quite to the contrary. Instead, people either consciously or negligently fail to obtain insurance, even when they could at least in theory afford it. A more realistic view of human behavior would embrace the more enforced community solidarity of a government administered single payer plan.\(^5\)

In addition, the legal fiction of individual rationality and omniscience also posits that when purchasing insurance, consumers will do so wisely and efficiently. But, as discussed above, most laypersons lack the

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5. See Stone, False Promise, supra note53, at 478:

[W]hen people live at the margin, they are apt to choose the option with the lowest short-term costs over the one with the lowest long-term or total costs. People living at the margin—and that margin may be well up into the middle class when families face chronic disease, disability, job loss, income decline, and all the other factors that make for economic squeeze— are simply not able to behave like the rational economic actors of consumer choice theory. They cannot afford to take the long-term view. They are forced to be "penny wise and pound foolish.

See also id. at 480 ("perhaps the worst feature of the consumer choice approach" is that "it substitutes lay judgment for professional judgment.").
knowledge, experience, training, or sophistication to understand and differentiate insurance products and providers. In contrast to the prevailing legal fiction, they are not good consumers of medical insurance. Even when people dutifully follow mandates to buy medical insurance, they will frequently make suboptimal choices regarding necessary coverage and make errors in choosing among whatever options are presented to them by the private market. Consequently, a system premised on the wisdom and utility of consumer choice via John Wayne-style individualism and invisible hand market behavior is unlikely to achieve sufficiently comprehensive and adequate medical insurance or medical care for the population at large.

C. THE LEGAL FRICTION OF MARKET MYTHOLOGY AND RUGGED INDIVIDUALISM IN TENSION WITH BOTH ITSELF AND IN TENSION WITH SOCIAL JUSTICE AND COMMUNITY SOLIDARITY

As discussed above, the American ethos has been to erroneously assume too much understanding and discipline by the consumer of insurance and to view with distain the consumer who fails to make good insurance choices. At the same time, empathy is not completely dead in American society. We worship idealized concepts of rugged individualism and personal responsibility but are unwilling to adopt a completely Darwinian approach to the ill or injured. Although there is a substantial amount of "blaming the victim," for health problems, Americans do not completely turn a cold shoulder to the ill or injured. The iconic image of Martin Luther King and the attendant social justice notion still competes for the hearts and minds of the public on issues of health care. Similarly, although the market efficiency wing of Adam Smith's own writings dominates much of the discourse, his thoughts on the importance of a

59. The Massachusetts plan and similar initiatives attempt to deal with this problem by placing some requirements on insurers as to the minimum content and features of health insurance policies sold. Like mandated private coverage itself, this regulatory effort is better than nothing, but it will leave many consumers without optimal coverage for their needs. However, to the extent that government-required minimum features of a medical insurance policy are effective, this is actually a powerful argument for simply traveling the extra mile to a government administered single payer system. Logically, if regulators can design an effective basic medical insurance policy, they can also effectively design the contours of a fair single payer system. See generally Edward A. Zelinsky, The New Massachusetts Health Law: Preemption and Experimentation, 49 WM. & MARY L. REV. 229 (2007).
ADAM, MARTIN AND JOHN

strong, competent, self-regulating professional class also play a role in the health care debate.

As the politicians continue to remind us during the 2008 election season, Americans are a compassionate people as well as a group that worships at the shrines of rugged individualism, personal responsibility and ambition. As a consequence, despite some rhetorical and social looking askance at the obese, the slothful, smokers, drunkards, and druggies, society (even its insurance element) has been unwilling to completely exclude most such people from coverage they would otherwise receive as members of an insured risk pool.

The inability of the body politic to adopt either the cold-hearted approach of letting the health or poor consumer choice chips fall where they may or the more emphatic communitarian approach of comprehensive universal health care leads to the legal friction or tension between allegiance to the norms of rugged individualism and personal responsibility and the recognition that, at least in the arena of human health, outcomes are often not within the control of the individual.

The result is, much like American medical insurance itself, a patchwork of occasionally spotty coverage that for the most part provides coverage even for the Louie Andersons (overweight) and Humphrey Bogarts (smoker) of the world but does so in a manner that may impose additional costs or reduced coverage, particularly when that person is not part of a group insurance plan. Increasingly, insurers in general have tried to restrict coverage accorded to insureds engaged in arguably wrongful or irresponsible activity and have tried to avoid providing medical insurance in such cases unless they can extract a sufficiently high premium. For auto insurers, we see this new judgmentalism in the form of clauses that exclude coverage if a car accident arises out of the policyholder's intoxicated driving or criminal act. For health insurers, we see measures such as broader and longer bans on coverage for pre-existing conditions, differential premiums rates based on lifestyle factors.

More important for purposes of the health care/medical insurance debate, the purported fault of patients provides insurers with an argument against single payer administration of universal coverage even if the argument is largely made sub silentio. Because of public ambivalence about how far to take the personal responsibility track in derogation of compassion, this argument has not been completely successful alone but at the margin has helped the status quo resist efforts toward universal health insurance coverage.

But this tension, like most, has strong elements of inconsistency, as does the so-called consumer driven health care movement. On one hand,
the theology of market-and-individual driven health care posits that many people are just too darned undisciplined, lazy and self-destructive and that, as a result, the costs that they bring upon themselves should not be heavily subsidized nor should the health consequences of their foibles be borne by a unified national insurance system. The consumer-driven, market-based model of medical insurance implicitly belittles individuals as undisciplined louts who fail to take adequate care of themselves, over-consume expensive medical care, and fail to exhibit apt discipline in lifestyle, insurance purchase, or resort to health care.

But on the proverbial other hand, the consumer-driven movement argues that individuals are sufficiently all-knowing that they don’t need universal health care and single payer medical coverage and that they can make shrewd, disciplined insurance purchasing decisions. In addition, the movement posits that people will be similarly shrewd, disciplined, price-controlling consumers of medical services.

The inconsistency is palpable. The problem, of course, is that slothful slackers and the shrewd consumers are the same people, or at least comprise the same population pool. Some subgroup of the populace may meet the implicit John Wayne/Adam Smith assumptions underlying the consumer-driven health movement (just as every neighborhood has a few nerds who never unwittingly violate even the most arcane neighborhood association rules regarding aesthetics). But this subgroup is logically much smaller than posited by the movement — and too small to sustain movement health care. People are not completely incompetent in health matters, but comparatively few have the education, training, time, discipline, and energy to manage their medical insurance portfolio in the manner posited by those favoring continued or increased market control over medical coverage.

II. THE MYTHOLOGY OF THE MARKET AND OF PRIVATE INSURER EFFICIENCY

A seemingly stronger arrow in the quiver of the status quo is public concern that anything but a market-based, private sector model for medical insurance will be too inefficient and expensive. The Adam Smith legacy of a belief in omniscient and omnipotent markets has created an unhelpful mythology positing that private sector health care and insurance is so dramatically and consistently more efficient than any government-run or
hybridized model that it should be tinkered with only under the most dire of circumstances and only to the most limited degree.\textsuperscript{60}

At the risk of picking more of a fight than I have already begun, much of David Hyman's scholarship is in this vein, although he is also highly critical of the role of private insurer payers in the current patchwork system as well as critical of government single payer plans such as Medicare.\textsuperscript{61} It's clever, knowledgeable, insightful and well-written, with occasionally counterintuitive nuggets of some support for particular types of regulation or government efforts on behalf of patient rights.\textsuperscript{62} But regardless of whether one finds it persuasive, it seems undeniable that it all proceeds from a Smithian world view exceedingly enamored of markets and consumer choice.\textsuperscript{63} (The Smith who advocated for professionals' financial

\textsuperscript{60} See Anna Bernasek, Health Care Problem? Check the American Psyche, N.Y. TIMES, Dec. 31, 2006, at B3 (noting resistance to government public insurance system based on American norms).

\textsuperscript{61} See e.g. Hyman & Silver, The Poor State of Health Care Quality in the U.S., supra note 16, at 959 (2005) ("markets dominated by third-party payment arrangements function relatively poorly...[p]ayers bear most of the costs of health care; patients enjoy most of the gains. Payers therefore care about cost more than quality."); David A. Hyman, Regulating Managed Care: What's Wrong With a Patient Bill of Rights, 73 S. CAL. L. REV. 221 (2001); David A. Hyman, Health Care Fraud and Abuse: Market Change, Social Norms, and the Trust "Reposed in the Workmen", 30 J. LEGAL STUD. 531 (2001); David A. Hyman & Charles Silver, Just What the Patient Ordered: The Case for Result-Based Compensation Arrangements, 29 J. L. MED & ETHICS 170 (2001); David A. Hyman, Drive-Through Deliveries: Is "Consumer Protection" Just What the Doctor Ordered?, 78 N. C. L. REV. 5 (1999); David A. Hyman, Patient Dumping and EMTALA: Past Imperfect/Future Shock, 8 HEALTH MATRIX 29 (1998); David A. Hyman, The Comundrum of Charitability: Reassessing Tax Exemption for Hospitals, 16 AM. J.L. & MED. 327, 370 (1990) ("In a world where patients are relatively ignorant about their medical conditions, a for-profit provider has a clear incentive to cheat on quality and quantity. Because there are no equity shareholders, nonprofit hospitals may be safer for the relatively helpless patient."). See also David A. Hyman, Medicine in the New Millennium: A Self-Help Guide for the Perplexed, 26 AM. J.L. & MED. 143, 152 (2000) (on the subject of "picking a fight": relating that his scholarship was described at one conference as reflecting "the sort of views that caused the Irish potato famine."). Presumably, I have not gone this far in my differing.

\textsuperscript{62} See, e.g., Hyman & Silver, The Poor State of Health Care Quality in the U.S., supra note 61; David A. Hyman, Does Medicare Care About Quality?, 46 PERSP. IN BIOLOGY. & MED. 55, 65 (2003) (finding that Medicare does care about quality – but suggesting that it achieves it less well than would private insurer or uninsured markets).

\textsuperscript{63} For the best example of all these traits of Hyman scholarship, see DAVID A. HYMAN, MEDICARE MEETS MEPHISTOPHELES (2006) (discussing fictitious memorandum in the manner of C.S. Lewis' The Screwtape Letters (1942) revealing Medicare to be diabolic plot designed to drain Americans of virtues of thrift and truthfulness and lead them into seven deadly sins of avarice, gluttony, envy, sloth, lust anger and vanity); David A. Hyman,
success is largely missing in Hyman's work but, like Smith, he holds professionals to an implicitly high standard of care and competence. Hyman is hardly alone, at least outside the academy, where the seemingly dominant view among policymakers is that any comprehensive program to effect full medical coverage must involve private insurers and that there should be no program that effectively eliminates private insurers in favor of government.\(^\text{64}\)

Notwithstanding its political dominance, the dominant market paradigm for configuring medical coverage appears substantially incorrect on a number of grounds. First, despite the supposed marvels of the market in controlling costs, both health care costs and insurance premium rates are high and tending higher. Market defenders typically ascribe this to the effects of government subsidization of group medical insurance, which is generally a fringe benefit that workers receive as untaxed compensation. The point has force but not nearly so much as its advocates claim. Even without tax subsidy, private insurance premiums would likely be high because of market concentration, generally rising medical costs, strong demand for coverage, and insurer inability to effectively control costs to any significantly better degree than the government.

Regardless of whether it is taxed when received by an employee, the employer's share of group health insurance premiums costs money for the employer. Although the cost can be deducted as a business expense, the corresponding reduction in tax liability is not, for most businesses, the same as avoiding the expenditure altogether. Health insurance still costs


64. *See* Hossain, supra note 1, at 1 (noting absence of even Democratic presidential support for government single-payer insurance or any plan that does not rely substantially on purchase of private medical insurance). Further, Hyman, albeit sometimes feeling embattled among the ivory tower types, is not without at least partial support in the academy as well. *See, e.g.*, Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537 (2006) (advocating continued significant role for private insurance along the lines of Massachusetts plan, with purchase mandates but subsidies for payment). *See also* Jacobson, supra note 9, at 734-35 (contending that four conceptual paradigms compete for dominance in health law: economic (market competitive); professional; rights-based (social justice) and institutional, and that "social justice model is on hold" which is a "euphemism for being dead in the water. Instead, the real struggle for doctrinal supremacy in health law is between the market and professional models."'). A soundly administered government single payer system holds the more promise than the current or market models for achieving professional and institutional goals as well as social justice and may actually work to enhance meaningful consumer choice regarding medical services.
money, which presumably gives employers plenty of incentive to keep premiums down. In spite of this, premiums consistently rise. Although this is not necessarily the "fault" of the market for employer-insurer health care bargaining, it at least demonstrates the strong limitations on this market as a vehicle for controlling premium costs.

Part of the problem is motivational disconnect between employers, who see medical insurance as an expensive fringe benefit on which to economize and workers who get to use the medical care and would like more, better care. Another part of the problem is that even large employers may not have as much leverage with insurers as necessary to provide effective cost control in the face of insurer drive for profit while individuals are particularly ill-suited to the cost-policing enterprise. By contrast, the


Even more troublesome from my point of view is the differential human cost of provider avarice in contrast to insurer avarice. Provider avarice may increase costs but should mean, at least in theory (and mostly in practice) that patients get more care and more than adequate care. But see Hyman, Medicare Meets Mephistopheles, supra note 63, at 1183 ("Shoveling money out the door to purchase health care services is, of course, not the same thing as purchasing high-quality health care."). By contrast, insurer avarice is manifested in claim denial that may lead to severe injury or even death for a patient unable to obtain coverage; see Jane Zhang, Chronic Condition: Amid Fight for Life, A Victim of Lupus Fights for Insurance; Lost in U.S. Health-Care Maze, Her Coverage Was Ended As Her Illness Worsened; Skipping a $2,000 CT Scan, WALL ST. J., Dec. 5, 2006, at A1. But, of course, Hyman is hardly alone in pinning much of the blame for rising medical costs (in my view, more of the blame) on providers rather than insurers who fail to control them.
federal government and individual states have bargaining clout exceeding that of even large companies. Even a small state (e.g., Nevada) has more employees than even the largest multinational companies. In addition, of course, insurance administered through a national government or 50 state administrations would be significantly more streamlined than insurance purchased through tens of thousands of companies (some large, some small) and administered by scores of health insurers.

Just as employer-insurer bargaining has not been the anticipated cost control panacea regarding premiums, bargaining between insurers and medical providers has not controlled costs to the degree anticipated by defenders of private medical insurers. It is not at all clear that insurers are particularly effective at controlling medical costs in a consistent and rational way. In spite of the central role of private insurers in the current medical care system, medical costs continue to rise, despite some occasional brief periods of relative stability. By comparison, the health care systems that stop with the half-measures of the American status quo and move directly to the government single-payer system have significantly lower per capita medical costs.

The evidence on insurer cost control is mixed. For example, insurers have been effective in negotiating provider discounts, at least this appears to be the case on the face of benefits explanation statements commonly sent by insurers to policyholders. A typical one indicates that Doctor X charged $85 for an office visit but discounted it to $45 in order to receive insurer payment. Even with my $20 deductible, Doctor X has, at least in theory, reduced his charges because of the presence of private insurance in this medical care transaction.

(particularly the particularly avaricious) and for often establishing economic incentives that are at least as misguided as anything the government could dream up; see e.g. Bruce C. Vladeck, The Political Economy of Medicare, HEALTH AFF., Jan./Feb. 1999, at 22.

66. See Rhonda L. Rundle, Critical Case: How an Email Rant Jolted a Big HMO: A 22-Year-Old’s Tirade Made Trouble for Kaiser; Mr. Deal Got Fired, Famous, WALL ST. J., Apr. 24, 2007, at A1 (whistleblower notes $1.5 billion annually in alleged waste expenditure by insurer on misconceived electronic records project); John C. Goodman, Perverse Incentives in Health Care, WALL ST. J., Apr. 5, 2007 at A13 (noting that Mayo Clinic may be cheaper than your local hospital).

67. See supra note 18.

68. Random walks through recent family medical bills reflect similarly deep discounts, at least on paper, for other services. Fore example, one specialist lists a charge of $220 for a comprehensive new patient visit, but accepts $96.72 from my insurer, “adjusts” the charges to eliminate $93.28 (effectively eating this portion of the charge and in effect knocking the $220 charge to $130, leaving $30 as the patient’s portion. For an ultrasound done separately for the examination, the list price is $175, for which the insurance company
Alternatively, Doctor Y may be unwilling to discount the retail price of an office building but has patients who prefer Dr. Y or doctors with a similar practice style and unwillingness to make deep discounts for insurers. Dr. Y may simply bill the patient for whatever portion of the bill the insurer does not cover. In effect, this subjects the patients of Dr. Y (e.g., me) to a 50 percent co-pay, a financial burden I am happy to bear for relatively lower cost medical needs of this magnitude. I don’t shop for a cheaper doctor or one more willing to make the insurer’s proffered discount because I prefer Dr. Y, who on average spends triple the time with me during an office visit than my previous family physician and also is willing to be involved with any hospitalization of patients.

pays $68.54, the doctor absorbs $89.32 and I am billed $17.14. The math looks about right, but I am not about to verify by taking the time to dig into the fine print of my group policy nor am I going to call a representative of the TPA that my employer’s plan has retained to process claims. The final tally of $47.85 billed to me (there were some small lab charges as well) seems reasonable in relation to the $405 retail price listed on the doctor’s invoice and leaves me paying the traditional 20 percent co-pay. So much for the power of patient consumerism. Because I was seeing the doctor over a relatively acute medical issue (an infection), bypassing medical care was not an option and, knowing that all doctors of this specialty generally charge roughly the same rates, I was unlikely to price shop as well. Nor would I be deterred by the 20 percent co-pay. The deterrence was the time and inconvenience of seeing the doctor. If I had not been previously told (based on a routine blood test) that I had an infection (accompanied by considerable symptoms of discomfort), I would gladly have skipped the trip to the doctor. So much for moral hazard.

A less extreme example of discount billing with reduced monopoly money character of U.S. medical insurance was reflected in a recent family bill for oral surgery, specifically the extraction of four wisdom teeth from my older son’s mouth. The dentist charged $1,465 ($285 for general anesthesia, and $295 per tooth. Of this total, the insurer paid 1,052, I paid $313, and the dentist absorbed $100 in discount.

Again tending to refute the picture of the world painted by market/consumer-oriented commentators, I was really pretty indifferent to both the doctor’s suggested retail price and the degree to which the insurer extracted pricing concessions, even though this was not emergency surgery. This was the dentist my son and I wanted to use based on the experience of his siblings (one with this dentist and another having a less successful wisdom teeth extraction with another well-regarded dentist in town). I did not think $1,400 was a particularly high price to pay for all this dental work, which required not only the time and skill of the oral surgeon but also specific and general staff assistance, considerable fixed office overhead (e.g., special equipment), and variable costs such as general and local anesthesia, gauze, surgical thread, etc. My $300 payment seemed more than reasonable, again paralleling the customary 20 percent co-pay, but I would hardly have blinked if the figure had been $400 or $500.

See also Hyman & Silver, supra note 61, at 966 (largely positing substantial efficacy of private insurers in controlling prices but castigating them for not caring sufficiently about quality of care delivered). See also id. at 981 (noting that medical malpractice insurance is “rarely risk rated”) (footnote omitted).
According to the market/consumer-oriented approach, I am not enough of a bargain hunter. In this realm, I am behaving more according to the professionalism paradigm of medicine than the market competition paradigm. I value more thorough professional treatment more than a reduced price tag. Once again, my own experience suggests that much of the view of patient behavior posited by those promoting the consumer-oriented approach does not accurately reflect actual patient behavior, at least for those with means or insurance.

In addition, something about the deep discounts given by providers to insurers is uncomfortably reminiscent of the property tax statements we all also receive as homeowners. A typical such statement gives an assessed value of the home that, even after the post-2005 housing downturn, is generally substantially lower than the actual current fair market value of the house. Thus, a tax rate per $1,000 of value that would seem unduly confiscatory if the home were valued at current market prices becomes a sufferable tax burden when applied to an artificially low value carried on the assessor’s books.

In similar fashion, the net cost of a medical service may be discounted only as a matter of cosmetics. If provider discounts are a part of the game of insurer-provider interaction, the situation evolves to one in which the provider’s list price is intentionally inflated in the knowledge that the insurer will impose a discount. In order to get his $45 payment from the medical insurer, Doctor X charges $90 for what would have otherwise been a $45 charge (or $65 if the patient’s co-pay is viewed as a sort of subsidizing middleman were eliminated from the equation).

My own view is that $90 for a routine office visit to a family doctor is high enough to border on the excessive, despite the high overhead of running a doctor’s office, if the doctor is applying the business school rule of thumb that a doctor’s “encounter” with the patient should be no more than seven minutes. Extrapolated, this results in an hourly rate of compensation for the doctor exceeding $700, a rate comparable with top partners in commercial law firms, which have high overhead resembling that of a doctor’s office.

However, if the doctor is seeing each patient for 15 minutes on average, the doctor’s gross hourly rate is less than $400 per hour, a rate comparable to that of top business lawyers in many cities and a higher rate of pay than found in most occupations. However, the net income to the doctor from this hour of work will be considerably less, perhaps even a comparative pittance, depending on the doctor’s overhead costs, which may be substantial, in some part because of expenditures required for dealing with private and government insurers. Understandably, even the most
professional of physicians is tempted by the thought of shorter patient encounters and greater profits. Spending 10 minutes per patient instead of 15 minutes per patient results in a 50 percent increase in gross income (to $600/hour). But if overhead costs are not too high, doctors can earn quite a good living and still give each patient on average 15 minutes of their professional attention.

The case that per-service charges and compensation to medical providers are on the high side becomes stronger when one examines the rate of insurer payment for medical procedures, which can involve thousands or even tens of thousands of dollars for a 45-75 minute surgery. Much depends on the locality, the procedure, and the insurer. Similarly, Medicare reimbursement rates vary widely by state. In spite of the higher overhead for surgery (as compared to an office providing patient examination), these compensation structures can make Wall Street lawyers look cheap. But it may also be the case that the surgery reimbursement rates are modest in light of the time, skill, training, and overhead required for performing a procedure. As previously discussed, one can in my city get wisdom teeth extracted from a highly regarded oral surgeon for a list price of less than $300 per tooth. Less prestigious dentists in town may charge as little as $145 per tooth. This is not a lot to spend for an important, one-time medical-dental event designed to minimize or avoid future problems.

Hospital charges are, from my own experience, more problematic. Hospital charges of $2,000 per day are not uncommon, with much of the cost of medical care received while staying in a hospital separately billed at

69. See Hyman, Mephistopheles, 60 WASH. & LEE L. REV. 1165, supra note 63, at 1179-81.

70. See supra note 68. As some point, too low a price for wisdom tooth extraction should presumably raise concerns about patient safety. Unless the doctor charging $145 per tooth simply has an Albert Schweitzer-like preference for lower income, it is more likely that he has fewer or less experienced office staff, less modern equipment and facilities, and a business model that requires greater speed in performing the operation and releasing the patient. All other things being equal, this has to increase the risk of adverse outcomes for the patient. The dividing line between safe-but-no-frills extraction and unduly risky extraction is one best made by trained professionals and competent regulators untainted by undue financial incentives. But at some point, cheaper medical care becomes less safe medical care. For example, poorly done wisdom tooth extraction can damage nerves, gums, other teeth or result in undue bleeding and severe infection as well as a painful “dry socket.”

71. But the medical cost-legal fee dichotomy breaks down somewhat. For example, expensive lawyers are generally retained and paid by business entities that deduct the cost from their taxable income. Individuals only have this luxury if medical expenses exceed 7.5 percent of gross income in a given year.
a separate time. In spite of the cost of physical overhead, nursing services, and liability insurance that a stay at the hospital somewhat different than grabbing a hotel room, this is a lot of money to spend for in essence parking a patient in a spot with access to medical facilities and nursing care personnel. If private insurers can force doctors to take 50 percent discounts, one wonders why similar cost reduction has not been imposed on hospitals.

Viewed broadly, it appears that private insurers standing in for individuals undoubtedly restrain medical care costs to a significant degree. But they are hardly great price-busters in this regard. More important for purposes of the medical insurance debate, there appears to be no reason that a government entity policing medical charges could not perform the price control function as effectively as private insurers. In practice, it appears that the Veteran’s Administration, Medicare, and Medicaid all do comparably well in this regard as compared to private insurers.

If nothing else, a quilt of private insurance funding much of health care logically imposes greater expenditures than a government plan simply from the higher administrative costs associated with documenting services, claims, and payment involving so many insurers who have different forms, procedures, and protocols. Typical doctor’s offices devote more than half their overhead simply to the administrative and paperwork burdens imposed by the current system. In effect, we have a system that acts as something of a private full-employment measure by requiring the hiring of several persons who do not actually provide medical services in order to support a single person or handful of persons actually offering medical services. In the private health insurance world, bureaucracy and paperwork dominate to a degree that few government agencies can match. For

72. Again, to me, personal and shared experience is as telling as any statistical report. As one example, I have a friend with a spouse in need of mental health care. Although her group insurance policy clearly covers these services, the claims administrator (which was retained by the managing general agent (which was retained by the self-insured employer’s group insurance plan) has repeatedly, erroneously refused treatment, incorrectly claiming that the spouse must be in an “acute” ready-to-jump-off-a-bridge mental state. After many hours of phone calls and emails, my friend finally reached someone in the MGA office who confirmed that indeed there was coverage under the policy. However, to effectuate treatment, she is again required to go through the same claims administrator that continues to claim non-coverage even though this issue has been decided favorably to the insured. It is hard to imagine a government agency doing a poorer, more wasteful job of determining coverage and policing the receipt of medical benefits. Cynics among us might wonder whether this is in fact part of a larger conspiracy (tacit or explicit) to delay treatment and
hospitals, the ratio or medical to administrative expenses is somewhat lower, but largely only because the cost of medical services at the hospital (e.g., surgery, intravenous feeding, intensive care) dwarfs the costs of the less intense medical care administered in a doctor’s office. Further, if one considers the provision of a basic room and bed to be administrative overhead rather than medical services, the hospital ratio of overhead to medical costs would be high. By contrast, government programs offer a consistency and streamlining superior to that of the current status quo affecting most insureds.

Reduction of paperwork provides the opportunity to deploy the savings in administrative costs for most substantive expenditures such as more useful treatment or better compensation of medical professionals who

payment or to discourage insureds from using mental health services that they literally have paid for in advance through insurance premiums.

Closer to home is my daughter’s experience with physical therapy after knee surgery. Pursuant to a doctor’s prescription (actually several over time), she has been receiving therapy for some months. Throughout this time, I have received scores of form letters informing me that my insurer cannot determine whether to pay its portion of the cost until it receives further information. The insurer claims it does not have the prescription(s) on file while the provider claims it was sent weeks earlier. Eventually, the provider and the insurer agree that these indeed are properly covered and documented services, although there has been for me some lost time from work making calls or writing letters.

For example, as this was being written, I received in the mail a thick envelope from my insurance plan’s claims administrator containing 30 separate forms (plus an additional two forms arriving under separate cover in the same day’s mail) indicating that, after all the dust had settled, my insurer was covering the physical therapy. I am course happy to be covered without dispute and to have my daughter receive needed post-operation physical therapy. But was it even remotely necessary to kill so many trees and incur so much administrative expense in coming to that decision and communicating it to me?

In effect, the bottom line is the same. But due to these miscommunications and delays, approximately 70 of my daughter’s PT sessions have resulted in insurer-generated letters and “explanation” of benefits that needlessly kill trees, require postage, distract me, and require filing. Meanwhile, the provider waits weeks or months for payment, which may explain part of why the cost for a simple physical therapy session is (at least by my reckoning) shockingly high (both in stated retail terms and after discount). Of course, the delay and extra expense may be the provider’s fault. But an efficient insurer would presumably find some way to avoid at least some of this seemingly needless expense.

It is hard to imagine a government single-payer system creating more waste for in connection with a claim that in the final analysis is covered as part of routine insurer operations. Nor does the private insurer/claims manager appear to be any better at communicating than much-maligned government bureaucracies. For example, the typical letter of this type I have received in connection with my daughter’s physical therapy informs me that this is a “2nd Notice” (even when it is the first notice) and that I must “[p]lease respond in 30 days.” A few lines later, I am told that “[n]o action is required of you at this time.”
might otherwise be unwilling to perform services for the payment rates promised by private insurers. For example, an increasing number of physicians will not accept private insurance (or at least certain types of private insurance) but will accept Medicaid or Medicare patients. In effect, this portion of the market of medical providers is refuting market-based defense of the status quo and demonstrating that for doctors there is nothing inherently superior about dealing with a private insurer as compared to a government insurer.

Perhaps the biggest elephant in the room for advocates of increase market-based, privatized, or consumer-driven health care is the simple fact that the United States long ago stopped resembling anything close to a pure market-based model for the delivery of medical care. In spite of this "[t]axpayers . . . don't get as much bang for their bucks because the government guarantees coverage for the elderly and the poor, groups that account for a disproportionately large amount of expenditures."73

Most obviously, we have Medicare and Medicaid and the VA and the Federal Employees Insurance Program as well as the de facto insurance of emergency room care that, for the uninsured, becomes subsidized or even "free" medical care, the costs of which are externalized on the medical community and society at large. This coverage accounts for 40 percent or more of the medical coverage provided in the country (and perhaps even more of the total expenditures on health care). Medicare is politically popular and will as only expand as the population ages. Medicaid, like most programs designed for the needy, has a less powerful political base but seemingly also one that can withstand attack. The VA enjoys similar

73. See Daniel Gross, National Health Care? We’re Halfway There, N.Y. TIMES, Dec. 3, 2006, §3, at 4 (stating that 38 percent of medical expenses in U.S. are publicly funded; "[t]he government spends money as if there were a national health insurance program. In 2004, government spending on health care equaled 9.6 percent of the gross domestic product, compared with 6.9 percent in Canada, which has a single-payer universal health care program," (quoting Harvard Medical School Professor David Himmelstein); considering all expenditures “government accounts for about two-thirds of health care spending” (quoting Princeton University economist Uwe Reinhardt)). Accord, Anna Bernasek, Health Care Problem? Check the American Psyche, N.Y. TIMES, Dec. 31, 2006 §3, at 1 (in U.S., government share of total medical care spending is 45 percent). See also Bobinski, supra note 13 ("In 1987, the public and private share of health expenditures were the mirror image of the distribution found in Candada, with the private sector picking up 70% of the costs of health care and the public sector paying for 30%. The public share of health care expenditures [in the U.S.] grew to 40% in 2005 and remained stable in 2006") (footnotes omitted).

74. See Gross, supra note 73 ("A rough rule holds that private insurance covers two-thirds of the population and pays for only one-third of all health care" (quoting Reinhardt)).
Although no one likes the use of emergency room visits as a substitute for regular health care (rather than true, acute emergencies or medical problems taking place at night or on weekends), political and social sentiment continues to weigh against giving Hospital ERs the prerogative to refuse services.

In addition, even the supposedly more private and market-oriented half of American health care is a far cry from ordinary retail selection, purchase and consumption. Beginning with the use of health insurance coverage as a means of escaping the strictures of World War II's wage and price controls, we have replaced individual fee-for-services purchase of medical care with not just an insurance-based system but one dominated by large group plans that are only "chosen" by policyholders at the margin. As this system has evolved, it has become, as well described by Nan Hunter, into "employer corporate sovereignty in the formulation and administration of risk pools for group health insurance in the workplace." Although this may be "private" (in that it is done by employers and non-government group insurers), it is not so much a market as a negotiated form of private legislation.

Advocates of greater efficiency in health care pricing and delivery can muster a number of good arguments against a greater government role and against government subsidization. But in addition to the problem of overlooking the humanitarian concern that adequate health care seems to many of us more a right than a consumer preference, the conservative side of the health insurance debate founders on empirical shoals. Political sentiment will almost certainly prevent any retrenchment of the existing governmental presence in the medical coverage status quo. Only a minority of voters seem to get enthused when political candidates rail against socialized medicine and only a few of even those that do have been willing to support any significant curtailment of the existing systems. Most voters want to at least maintain the government presents that already exists. That sentiment will only grow stronger as more voters reach age 65 and the total medical costs of the Iraq War and Afghanistan intervention continue to roll on for years to come.

Because of this political reality, conservatives will never again see an open market world regarding the purchase and delivery of medical services. Consequently, many of the proposed conservative remedies for current health care problems are simply not likely to be effective. They cannot

supplant the current mixture of public and private with a tabula rasa that permits the purported full flowering of benefits they posit from a private market model. Consequently, they are reduced to proposing incentives for more efficient behavior or isolated market-mimicking initiatives such as health savings accounts.

As Tim Jost persuasively argues, HSAs appear largely a government subsidized benefit to the healthy and wealthy.\(^6\) This is hardly the return of the free, private market. Rather, it looks instead like successful rent-seeking by interest groups (the wealthy, banks, and insurers selling the high-deductible catastrophic plans that accompany HSAs). Since the nation is not overrun with wealthy people in good health looking for tax shelters and humans are not the posited rational option maximers consumed with financial planning, the predicted boom in HSAs has been slow to materialize, suggesting that they are not the panacea painted by their advocates.\(^7\)

The second empirical shoal upon which the conservative ship founders is the experience of other industrialized nations. As previously noted, Canada and Western Europe, after embarking on national government-run plans for universal coverage, have never retreated from that goal. More important, as also previously noted, the per capita costs of medical care in those nations is dramatically lower than the U.S. and their citizenry appears to be at least as health as that of the U.S.\(^8\) Simply put, one must ask the

\(^{66}\) See Jost, supra note 4.

\(^{77}\) See Vanessa Fuhrmans, Health Savings Plans Start to Falter; Despite Employer Enthusiasm for Consumer-Directed Approach, Patients Express Dissatisfaction With How the Accounts Work, WALL ST. J., June 12, 2007, at D1.

\(^{78}\) See Timothy Stoltzfus Jost, Private or Public Approaches to Insuring the Uninsured: Lessons From International Experience With Private Insurance, 76 N.Y.U. L. REV. 419, 437-39 (2001) (noting higher costs of U.S. system as compared to those of other countries); Justin Lahart, Rethinking Health Are and the GDP, WALL ST. J., Jan. 25, 2007, at C1 (noting dramatically higher costs per capita of U.S. System but U.S. measuring worse according to life expectancy, infant mortality, and other metrics); But see Tyler Cowen, Abolishing the Middlemen Won’t Make Health Care a Free Lunch, N.Y. TIMES, Mar. 22, 2007, at C3 (contending that full amount of medical overhead costs in Europe and Canada is systemically understated in cost comparison studies because of failure to consider longer waiting times for some services in non-U.S. countries, which shifts in-kind overhead cost to consumer and also arguing that European systems are less responsive to paying for new treatments and drugs); Froma Harrop, Canada’s the Wrong Model for Universal Health Care, SEATTLE TIMES, Feb. 28, 2007, available at http://seattletimes.nwsource.com/html/opinion/2003592432_harrop28.html (referring to study by Fraser Institute, an organization that “promotes privatization” as finding Canadian system “wanting” in comparison to others but failing to provide concrete examples).
question: If movement toward greater privatization, market competition, or personal choice is so wonderful, why have these other nations not moved in this direction? And why has there failure to make any such movement not seemingly harmed health care in those countries relative to the more privatized, market-based, consumer-driven United States?

III. THE INEFFICACY OF INSURERS IN ACHIEVING FAIR COST CONSTRAINT

Another aspect of Adam Smith's legacy in the U.S. is a widely held belief that the private sector is always considerably more efficient than the public sector in accomplishing goals. Applied to medical coverage, this mythology posits that private sector insurers play a vital role in controlling health care costs that stems from the private sector's greater talent in achieving efficiency. A significant fear standing in the way of movement toward government as single payer is that health care costs, already rising well faster than inflation, will be even less effectively checked by government than it has been by the private sector.

The mythology of Smithian invisible hand efficiency is so strong that its advocates conveniently overlook the degree to which much of the American economy has implicitly found that in many instances,
government regulation in derogation of private markets has been necessary for sound and efficient economic and social policy. Occasionally, even government operation of certain activities may be more efficient than regulated or unfettered market activity. For example, we have largely forsaken the invisible hand in the cases of utility provision (gas, electricity, water), transportation (roads and mass transit), airports, cargo hauling, military procurement, and infrastructure generally.

One can view the provision of adequate health care as an infrastructure problem. Like many such problems, it is best solved by government intervention (and funding) to create the infrastructure platform, which in turn decreases administrative costs, provides consistency, and increases social productivity. Efforts initially perhaps seen as in derogation of Smith's invisible hand thus ultimately help create an environment in which markets and productivity can flourish beyond what would occur in the absence of adequate infrastructure.

This portion of the health insurance problem also reflects another legal friction or inconsistency in attitudes. On the one hand, the public wants to hold down health care cost increases. But on the metaphorical other hand, the public appears unwilling to embrace many cost-containing measures. For example, health costs during the 1990s were relatively stable but this appears to have resulted in significant part from the limitations on care imposed by HMOs. Many insureds chafed at these restrictions and their discontent fueled policy measures restricting HMO gatekeeping or mandating benefits. Although the reining in of HMOs may not have been the sole or even prime cause, health care costs began to rise again significantly in the late 1990s and early 20th Century.

Critics of a national medical insurance plan have at least something of a point: if left to their own devices, consumers will take and take and take when it comes to medical care, at least if they are not paying sufficiently directly with their own money. Consequently, they argue, under a government funded and administered system, individuals will lack adequate incentive to control themselves and will consistently opt for more treatment when less would suffice. Hydraulically, this drives up the cost of health care (quite substantially in the aggregate) unless it is tamped down by a gatekeeper.

Defenders of the current model argue that the private insurance industry does this better than government. Although some of the "proof" for this assertion is essentially a second bare assertion that government is always more wasteful than the private sector, defenders to the status quo can point to government reaction to HMO controls as an example of the government's greater sensitivity toward consumer sentiment. Insurers
argue, at least implicitly, that this is bad because it gives government insufficient backbone to control health care costs, by rationing if necessary and that by contrast the insurance industry, fueled by the profit motive of Smith's invisible hand, has the fortitude to hold the line on costs (or at least hold the line better than the government).

This is not an unpersuasive or illogical argument. However, it ignores two substantial problems. First, advocates of holding the line on costs appear not to recognize that holding the line is not always a good thing. Sometimes, some things are worth a higher price in order to better provide the good or service in question. Sometimes this is for utilitarian reasons: doing something right will increase productivity further down the line. Sometimes, this is for humanitarian reasons: doing something right is worth simply to provide better, more humane treatment to patients.

Government regulation banning "drive-by" deliveries of babies (so named because insurers would not pay for more than 48 hours of hospital care after a delivery, and hospitals tended to seek discharge within 48 hours even if individuals were willing to pay for longer stays) provides a good example. In his previous writings, David Hyman has attacked these regulations with a sustained ferocity usually reserved for Red Sox fans talking about the Yankees. In his contribution to this Symposium, he again makes the argument that these regulations needlessly increased hospital stays and medical costs, resulting in a corresponding increase in medical insurance that encouraged shrinkage of coverage.

I have quite a different view, one formed in large part as a result of my wife's experience with three baby deliveries, all by Caesarian section. Although Hyman would undoubtedly criticize this as argument by anecdote, I think the points made by reciting my own family experience make a useful point. Further, although policymaking that is too driven by anecdote of course is dangerous, it is equally dangerous to lose sight of the application of policies by paying insufficient attention to personal experience and giving exclusive focus to aggregate data that may obscure or minimize the consequences of practices on the ground. Josef Stalin was not addressing medical insurance when he infamously uttered that "a single death is a tragedy; a million deaths is a statistic." But he could just as well have been. It may be a mistake to legislate on the basis of a single moving


personal story. But it can be just as mistaken to legislate (or refrain from legislation) based on aggregate data that glosses over the daily operation of medical care and insurance for real people.

My story (or rather, my wife’s) is not tragic and moving in the manner of a patient’s needless death due to malpractice or lack of even achieving patient status because of lack of insurance, but it is instructive. When our first child was born, there was a long, difficult delivery in which, after 20 hours of labor, the medical professionals concluded (about 12 hours too late for my taste, but that was the orientation of this practice) that Caesarian section was necessary for a safe birth. Surgery successfully occurred in the wee hours of the morning and a healthy baby emerged. Mom was exhausted, looking and feeling a bit like someone who had been in a marathon boxing match.

Nonetheless, the hospital gave us the bum’s rush out after a two-day stay in the hospital.82 We were comparatively young, unsophisticated in these matters, and probably should have fought harder to stay in the hospital for two days (perhaps more) of much needed rest and care. I even made an attempt at offering to pick up the extra care out of personal funds. The hospital was distinctly uninterested in working with us. If the insurance would not pay for more than 48 hours of post-op care, it seemingly wanted us out, in spite of our middle class ability to pay. So much for consumer-driven health care.

Back home, the consequences of a rushed, abbreviated stay in the hospital were palpable. The new mother, still physically exhausted from delivery, was now attempting to recover from the wounds of a C-section at home while caring for a newborn. Although the dutiful husband did his semi-competent best to manage care for baby and mother, this was a far cry from the type of rest and care both would have received from the hospital. It took weeks for my wife to recover sufficiently to do anything of modest strenuousness. Anecdotal or not, I remain convinced that she would have returned to her normal energy, health, productivity much sooner if she could have only had a few more days in the hospital.

82. Which means that we were accorded less coverage (and less maternal recovery time in the hospital) than even if we had been subject to a standard “drive-through delivery,” which Hyman defines as the practice of discharging women and newborns from the hospital less than forty-eight hours after a vaginal delivery and ninety-six hours after a Cesarean section. See Hyman, Drive-Through Deliveries, supra note 69, at 9. Consequently, our family medical insurance situation would have been helped significantly with legislation that did not go as far as the Newborns and Mothers’ Health Protection Act of 1996. 42 U.S.C. § 300gg-4 (2003).
In addition, the newborn in question (our elder son) at age three weeks developed a viral infection, exhibited meningitis-like symptoms, and was hospitalized and given considerable medical care for days before recovering, which of necessity took mom and dad further away from work and productivity. Although proving a link between my son’s severe problems at age three weeks and the shortened hospital stay is impossible, I can’t help but think that his mother’s bedraggled condition on discharge, which made for lactation and nursing problems, which in turn posed nutrition and immunity issues for the baby, might have played a role. In any event, what resulted was a 4-5 week period in which two previously productive adults were largely out of commission in at least some part due to the supposedly cost-saving, efficient mechanism of kicking new mothers to the curb two days after a particularly rough delivery and C-section birth.

When subsequent children arrived, C-section was also required. By then, we were a little more sophisticated and assertive (and had broader insurance coverage and better medical care). In addition to performing the operations much earlier without physically punishing the mother for hours, additional hospital recovery time was obtained. Maternal recovery and new baby care proceeded far more smoothly and effectively. Neither of the children had any post-partum health problems and both Mom and Dad got considerably more done during the ensuing five weeks after these deliveries than was the case with the first delivery.

With this personal history, it is understandable that I was never a fan of drive-by deliveries and was thrilled to see government intervention to stop them. Notwithstanding Hyman’s cogent (if perhaps overheated) arguments of net policy detriment, I remain a fan of this regulation. Although it will not always result in greater family productivity and reduced overall medical costs, I am convinced that in many cases giving a new mother and baby a couple more days of hospital care (while the often hapless husband also has more time to get the home situation under control) will have that effect. More important, it is simply a more humane way to treat new mothers and children. American society regularly purports to value families. Providing an additional increment of medical care – or at least removing the incentive for hospitals to rush patients home – is a small price to pay in the service of those values.

A second problem with the conventional wisdom (that the private sector controls costs much better than the government) is that considerable evidence exists to suggest the sentiment is overblown or perhaps even erroneous. At the least, it appears that private insurers do an inconsistent job of holding the line. More important, it is to me unclear whether private insurers do any better job of cost containment than does the government.
Alternatively, if private insurers do too much better than the government in holding down the price of medical services, this may create incentives that undermine the availability and provision of sound medical care.

As previously noted, private insurers have been able to extract from medical providers significant discounts from what the provider otherwise states as the “list price” for a medical or laboratory service. This may simply mean that medical pricing has become like automobile shopping. The “sticker price” exists only as an outside anchor or measuring stick but no one really pays this list price (except the rare uninsured patient who actually has independent financial resources). For purposes of argument, I will give credit to insurers for actually enforcing some type of real price constraint about medical providers. At the very least, one certainly hears doctors consistently complain about the low payment rates provided by insurers.\textsuperscript{83}

The question then becomes: does the private insurer do a better job of payment-for-services containment than comparable government programs. Here, the evidence seems mixed. Insurers may be doing a pretty good job of keeping doctors from charging exorbitant amounts (even if they are also encouraging doctors to provide assembly-line care). But Medicare and Medicaid also appear to be effective in tamping down costs-per-medical service. And the VA, with its system of staff physicians on salary, may be the most efficient of all in controlling doctor-related costs. Even where the insurer suppresses provider rates more than does a government payer, this hardly means the net benefit to patients and society is greater. Excessive cost cutting may lead to unwanted collateral consequences.\textsuperscript{84}

\textsuperscript{83} Doctors also differentiate among insurers. Many refuse to see patients insured by carriers whose payment rates are simply too low. One former internist of mine explained he rejected patients covered by the HMO then known as US Healthcare because it paid “coolye wages” for office visits. Whatever the political incorrectness of the comment, it is a pretty good reflection of the way many doctors today do business. They will work with some health insurers but not others based on the amounts paid for service, the administrative burden, and the overall difficulty of working with some providers. Other physicians may take an “all comers” attitude, assuming that by seeing enough patients fast enough, they can make more money than if they simply avoid the stingiest, most difficult insurers altogether.

\textsuperscript{84} The same, of course, can be true for excessive imposition of costs. See Stephen Dubner & Steven D. Levitt, \textit{Unintended Consequences, The Case of the Red-Cockaded Woodpecker}, N.Y. Times, Jan 20, 2008 (Magazine) available at http://www.nytimes.com/2008/01/20/magazine/20wwln-freak-t.html?_r=1&oref=slogin.

Dubner & Levitt, in an installment of their now well-known “Freakonomics” feature in the \textit{Times} (see also Stephen Dubner & Steven D. Levitt, \textit{Freakonomics}: A Rogue Economist Explores the Hidden Side of Everything (William Morrow 2005)), give the example of a deaf patient consulting an orthopedic surgeon and insisting on her
Clearly there is inherent tension (legal friction once again) between the goal of making provision of quality medical services economically attractive to prospective providers and holding back runaway medical costs. Hyman's resolution of the tension is largely against medical providers and in favor of insurers and the posited cost-controlling force of more empowered consumers. In addition to disagreeing with Hyman about the actual efficacy of consumer constraint, particularly where the consumer is too poor or uninsured to have much clout, I question whether excessive payment to providers, particularly doctors, is the culprit.

Consider my eye doctor, who in addition to being very competent is also professional in the classic sense. Although he is repeatedly identified as one of the best doctors in the area in local magazine's "best of" features, he carries a comparatively low patient load, spends significant time with each patient, and has an uncrowded waiting room. He accepts Medicare but not many private insurers, where he not only has found the reimbursement rate too low but also has found the private insurers' paperwork and bureaucratic hassle to be too much for his staff. He also expresses support for a comprehensive single-payer system along the lines of Medicare and suspects that a large portion of doctors, particularly younger doctors less reared on the traditional AMA stances against "socialized" medicine, agree with him.

right (per the Americans With Disabilities Act) to a sign language interpreter so that she could better understand the doctor's diagnosis and recommendation. In the Los Angeles metro area where this took place, a qualified interpreter generally charges $120/hour with a two-hour minimum, an amount required to be borne by the physician and which the patient's private health insurer refused to cover. Not surprisingly, the good doctor who initially accepted this needy patient and then was hit with unexpected interpreter charges made no money on this patient. His solution and that of similarly situated doctors in the future will be to attempt to avoid taking such patients. Id.

The episode serves of course as a good example of the occasional incidence of negative unintended consequences from well-meaning legislation. In addition, it serves to illustrate the degree to which too much of the modern health care burden has been placed on doctors relative to insurers. Further, it provides additional support for a government single payer system. Imposing translator costs on a single doctor, or even a medical group or hospital, has great potential for unfairness simply because of the fortuity of when a deaf prospective patient may approach a particularly provider seeking medical care. Imposing mandatory coverage on a single private insurer is a better approach but still may result in lopsided distribution of the added costs of improving the access and experience of the deaf seeking medical care. But if the coverage is provided by a national government single payer system, the added costs of translation are spread as broadly as possible and amortized among many beneficiaries of the medical-economic system. This optimal risk spreading seems the fairest solution as well as one efficient in administrative terms and unlikely to deter any particular deaf patient from seeking and receiving desired care.
Regarding costs: when he first began performing cataract surgery, he reports that the Medicare reimbursement rate was approximately $1,200 and that of private insurers was about $1,100. Notwithstanding the aggregate data about overall increase in medical costs, he has seen the rate of payment for cataract surgery go down (at least in Las Vegas) to a current rough range of $600 - $900, depending on the insurer. Medicare pays about $750. In a world where a visit from the plumber or electrician routinely results in minimum bills of $125 or more, this hardly seems like excessive compensation for the doctor. Purchase of cataract surgery logically should cover not only the doctor's actual time and skill in performing the procedure but must provide reasonable contribution to defraying his overhead and recoupment of investment in human capital such as medical school and additional training and education.

Successful cataract surgery of course dramatically improves the patient's vision and quality of life and probably improves their economic productivity as well (even though many cataract patients are older and retired). Compared to other expenditures, particularly those for personal services,\(^8^5\) paying $750 to the doctor for the procedure does not seem like price gouging or an otherwise bad deal. More important, if high quality physicians are reluctant to discount their prices below this amount, trouble can ensue. Perhaps less competent doctors will be the ones performing the $600 cataract surgeries. Or perhaps the doctor will make sure he takes on additional patients and schedules an additional procedure or two on surgery days, even if this results in more error due to haste or mistakes born of tiredness.

\(^8^5\)Economies of scale are easier to achieve with manufactured goods than with delivery of even relatively routine personal services. For example, once the mold has been established, a manufacturer can crank out I-pods or televisions at a lower cost per additional unit than even the most rushed, robotic surgeon. Personal services of necessity require investment of at least a minimum amount of time and present individual variants not found in manufacturing. Every defective plumbing joint or electric socket is a bit different while mass-produced goods are not. As a result, an I-pod that lasts for years can be sold for $300 but the same amount of medical care quickly disappears into the mists of consumer memory. As a result, people tend to see services as overprice relative to hard goods. Hence, the problem faced by family doctors, pediatricians, dermatologists, and other doctors whose primary work is seeing patients. By contrast, surgeons and doctors performing diagnostic procedures are better compensated per minute of their time. Surgical procedures are a bit of a hybrid in that something like successful cataract removal is a one-time event with long-lasting, positive consequences. Prescription drugs have elements of both manufacturing (although research and development costs may be high and harder to recoup than found for consumer goods) and ongoing personal service because one needs in many cases to continue purchasing and using the pharmaceutical product for years on end.
Ultimately, these are empirical questions. My point is that there is nothing to suggest that Medicare has resolved them less well than a more tight-fisted insurer. Although government programs might be more vulnerable to inflationary pressures stemming from politics and public opinion, private insurers are similarly vulnerable to excessive deference to the profit motive. If I were having cataract surgery (or most any other medical procedure), I would rather have the decisionmakers err on the side of pricing and policies that will make skill service and good treatment outcomes more likely. This of course may make for higher per service costs under a government single-payer program. But administrative cost savings may make up the difference and certainly appear to do so in Canada and Europe. To the extent that they do not fully do so, this may simply be the price paid to medical providers by a wealthy nation for high quality health care that produces collateral economic and social benefits.

In other areas of medical costs, it is similarly hard to see private insurers doing particularly better than government insurers regarding cost control. Consider the matter of hospital costs. Again, personal experience drives my thinking along with aggregate data. In January 2006, I was stricken with a severe infection, high (105 degrees Fahrenheit) fever, substantial body aches and pain and a tennis-ball sized cyst on my liver. After this was detected in an MRI, I was instructed by my doctor to get into the nearest hospital for further care, which consisted primarily of intravenous antibiotics. The IV antibiotics worked wonders. Within 36 hours, my fever had abated and I was considered out of danger, although still feeling weak, horrible, achy, etc. The infectious disease specialist prescribed a six-week regime of continued IV drugs followed by weeks of orally taken antibiotics. Eventually (but probably not fast enough), I began self-administering my IV antibiotics at home with "picc" line in my arm.

The draining of the liver cyst presented more complex and confrontational issues. At the hospital, it was quickly agreed that the cyst should be drained. The staff radiologist felt it was too dangerous to do this without surgery, which the general surgeon was only too happy to perform, although this would have necessitated a long (6-8 week) recovery period from the invasive surgery alone. On the good advice of doctor friends, we located another radiologist who reviewed the CT scan and X-ray film and concluded that the cyst could be safely drained with the less invasive insertion of a needle, preferably as an outpatient proceeding but possibly requiring post-op hospitalization depending on the results. It took days of wrangling to get discharged from the first hospital. Drainage at the second hospital (where the second radiologist had privileges) went well but the
condition of the withdrawn cyst material prompted the doctor to require hospitalization because of fears of internal bleeding.

All this happened on the Friday before the 2006 Martin Luther King holiday weekend, which meant that getting physician follow-up was difficult. Finally, by the ensuing Wednesday, I was discharged. The situation was made more difficult because my former primary care physician did not visit patients in the hospital. Instead, the overall supervision of my care fell to the "hospitalists" or general care internists that contracted with the hospital. During both my hospital stays (10 days total), the hospitalists spent a total of about 15 minutes with me (or which they billed more than $750, a rate that most would agree is unconscionably high for doctors with this level of skill and comparatively little overhead as compared to "regular" doctors maintaining an office). During those 15 minutes, they (four different doctors for the hospitalist group were involved) misstated my record on several occasions. Fortunately, I was conscious and could correct them. They also were slow to discharge me, first for the drainage of the cyst and second for home IV care.

During our cumulative 15 minutes together, they asked probing questions such as whether I raised goats in the back yard and whether that might be a source of the infection. I successfully suppressed the urge to remind the doctor in question (a non-native graduated from a non-U.S. medical school) that we were in Las Vegas, not Waziristan. Subsequently, I switched to a primary care physician who would (a) visit me in the hospital to make sure my care was appropriate and (b) did not have an economic incentive with his hospital client to keep me in the hospital longer than necessary (a goal that Wayne, Smith and King would presumably support).

Finally, some weeks after this experience, I received communication from the hospital and other care providers (although, perhaps unsurprisingly, the hospitalists lagged, not billing for the services until more than a year later, without having submitted the bill to my insurer, even though I had provided them insurance information upon admission to the hospital). My insurer (or rather the claims administrator that contracts with the State of Nevada's self-insured plan) was reasonable.86

86. Our biggest imbroglio was that it did not want to pay for the second hospitalization because it had not been pre-cleared. In response to the insurer's original denial, I explained that the original treatment plan was to perform cyst drainage on an outpatient basis and forgo hospitalization but that, reacting to what he saw during the procedure, the radiologist, a senior, well-respected doctor in town, required hospitalization as a precaution out of concern over possible post-drainage internal bleeding. (I suspect he
When the final bills rolled in, they were substantial, although having survived, I was more than happy to pay my 20 percent co-pay and move on with life (which, in cliché-like fashion, I appreciated all the more after this series of misadventures in the medical system). What continues to bug me, however, is that there seemed to be lots of fat in this system that could have been much better controlled by non-avaricious medical professionals and a more enlightened private insurer/claims management company.

First, there is the absolute cost of hospitalization. It averaged about $2,000 a day. I realize there is a lot of overhead required for a hospital, but this seems just too much for ordinary, brand-x rooms and nursing care. As in many cities, nursing staffs are stretched thin. There were typically only four nurses on the floor and, judging from my regular sojourns around the floor, they had many patients in far worse shape than me. They also spent a considerable amount of their time in record-keeping, even to the neglect of patients buzzing for assistance. I was ambulatory within a day or so of the first admission, another sign that it might have been appropriate to have both hospital stays shortened. (But it was a major boon to be able to walk to the juice cooler with my IV tower in tow because waiting for the nurses resembled waiting for Godot.)

Two thousand dollars a day for basic hospitalization? In most cities, one can get a suite at the Ritz for about a third of that amount. And, presumably, one could purchase a considerable amount of private nursing care and rented medical equipment for the other half. Part of the problem, of course, is that patients like me are not in much of a position to shop among hospitals, compare prices, and make price-conscious decisions. Residents of rural areas have even less opportunity for comparison shopping--another problem with the consumer-driven mythology. Even for elective surgery, one finds relatively little difference in cost when shopping around (which I did some years before in connection with a hip replacement), assuming one can get a hospital or doctor's business office to provide straight answers to questions about costs (reticence I suspect comes from difficulty in talking about their stated rates and discounted rates paid by insurers). Under these circumstances, one might hope that insurers could drive a harder bargain with hospitals. In addition, one must again ask the comparative question: Are the rates paid by private insurers committed to quality care significantly less than those paid by government programs?

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would not have kept me in the hospital as long as the hospitalists and the hospital, who had an economic interest in my continued stay, did). So informed, my insurer agreed the hospitalization was apt.
If not, much of the efficiency-based argument for continuing to cling to a private insurance model loses its steam.

If nothing else, private insurers (at least judging from my experience) have not done much to control adverse financial incentives of medical providers. In fact, one might argue to the contrary. Once the hospitals discovered that I had good insurance, they wanted to keep me as long as possible. The hospitalist physicians, when they could be found at all, were distinctly unhelpful in trying to speed my release even after it became clear that further hospitalization was not required. The hospitalists also wanted more and repetitive tests. (I was CT-scanned twice in three days and had to figuratively stomp my feet in refusing to have a third before getting out of the first hospital after a five-day stay). The hospitalists and a general surgeon practicing at the first hospital were only too eager to subject me to major abdominal surgery without even exploring the possibility that perhaps my liver cyst could be drained by needle after all. In the end, I had a feeling akin to a tourist on a desert island with one vendor, who wanted to exploit this market advantage for all it was worth until the ship to shore arrived.

My question: why do insurers, who supposedly want to control runaway costs, not do more to forbid these adverse incentives (more on that below regarding problematic professionalism) or police them more aggressively? In my experience, the only real check on price gouging through churning of services and an excessively extended stay was the professionalism of some of medical personnel involved\textsuperscript{87} and my own nagging (aided by my family), which avoided more expensive surgery and finally got me released from the two hospitals.

Of course, this latter factor suggests that market cheerleaders are on to something in wanting to empower consumers. They simply fail to appreciate the practical limitations on even educated consumers and seem to forget that the uninsured patient of modest means have almost no leverage over anything relating to medicine. Perhaps most important, they

\textsuperscript{87} For example, the invasive radiologist, the infectious disease specialist, the hospital nursing staff, and the insurance administrator's case manager were all supportive of an earlier discharge and transitioning to less expensive outpatient home care as soon as possible but were delayed by the slowness or mixed motives of the hospitalists. In addition, my efforts to obtain better, safer, less expensive treatment were aided by doctor friends in the local medical community, even though they were not my treating physicians. An impoverished, working class, uninsured, or less educated person would be less likely to know a helpful doctor through social connections.
fail to realize the practical limits on my degree of empowerment as a consumer, at least in this manner with some concrete potential for reducing medical costs, is no less if I am covered under Medicare or a government single-payer program rather than a private insurer.

During my time in hospital purgatory, there were other examples of the insurer being relatively lax in cost control. Consider prescription drugs that I regularly take. Once admitted to the hospital, I was forbidden to bring my regular “stash” of pharmaceuticals, which includes cholesterol, blood pressure, and anti-gout medicine. Instead, the hospital insisted on administering these prescriptions to me from its stock – at a cost of about $20 per pill (as compared to the regular cost of about a dollar per dose). I realize that there can be problems with patients self-medicating. But this hardly seems to justify a system in which hospitals (who probably get the drugs for less than I would “on the outside”) are permitted to impose a 2000 percent markup in price – willingly paid by the insurer that is supposed to be such a stringent guardian of costs.

When I was finally liberated from the hospitals, I was visited by a wonderfully competent, straight-to-the-point home care nurse who instructed me in self-administration of the antibiotics and then peacefully left without looking for any other ways to run up costs (although she was helpfully available by phone for questions and her company replenished supplies as necessary). Notwithstanding that this part of my treatment was sensibly streamlined, the costs for the IV equipment and drugs was significant, approximately $500 per week. Although this is a lot less than the $2,000 per day at the hospital (plus itemized charges, including the IV drugs received at the hospital), it still seems high. I realize that drug manufacturers need to recoup the cost of research and development as well as continuing overhead and distribution costs. But I was receiving Zocyn, a common antibiotic that has been in use for years. One might reasonably expect a truly efficient private medical and insurance system to be able to get the costs of such at-home drug care down to something like $200 per week.

All in all, then, my medical experiences of early 2006 strongly suggested that the medical community and private insurance does a quite imperfect job in both treating patients and containing costs. During the course of 10 days in two hospitals and three months of treatment (including visits to other specialists recommended in light of possible wear-and-tear on my liver and kidneys from all this), I was treated by a couple physicians I came to see as highly competent, with a fairly wide range of empathy and willingness to explain things to the patient. Overall, my condition was treated appropriately and successfully, but not very efficiently. However,
some of the medical professionals cut a less positive figure. The hospitalist physicians were worse than worthless from my patient’s perspective. Ironically, this business model of medicine is touted in many quarters as a more efficient way to deliver services. The primary family physician can remain in her suburban office park and see more patients more often while the hospitalist can efficiently attend to the needs of the hospitalized patients. My experience suggests this theory is seriously flawed.\(^8\)

To the extent that the private insurer involved attempted to control costs, it was with fairly crude all-or-nothing measures rather than targeted attempts to prevent churning or inflated prices. For example, my insurer initially balked at my second hospitalization before accepting that it was medically necessary.\(^9\) But it readily paid for $20 pills, multiple expensive tests, fairly expensive IV drugs, and hospital rooms at Helmsley Palace prices. Could, Medicare and Medicaid really be worse in this regard, as Hyman argues? If not, there is no reason to fear a national single payer system on efficiency grounds. The question is not how government programs compare with perfection. The question is how government programs compare to their private insurer counterparts.

More to the point of this Symposium: many aspects of medical treatment and coverage today are intrinsically removed from the consumer. In my case, I perhaps could have shopped better for a hospital with lower rates, a more daring or accomplished resident radiologist, or better hospitalist physicians. But I was running a 105 degree fever at the time and my primary care physician was counseling immediate hospitalization and treatment of a rather large liver cyst. Under those circumstances, comparison shopping and shrewd consumerism is unlikely.

Of course, not all medical situations are acute or time-sensitive. But even garden variety routine medical care is reasonably esoteric and has some temporal imperative that prevents consumer choice. If a five-year old has a fever and joint aches, this is probably just the flu. But what parent other than Joan Crawford\(^90\) will delay treatment while calling doctors for a

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88. I have since switched to a primary physician who will visit hospitalized patients and serve as a check on the quality and expense of care provided by the hospitals and their associated vendors. What continues to astound me is the popularity of a professional and business model so rife with conflicts of interest and incentives for more bureaucratic, expensive, lower quality care.

89. See supra note 86.

90. The parental shortcomings of Crawford, a popular actress in the 1940s and 1950s, were extensively chronicled in her daughter’s memoir. See CHRISTINA CRAWFORD, MOMMIE DEAREST (William Morrow 1978).
price quote? In addition, there are practical problems that likely limit aggressive consumer cherry picking. What doctor will accept episodic patients who come to her for flu symptoms, go elsewhere for earache, and try a third doctor for annual checkups because of lower prices? Even if doctors had no problem being commodified in this manner, there would likely be a rise in both the logistical costs of coordinating care and the substantive quality of care. My experience in the hospital suggested that doctors seeing patients episodically are overly dependent on patient charts, which may be inaccurate or misread.

For elective surgery, comparison shopping is equally or more difficult. Patients can get information, but it is not easy or cost free (all of this takes time, usually from working parents who lose productivity from this process as well as the need to nurse a sick family member or themselves back to health after medical care). Costs will be roughly the same, since they are driven more by the status quo of government and employer corporate sovereignty more than any kind of market for services. Even if HSAs and other consumer-driven initiatives catch on, this will remain the case. In the real world, away from the drawing boards of the CATO institute and similar market-utopian think tanks, consumers are not in much of a position to improve health care or medical coverage.

III. PROBLEMATIC PROFESSIONALISM

Veneration of the private sector (Smith) also supports the traditional prestige of physicians. In a less well-known segment of the Wealth of Nations, Smith argued that professionals entrusted with important social functions, such as doctors (and lawyers, of course) should be well-compensated so that they had adequate incentive to provide thorough and competent care. In addition, although Smith did not specifically make this point, professionals under economic pressure can too often behave in distinctly unprofessional or sub-professional ways. The current system has managed to put such pressure on medical providers, particularly doctors, but at the same time has not provided universal care or adequate supervision of professional error.

Doctors are perhaps no longer placed on a pedestal or idolized or iconographic in the manner of the 1970s television series Marcus Welby. But they enjoy at least the ordinary prestige and deference accorded successful businesspersons (a legacy of Smith and Wayne) and in addition

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91. See SMITH, supra note 6, at 111.
continued to be venerated for their assistance to patients in time of need. Other professionals (e.g., lawyers, accountants, architects, engineers) can only dream of enjoying the prestige and public good will held by doctors. As a result, the public is resistant to any medical coverage solution that even appears to reduce patient access to doctors of choice or to restrict the physician’s professional discretion.

The problem with this aspect of modern medical insurance mythology is the public does not realize the degree to which doctor discretion and professionalism has already been severely compromised by the private sector and overall economic factors. Although the worst excesses from the era of HMO hegemony (e.g., “drive-by” maternity delivery) have been curbed, private insurers still have a great deal to say about the manner in which most doctors practice medicine.

In addition, even where an insurer is not directly choreographing the physician’s treatment of a patient, other incentives of the current structure give rise to a situation in which we now have what I term “problematic professionalism.” Although most doctors continue to perform acceptably well under adverse circumstances, medical care remains sub-optimal in spite of its costs due to twisted incentive structures.

Although the health care quilt is a mixture of public and private, for-profit insurers and their agents (e.g., claims administrators) have a central role in determining the quantity and quality of care received. Employers, particularly large employers, of course, have some leverage as purchasers of group insurance in that insurers will want to accommodate them for business reasons, particularly if the employer is willing to pay a sufficiently higher premium in return for desired coverage in a group policy. Employers thus play a key role to the extent they negotiate with insurers over the parameters of coverage.

But insurers appear to be the real 800-pound gorillas of this process in that they design the basic menu of standardized medical insurance options, shape the parameters of negotiation, and largely have the final say over the contours of coverage.92 To a large degree in the U.S. the private insurance industry sets the parameters of compensation, treatment with as much practical force as any government (although Medicare as the largest insurer is also important). Although really large employers may

92. Once again, I differ with Hyman, who contends that Medicare is the “real” 800-pound gorilla in the health care jungle. See Hyman, supra note 63, at 1166 (“Medicare is the 800 pound gorilla of American health policy.”). But see Hunter, , supra note 75 (employers and insurers in tandem are figurative king of health care beast).
self-fund their insurance program by collecting funds that in theory will be adequate for the number of predicted claims, they also typically delegate policy and claims administration to an MGA or TPA that effectively operates as an insurer. Employers also typically purchase stop-loss insurance from a private carrier as well in order to spread the risk assumed by self-funding.

When the metaphorical dust settles, the insurance industry in effect operates as a private administrative agency regulating medical insurance coverage and delivery of medical services. Doctors can avoid this governance by insurance only if they are willing to forgo accepting patients' insurance or membership in an insurer HMO or network of preferred providers. And once participating in a PPO or HMO, the doctor must do it the insurer's way in order to remain in good standing and in order for services to the patient to be covered. The law to some extent gives insurers a further leg up by exempting them from antitrust law (subject to some limitations) per the McCarran-Ferguson Act while doctors remain subject to antitrust law and are forbidden from concerted action in restraint of trade.

Doctors are now more than ever acting as small (or in the case of some large practice groups medium) sized businessmen, placing greater emphasis on cost control, customer volume, marketing, and reduction of costs in delivering services. This can adversely affect the quality of care simply


because of the undue pressure to see many patients as fast as possible in a typical business day in order to obtain sufficient revenues to earn desired income.95

patient's right to safety, TRIAL, Oct. 2006, 38 (Hospitals have been slow to adopt measures that would prevent medical errors that injure patients.


95. See JEROME GROOPMAN, HOW DOCTORS THINK 97 (2007) (describing financial and insurance incentives pushing physicians in direction of spending inadequate time with patients learning of their symptoms and case history); Uwe E. Reinhardt, Economists' Model, supra note 3; Peter Salgo, The Doctor Will See You for Exactly Seven Minutes, Peter Salgo, The Doctor Will See You for Exactly Seven Minutes, N.Y. TIMES, Mar. 22, 2006.

According to Salgo, a professor at Columbia University's College of Physicians and Surgeons, the new assembly line approach to seeing patients is closely linked to pressure from insurers, business consultants, and particularly HMOs, to which he attributes the formal requirements that doctors have no more than a seven-minute "encounter" with patients rather than a more flexible, open-ended interview that is likely to reveal more about the patient's condition.

This apparently kept shareholders happy. But it reduced the doctor-patient relationship to a financial concept in a business school term paper.

Doctors know you cannot provide compassion in seven-minute aliquots. But we have felt powerless to change things. The medical establishment has, many of us feel, simply rolled over and gone along to get along. It has sacrificed patients' best interests on the altar of financial return.

See Salgo, supra. Accord, Reinhardt, Economist's Model, supra note 3, at 463 ("group medical practices may tie the distribution of income to their members closely to each physician's 'productivity' and then unabashedly define productivity in terms of neither clinical outcomes nor patients' satisfaction, but strictly in terms of the gross revenue the physician brought into the clinic.")(footnote omitted); Carl Elliott, The Drug Pushers, ATLANTIC MONTHLY, April 2006, 82 ("As American turns its health-care system over to the market, pharmaceutical reps are wielding more and more influence - and the line between them and doctors is beginning to blur\)(italics in original); Vanessa Fuhrmans, Doctors Assail UnitedHealth's Threat of Fines: Sanctions would be imposed on physicians sending patients to out-of-network labs for tests, WALL ST. J., April 10, 2007; Theresa Agovino, Doctors Suspect Insurers' Rankings Measure Cost, Not Quality, INS. J., Feb. 9, 2007, available at www.insurancejournal.com/news/national/2007/02/09/76830.htm; David
According to one widely taught business model, a physician who sees patients as part of her practice (as contrasted to a medical group providing only procedures) should spend no more than seven minutes with each patient. As Jerome Groopman has powerfully demonstrated, truncated time with patients contributes significantly to diagnostic error, especially if the patient’s problems are atypical or complex. Without taking sufficient time to learn about the patient’s malady, the doctor has an insufficient data base for applying her exercise of professional judgment, even if one assumes that some subset of seven minutes gives the doctor sufficient time to reflect adequately and reach a considered personal opinion.96


However, to some extent, Salgo’s proposed realistic solution to the problem of assembly line medicine involves a reasonable dose of the consumer-driven, market competition efficiency championed by Hyman. See id. (“solution to the problem” is “in the hands of our patients” who should “adopt a business mind-set when shopping for health care” and refuse to patronize brusque, patient-unfriendly physicians).

The problem, of course, is that it is increasingly hard to find these types of Marcus Welby-style doctors with room to take on additional patients. The seven-minute, assembly line doctor increasingly dominates the provider landscape and will continue to do so until the medical insurance and payment system provides better incentives for better quality care, including spending adequate time with patients.

This sort of medical consumerism is perfectly consistent with my preferences as outlined in this article. What separates Hyman and me to a large degree is that Hyman seems to me to convey the impression that insured patients are morally hazardous louts who over-consume medical care without acting as a check on cost or quality while I contend that natural patient desires for good care and experiences with the physician will allow some consumer policing of medicine – if the patients have the ability to pay. Without it, patients either skip care altogether, go to the cheapest doctor or the one with the most lenient collection agency, or rely on inefficient emergency room care for what should be office visits. See Bobinski, supra note 13, noting that Canadians on whole are much more likely to get concededly necessary medical care than Americans); Edit., Emergency Room Delays, N.Y. TIMES, Jan. 19, 2008 (attributing much of delay to demands placed by uninsured patients).

96. See GROOPMAN, supra note 95, at 268. The problem is hardly confined to private insurance providers. See, e.g., Alex Berenson, Cancer Drug Representatives Spelled Out the Way to Profit, N.Y. TIMES, June 12, 2007; Dan Stockman, State service’s Medicaid bills squeeze doctors, Ft. WAYNE JOUR.-GAZETTE, Sept. 10, 2006 (describing doctor’s receipt of $260,000 bill from government because “his pool of Medicaid patients costs too much money”). In the “haste makes waste” department, see also Shirley S. Wang, Institute Cites Medication Errors, Suggests Changes to Cut Injuries, WALL ST. J., July 21, 2006.
The cost-reduction programs for actual delivery of medical care and the higher office overhead (it takes more office staff to process required paperwork and haggle with insurers) prompted by insurers pushes against traditional professional excellence and tends to undermine the quality of medical care. In a sense, the insurance industry and government programs like Medicare, Medicaid, and the VA are no different. The question then becomes which type of entity will provide a better brand of coverage and medical care regulation when measured along the multiple dimensions of quality of care, amount of care, and cost.

Assessment of the quality-of-care dimension strongly suggests that private insurers, driven by profit motive as well as legitimate cost concerns, has to a large degree made medicine less of a profession and more of an assembly-line style business. The product dispensed is health care, but the mass produced health care of a medical Wal-Mart more than Marcus Welby.

On one level, this may be a positive development for a large category of consumers with routine medical problems that require only basic solutions. The Marcus Welby method (which included house calls) made for heart-warming (if occasionally corny) television but it wasn’t very efficient. Some cost-benefit sharpening of service delivery under the traditional model is a positive development. On another level, however, the assembly line commodification and economy of scale in much current medical practice is undesirable in that it weakens the accuracy and depth of diagnosis. It can have particularly serious adverse consequences where medical problems are less typical or readily apparent and require greater professional involvement by the doctor.

Even for not particularly esoteric patient problems, the quality of medical care in this brave new world of medicine-as-a-business seems suspect. As recounted above in my simple brush with infection, IV antibiotics, and cyst drainage, the economic pressure placed on the medical care system by the current medical coverage system appears to produce suboptimal results, even if one credits the system with some significant restraint on costs. In my relatively unremarkable case, the supposedly wonderful system of private sector medical care and insurance produced primary physicians who don’t go to hospitals or otherwise follow through with patient care and disengaged, ill-informed, hospitalists who provided no continuity of care but who appeared to be protecting the economic self-interest of hospitals at the expense of the patient. It also produced long waits and needlessly protracted hospitalization; excessive testing to "churn" my medical insurance portfolio to the benefit of hospitals and
providers; and exorbitant requests for compensation by doctors with limited diagnostic skill as well as inadequate motivation.\footnote{97}

In general, much of modern medical care appears organized around the needs of insurers and medical providers rather than the patient. In addition to long waits, there are the "banker's hours" of many physicians and practices as well as poor response to patients unfortunate enough to be stricken on evenings and weekends. Outside of the walls of a hospital, medical service providers appear fragmented and scattered almost as if intentionally attempting to test the patience of patients. In few medical practices can the patient be seen by the doctor and take common required lab tests that are part of shared medical records. The economics of the current system militate against it. As a result, patients requiring relatively simple things such as blood work, urine samples, x-rays, a CT scan, an MRI, or more intrusive scoping, can almost never get this done under the same roof (and certainly not on the same day or even a reasonably compressed time frame.

The net result is to require patients, most of who must miss work for medical care, to spent substantial hours crisscrossing metropolitan (or worse yet, larger rural) areas for hours or days on end in order to get a basic diagnosis, which then requires the patient to again relocate and queue in line for any procedures required to attack a medical problem.\footnote{98} Add to this substantial repetitive paperwork and at least some jousting with medical insurers, all against a backdrop of legitimate quality concerns, and there is more than a little worth criticizing in the status quo.\footnote{99}

\footnote{97. See supra notes 84-88.}
\footnote{98. See Hyman & Silver, supra note 61, at 959 (labeling situation "deplorable"). See also Regina E. Herzlinger, Market-Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry 20-33, 250-51 (1997). The inconvenience of obtaining care of course pales in comparison to the problems and lost productivity that occurs when people are uninsured or lack adequate coverage. See generally Melissa B. Jacoby, The Debtor-Patient Revisited, 51 St. Louis L.J. 307 (2007) (collecting data regarding lost productivity and value resulting from illness, injury, and medical treatment).}
\footnote{99. There also appears generally to be inadequate regulation of physicians. It appears, for example, that a disturbingly large number of doctors relocate their practices to new states simply to stay a step ahead of regulators in their former state of licensing. Some doctors are essentially on the lam from one state to another because of past problems in the prior state. For years, state medical boards have embarrassed themselves by failing to stop this sort of opportunistic pulling up of stakes and failed to required adequate disclosure of a doctor's past problems. In one relatively recent and notorious case, a doctor with a checkered past who had relocated to Colorado committed egregious malpractice and seriously injured a boy. In outraged response, the state legislature enacted a law requiring}
The economics of the current system appears to have undermined or even imperiled professionalism by encouraging an assembly-line like commodification of medicine and medical procedures. For receipt of diagnostic testing, lab work, and corrective procedures, including surgery, the problems appear primarily to be the inefficiency of delay and questions of competence by the service providers (who may puncture an organ, amputate the wrong appendage, etc.). For delivery of physician consultation, the effect is arguably more pernicious in that it robs diagnosticians of a precious tool — information — because primary care physicians, internists and other specialists often are unwilling or unable to listen effectively long enough due to the pressure of their business models and income goals.\(^\text{100}\)

Ironically, the financial pressure on doctors and their perceived need to ramp up the quantity of care delivered to make up for reduced insurer payments was arguably supported by the inventor of the invisible hand. Smith wanted professionals to be adequately paid and to have decent working conditions that would permit the professional to acquire necessary skill and breathing space for good judgment focused on the instant patient or client. He saw this as a necessary price to pay to obtain adequate professional services.\(^\text{101}\) But misapplication of Smith’s primary faith in markets, coupled with the perhaps pathological ways in which the U.S. has deviated from a market model without replacing it with a comprehensive government model, has produced a status quo Smith would have abhorred: medical professionals who so scurry to earn what they consider an adequate income that they devote insufficient time to many patients, thereby truncating the information they receive, rushing to judgment that is often erroneous. As a result, diagnostic error is much higher than it should be. The correct diagnosis may not come until the patient has endured considerable pain and inconvenience at substantial cost and, in some cases, may not come at all or only after the patient’s demise.

disclosure of such past events to prospective and current patients. Good doctors should embrace this type of regulation because it would be both good marketing and diminish the business of problematic doctors. It appears that only 17 percent of physicians ever are sued for malpractice and that a relatively small group of doctors create the bulk medical malpractice claims. As the saying goes, five percent of the people create 90 percent of the problems But if the regulatory system does not adequately intervene, these five percent can wreak havoc for years or even decades.

100. See GROOPMAN, \textit{supra} note 95, at 226-231.

101. See SMITH, \textit{Wealth of Nations}, \textit{supra} note 6, at 111.
Alternatively, it would seem much better to operate a system that was not so dependent on squeezing doctor income that it produced adverse collateral impact. One would expect a rational health care system to make it sufficiently attractive for a high quality treating physician to be sufficiently compensated for each interaction with a patient to spend adequate time with the patient.

IV. THE LIMITS OF CONSUMERISM AS A HEALTH CARE POLICY AND THE INEXORABLE CASE FOR COMPREHENSIVE PUBLIC MEDICAL INSURANCE

By now, it is obvious that more of my sympathies lie with the social justice and professionalism paradigms more than market and consumer choice models. Consequently, my sympathies lie more with Jost and Mariner, even though I am concerned that even their informative writings use what I have come to regard as the subtle but misleading nomenclature of personal responsibility and actuarial fairness. Notwithstanding these quibbles, Jost’s piece persuasively highlights a major problem with HSAs and the larger consumer-driven movement. Even if it works for many, the primary beneficiaries are the largely healthy and wealthy, who hardly need the tax subsidy/shelter provided by HSAs. Beyond this, the consumer-driven health movement works against the communitarian norm and makes a universally effective medical coverage program harder to obtain. Mariner, in addition, to also noting the limitations of the consumer-driven health care initiative, presents the important insight that even something as seemingly uncontroversial as “wellness” programs can contribute to the undesirable erosion of community solidarity and social justice in medical care and coverage.

Hyman, although as usual raising many excellent points regarding the operation of government programs, remains too enamored of the market as a cure-all. This is too unrealistically sanguine a view, even for a Smithite, in light of the muddled, path-dependent history of American health policy. Establishment of true market hegemony is both practically feasible and undesirable in light of the core necessity of medical care, even for the comparatively impoverished, unwise, and irresponsible. Playing John Wayne to the more Martin Luther King-like postures of Jost and Mariner, Hyman also continues to give short shrift to the professionalism wing of Adam Smith’s writing in that Hyman, although deferring to medical expertise over consumer preference on some matters (e.g., drive-by deliveries), often paints a picture of medical providers as greedy opportunists who would have been at home in the Enron boardroom. My
own view toward providers, particularly physicians, is more charitable, although Hyman’s warnings in this regard cannot be totally ignored.

Ultimately, however, Hyman fails to persuade because his proposed solution to health care issues favors an impractical return to the pre-World War II yesteryear of the allegedly pure market-based medical care that supposedly once existed, accompanied by a presumed shrewd consumer participation in the market which will, according to Hyman, lower medical costs and enable patients to receive affordable medical care most pertinent to their needs. One might as readily believe that the tooth fairy will be coming to everyone’s neighborhood soon.

First, it is too late to turn back the clock. Better to look forward rather than back and move from oligarchic medical insurance to true universal government-funded care. Second, Hyman presumes an infallibly

102. Nor can it be ignored that much of Hyman’s scholarship urges increased quality-enhancement efforts directed toward improving the performance of medical professionals. See, e.g., Hyman & Silver, supra note 61 at 958-59. In this quest, he sees a more effective role for consumer than I think is realistic while I support more stringent government efforts in this regard that will not be diluted by the economic incentives of private medical insurers.

103. This increasingly seems to be the position of many commentators. See, e.g., KRUGMAN, supra note 18, at 237-43 (proposing that Medicare be expanded to cover entire population); Peter D. Jacobson & Rebecca L. Braun, Let 1000 Flowers Wilt: The Futility of State-Level Health Care Reform, 55 KAN. L. REV. 1173 (2007); Maxwell J. Mehlman, "Medicover": A Proposal for National Health Insurance, 17 HEALTH MATRIX 1 (2007) (essentially suggesting expansion of Medicare, "[t]he most efficient administrative system for health insurance" based on October 2006 conference of health law experts); Artur Davis, The Health Care We Owe Each Other: Universal Care as the 21st Century Social Compact, 37 CUMB. L. REV. 425 (2006); John A. Nyman, The Efficiency of Equity, 37 CUMB. L. REV. 461 (2006); David U. Himmelstein & Steffie Woolhandler, A National Health Program for the United States: A Physician’s Proposal, 320 NEW ENG. J. MED. 102 (1989) (proposing comprehensive national health care system); Annette Fuentes, What’s wrong with nationalized health care?, USA TODAY, Sept. 19, 2007, available at http://blogs.usatoday.com/oped/2007/09/what-wrong-wit.html (supporting single-payer system); Milt Freudenheim, Mayo Clinic Proposing A Universal Health Plan, N.Y. TIMES, Sept. 15, 2007, C4, col. 4 ("But Mayo, in a proposal hammered out over 18 months by a panel of more than 400 health policy experts, is not advocating a government-run single-payer system. Instead, it suggested that private insurance companies be required to offer standard plans with many options, like the Federal Employees Health Benefit Plan available to government workers. Applicants for this insurance could not be turned down ... Lower-income people would get government help on a sliding scale.") Ironically, Mayo Clinic co-founder Charles Mayo, then president of the AMA, had during the early 20th Century warned doctors to be wary of universal health insurance out of fear it would not only reduce physician incomes but undermine professional judgment and the doctor-patient relationship. See Cynthia Crossen, Before WWI Began, Universal Health Care Seemed a Sure Thing, WALL ST. J., April 30, 2007; Robert H. Frank, A Health Care Plan So Simple, Even Stephen Colbert Couldn’t Simplify It, N.Y. TIMES, Feb. 15, 2007, C3, col. 1 (noting that “American
shrewd, disciplined consumer that never was and never will be, at least where medical and insurance purchases are concerned.\textsuperscript{104} Third, as discussed above, Hyman's perspective, however wonderful it may sound in theory, fails to square with the practical realities of consumer ignorance, bounded rationality, heuristic error, reduced choice, lack of time for investigation, and general lack of meaningful ability to comparison shop for medical insurance coverage. In addition to the practical limitations on lay patients, the dominance of group medical plans alone dramatically distorts whatever chance might otherwise exist to tame medical costs and excessive use of services through empowered consumerism.

Realistic assessment of the lay citizenry should appreciate that people are on average normally not sufficiently rational, informed, or disciplined to be able make the type of consistently intelligent medical treatment decisions upon which the consumer-driven model depends if it is to be anything other than a government-subsidized tax break for the rich. Perhaps more important, nearly half of medical care already is subject to government funding and substantial regulation. A move toward a more market based, consumer-driven system would at best produce a hybrid that continues the inefficiencies of the status quo without much countervailing efficiency advantage and a redistributive trend toward the already well-off.

All this leads me to the inexorable conclusion that the optimal practical means to serve both community solidarity and true consumer choice is to expand Medicare and make it the mandatory medical insurance coverage for all Americans. This will, according to Hyman, bring cackles of delight in Hades as another American jumps on his posited road to hell paved with
good intentions\textsuperscript{105} by giving even more power to the Medicare juggernaut. I disagree, in part for reasons stemming from Hyman’s own critique of Medicare, which he describes as a “Ponzi” scheme dependent on the attraction of new participants (a/k/a “marks” in Hyman’s view) to finance the benefits of those who entered the Ponzi period at an earlier juncture.

Hyman is correct to point out that Medicare in its current form is too dependent on the young and healthy subsidizing older persons more demanding of (and in need of) medical care. As his devilish alter ego put it:

As you [Mephistopheles] correctly perceived many years ago, allowing everyone into Medicare would immediately bankrupt the program because the cross-subsidies that sustain Medicare are only achievable if there are sufficient marks \emph{outside} the program to pay the necessary funds \emph{into} the program. Program beneficiaries understand this point perfectly well. The demise of the [proposed 1993] Clinton plan was inevitable once it became clear that the plan would “take” from the elderly and “give” to the uninsured. We are far better off delaying the day of reckoning by a few years and allowing the gluttony of Medicare beneficiaries and the passage of time to increase the number of unsustainable commitments . . 

\textsuperscript{106}

This portion of Hyman’s critique resonates, but does so in favor of making the move toward expanded Medicare sooner rather than later. To be sure, moving from a system designed to protect the elderly, and which as to some extent becomes afflicted with excessive interest group politics,\textsuperscript{107} to one covering a larger, more diverse population with differing

\textsuperscript{105}. Although considerably less extreme, Hyman in a sense is an intellectual heir of Friedrich Hayek, a libertarian who embraced individualism so strongly that he and his followers not only inveighed against the very real evils of communism and other forms of totalitarianism but also opposed even the sort of “soft socialism” that can provide the infrastructure necessary for civilized progress. \textit{See, e.g.}, \textsc{Friedrich Hayek, The Road to Serfdom} (1944). This also arguably makes Hyman heir to the considerably less intellectual John Wayne legacy.

\textsuperscript{106}. \textit{See} Hyman, \textit{Mephistopheles, supra} note 63, 60 \textsc{Wash. \\& Lee L. Rev.} at 1185-86 (emphasis in original; footnotes omitted).

\textsuperscript{107}. As Hyman correctly points out, the adverse reaction of so-called “greedy geezers” (my and the media’s term, not Hyman’s) to the Medicare Catastrophic Coverage Act of 1988, which merely required Medicare beneficiaries to pay some of the cost of
incidence of medical needs will require some recalibration of benefits offered, prices paid, and funds collected (through tax, premiums, co-pays, and deductibles). But the experience of other nations strongly suggests that this can be effectively done in a manner that will eventually result in overall improvement of care at lower cost.

"[C]ritics of the single-payer plan have long railed against the specter of socialized medicine, suggesting that it means being treated by government functionaries" the "people who have experienced single-payer coverage firsthand seem unconcerned." As Cornell economist Robert Frank relates: "When one of my sons needed surgery for a broken arm during a sabbatical in Paris, for example, the medical system we encountered was just as professional as the American one and far less bureaucratic." My own experience with my son's attack of bronchitis in Germany was similar. Seeing a doctor and filling the required prescription was faster, easier, and cheaper than had the same adverse medical event occurred in the United States – and my son was of course not even part of the German citizenry for whose benefit the plan was designed. At some

expanded coverage, and the political cowardice of Congress in repealing the act in the face of these tantrums, illustrates a problem with having government in the insurance business. See supra note 62. But there is no iron law that Medicare must be under-funded or poorly administered. More to the point: the occasional electoral pathologies of Medicare seem to me no worse than the chronic problems besetting system using private insurance. See, e.g., supra notes 4, 13, 18, supra (discussing high relative cost of U.S. medical care system); Mary Crossley, Discrimination Against the Unhealthy in Health Insurance, 54 Kan. L. Rev. 73, 152 (2005) ("[P]eople with health problems increasingly are forced to shoulder the load of their own medical costs. The trend toward consumerism in health coverage shifts not simply costs, but also insurance risk, to individual insureds, and the results may be particularly dire for people in poor health."); Nan D. Hunter, Managed Process, Due Care: Structures of Accountability in Health Care, 6 Yale J. Health, Pol'y, L. & Ethics 93, 145 (2006) (discussing problems associated with current system's private adjudicative mechanisms for determination of necessity of care); George A. Nation III, Obscene Contracts: The Doctrine of Unconscionability and Hospital Billing of the Uninsured, 94 Ky. L.J. 101, 112 (2005) (noting degree to which current system warps pricing, resulting in posted retail price inflicted upon uninsured as contrasted to discounted price charged to insured patients).

108. See Frank, supra note 103, at C3, col. 1.

109. Id. at col. 5 "And [as Frank emphasizes for the slow to grasp] in France, which spends half as much on health care as the United States and has more doctors and hospital beds per capita, everyone is covered." Id.

110. I realize that Germany has a system someone different than the arguably "purer" government single payer systems of France and Canada in that private insurance plays more of a role in Germany. But for purposes of this comment, I do not believe it unfair to lump Germany with what I call "single-payer" countries (because of national government commitment to and administration of medical insurance), to whom they are far closer
point, all the ideology and theorizing in the world must yield to the hard empirical facts suggesting that medical care in Western Europe and Canada appears to be both cheaper and superior on the whole that that of the United States.\(^{111}\)

Rather than attempting to demonize (in Hyman’s case, quite literally) government insurance plans as spendthrift bureaucracies, we would be better off appreciating them as aspects of national infrastructure akin to roads, police and fire protection, and national defense.\(^{112}\) A comprehensive medical care program for all (which realistically can only be achieved through the government-run, single-payer approach), like these other


112. Of course, the current American government treatment of these infrastructure issues is not particularly encouraging. See Free Hiatt, She Brakes for Ideology, WASH. POST, Jan. 23, 2008, A15, available at http://www.washingtonpost.com/wp-dyn/content/article/2008/01/20/AR2008012002275.html (“[T]raffic congestion already is costing the U.S. economy as much as $200 billion a year.”).

My primary point, however, is that there is no doubt that inadequate infrastructure imposes costs on society. We do not enjoy net savings simply because we spend less (and do less) regarding roads, bridges, policemen, fireman, soldiers – or health insurance.

Further, many of the current government’s failures concerning the transportation infrastructure stem not from institutional incompetence but from ideology-based resistance that recently has trumped sound policy analysis. See Hiatt, supra ([According to the Bush Administration, the “main reason you are sitting in traffic ... is not that the purchasing power of Highway Trust Fund revenue has been dwindling for the past decade, not that population and freight traffic have been soaring with no government response – but that you are not being asked to pay enough to use the road you are on.”]) Hiatt also notes that the Bush Administration rejected a bipartisan federal commission’s “comprehensive, balanced plan for the next 50 years, calling for maintenance and construction, road and rail, public and private roads.” Id. (emphasis in original).
infrastructure programs, provides a platform for greater national productivity as well as social justice and a chance for medical professionals to practice their craft under a set of incentives more supportive of quality care. Only some small increment of faux individualism is lost.

American attitudes toward health care and medical insurance continue to be unduly dominated by accidents of history and the mythological power of the nation’s archetypes. The rugged individualism embodied in John Wayne, and the market efficiency associated with Adam Smith are today’s dominant archetypes. Although each embodies characteristics that are desirable in general (who can, as a general proposition, be against individualism, personal responsibility, ambition, free markets and greater

113. See, e.g., Jennifer Robison, Staffs May Shrink: Plurality of companies say they’ll thin ranks as costs for health insurance rise, LAS VEGAS REV.-J., Jan. 21, 2008, available at http://www.lvrj.com/business/13942712.html. For example, employers freed of the burden of being the nation’s front line source of medical coverage would also be freed of the need to make personnel and payment decisions based on consideration of the cost of group medical care.

114. See Furrow, supra note 14, at 417 (“[T]he moral argument of social solidarity with our fellows, so eloquently put by Timothy Jost in his comparative work on European systems, pulls in tandem with the conservative argument that more health care is better for the economy.”) (citing TIMOTHY S. JOST, DISENTITLEMENT?: THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE (Oxford University Press 2003)).

115. In Wealth of Nations, Adam Smith made a similar defense of public works spending as a useful investment to assist the market economy in reaching its full potential. See SMITH, supra note 6, at 473-85. Thus, there was an “infrastructure” Smith as well as a professionalism Smith and a market Smith. Although the pro-market, “invisible hand” Smith is most prominent in his writing, the American adaptation of Smith has tended to completely ignore Smith’s support of professionalism and infrastructure.

Some see this and the overwhelming American aversion to self-consciously adopting a government single-payer system as a product of interest group conspiracy. See, e.g., MICHAEL TOWNES WATSON, AMERICA’S TUNNEL VISION: HOW INSURANCE COMPANIES’ PROPAGANDA IS CORRUPTING MEDICINE & LAW 276 (Horatio Press 2006). Although the lobbying and public relations campaigns of insurers, drug companies, medical providers, and other interest groups have undoubtedly all contributed to fostering the “market-uber-alles” ethos of the U.S., my own view is that it is largely the organic product of the historical evolution of American self-identity.

America celebrates markets, personal wealth, and rugged individualism like no other country in the world. By contrast, Canadian culture gives proportionately greater celebration to collective national enterprise, such as the building of the Trans-Canadian railroad. In Canada, the thousands of workers get credit. In the U.S., the CEO of the railroad company would likely be the hero of the story. This difference in national psyche goes a long way toward explaining the different national systems of medical care and insurance.
economic wealth?), slavish, blind, and inflexible devotion to these idealized concepts has produced an unwillingness to face basic operational and empirical facts about the optimal means for maximizing access to health care and medical coverage for the citizenry.116

Without doubt, a government-administered public insurance plan is the optimal route. Whatever theoretical uncertainty may exist in thought experiments or political debate is belied by the empirical evidence. Canada, Great Britain, France, Italy, Scandinavia and Germany all spent about half as much per capita on health care as the U.S. and have healthier, longer-lived populations. Of these countries, only Germany has anything looking in any way similar to the public-private partnerships urged by the most liberal of American politicians. The others are all government-run single payer systems of medical insurance. England actually runs the medical side as well as the insurance side and has what might accurately be termed socialized medicine in which the doctors work for the government. Most important, Medicare has operated successfully as a single-payer form of public insurance for 40 years. Its imperfections can be improved upon and its reach extended.

116. See Stone, supra note 53, at 486-87. Deborah Stone’s assessment of the excesses of this ethos is even more condemning:

The consumer choice approach to social policy represents a cynical turn in American public philosophy. . . . More often than not, “consumer choice” and “consumer direction” are glittery wrappings in which employers, insurers, and politicians package benefit reductions, program contractions, and budget cuts.

Giving people a budget that is too small for their needs does not give them the experience of freedom. Instead, they experience every decision not as free choice but as a terrible trade-off.

*   *   *

Consumer choice theory is thus an ideology. It is a way of seeing the world, and particularly a way of interpreting social justice. It is a philosophy that minimizes communal obligations to citizens, maximizes individually responsibility for one’s own well-being, and tolerates great inequalities in well-being as morally acceptable. It replaces a social commitment to meeting needs with commitment to meeting budgets. It uses the rhetoric of “freedom” and “autonomy” to justify the abdication of social responsibility and the failure to provide appropriate and compassionate care.

See Stone, False Promise, supra note 53, at 486-87. See also Stone, Beyond Moral Hazard, supra note 48.
The actual operation of health care and insurance in the real world demonstrates that the single payer system and close equivalents are simply more efficacious than the American status quo and so-called “consumer-driven” alternatives. It no longer makes sense to shy away from this approach simply because of the aura associated with Wayne and the market side of Smith’s persona. After too long a period of the dominance of these images, the time has come to reassert the professionalism side of Smith and, more important, the social justice and community solidarity values embodied in Martin Luther King’s legacy.

CONCLUSION

To be sure, a government can administer a medical coverage system badly. But it is equally true that a government-run system can be efficient, probably at least as efficient as the current insurer-dominated, employer-dominated system. Greater progress will be made when policymakers focus on the factors that make for effective government operation of insurance coverage and free themselves from the tyranny of legal fictions and mythology about the infallibility of markets, personal fault, consumer omniscience, medical provider behavior, and private insurer efficacy.